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The Interaction Between Nurses and Patients' Relatives

Submitted by

Ruth Hawker

to the University of Exeter

as a thesis for the Degree of

Doctor of Philosophy

in the Faculty of Social Studies

May 1982

I certify that all material in this thesis which is not my own work has been identified and that no material is included for which a degree has previously been conferred upon me.

R. Hawker.

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CHAPTER 1

INTRODUCTION

During the course of a span of duty the nurse in hospital has to relate to a number of different people including other occupational groups, other nurses, patients and patients' relatives. The present study has been designed to examine one of these role-relationships, that between the nurse and the patients' relatives.

Nurses, more than any other occupational group within the hospital organisation interact with patients' relatives as part of their professional activity. One contemporary definition of nursing refers specifically to this aspect of nursing practice:

> "Nursing is an interpersonal process whereby the professional nurse practitioner assists an individual, family or community to prevent or cope with the experience of illness and suffering and, if necessary, to find meaning in these experiences."
>
> (Travelbee 1966 p. 6)

Many definitions of nursing practice itself also refer to the nurse's role vis-a-vis the patients' relatives. Reiter and Kakosh (1963) for example, point out that nursing practice as an activity takes place:

> "either through service given directly, or through instruction given to the patient and his family, or through co-ordination of services given to the patient and his family during the period of nursing care."
>
> (p. 7)

However, this is an aspect of nursing which has received little attention from either nurse researchers or others engaged in research in the past, although much attention has been given to its importance by both the 'prescribers' of 'good' nursing care, and also by different 'consumer protection' agencies.

The 'prescribers' of 'good' nursing care have focussed on two different notions, that of 'understanding' and that of 'communication'.

> "For the nurse, an understanding of the attitudes and beliefs of patients, (or of others in the ward such as doctors, sisters, nurses and visitors) is critical to adequate performance."
>
> (Congalton, 1977 p. 81)

> "The ability to communicate with patients and their relatives is fundamental to the practice of nursing: it applies to all levels and in all parts of the service."
>
> (Friend, 1977 p. 1)

In spite of such 'prescriptions' the Annual Report of the Health Services Commissioner (1978-79) pointed out that 57% of all complaints made against nursing and medical staff which were found by him to be justified were due to 'lack of information' given to, or 'wrong attitudes' shown to 'patients or their relatives'. This latter finding suggests that there may be some difficulty experienced by practitioners in delivering the 'prescribed' care.

Although this aspect of nursing practice has not received much attention from researchers in the past it has been recognised by a number of nurses and sociologists as an area worthy of further investigation. Macleod-Clarke and Hockey (1975), after noting that communication was central to the practice of nursing, pointed out that in order to increase knowledge and understanding of nursing, research should be carried out into all aspects of communication, including "the interaction between the nurse and the patient's relatives" (p. 92). It has also been suggested that an examination of the way in which nurses interact with different groups of personnel and of the setting in which such exchanges take place would be a valuable contribution to a 'sociology of nursing', from which it would be possible to establish the consequences for nursing

practice (Dingwall 1974). In addition it has also been indicated that such a study could lead to an increased understanding of the social organisation of health care (Stacey and Homans, 1978).

In some areas of health care the recognition that illness affects the whole family is now well established. The psychiatrist in 'The Cocktail Party' (T.S. Eliot, 1950) summarises the present situation in the psychiatric field:

> "... it is often the case that my patients
> Are only pieces of a total situation
> Which I have to explore. The single patient
> Who is ill by himself, is rather the exception."
>
> (p. 114-115)

The present study has been designed to examine the interaction which takes place between nurses and patients' relatives in a general hospital in which less importance is placed on the family as the social unit of illness than in the psychiatric hospital, but in which certain changes concerning the role of the family in illness are also taking place.

It would appear that talking to patients' relatives and identifying their needs which arise as a result of the patient's illness was of little significance in nursing practice in the general hospital until after the Second World War. Since the mid-1940's a number of changes, both environmental and intraorganisational, (which will be fully documented in the text) appear to have altered the structure of the relationship between these two groups. There are also indications that changes in the relationship are still taking place. It is important therefore to place this study accurately in historical time, and in the context of the development of nursing as a profession, that is 1979-1980.

Before briefly describing the way in which this thesis is presented some consideration should be given to the terms 'nurse' and 'relative' as used in this study. Throughout the text the term 'nurse' is used to indicate any person carrying out nursing activity from the nursing auxiliary up to and including the nursing officer.[1] In order to preserve anonymity wherever it is necessary to quote comments made by a 'nurse' a distinction is made between the qualified and the unqualified nurse, and a further distinction is also made among qualified nurses between the State Registered Nurse (SRN) and the State Enrolled Nurse (SEN).[2]

The term 'relative' is much more difficult to define for none of the accepted sociological definitions concerning either a relationship due to consanguinity or due to marriage appeared to be appropriate for this study. After much consideration it was decided to use the term in a way which would be immediately recognised by the nurse, the patient and the relatives themselves, and that the group of 'relatives' studied would be those persons who appeared to have an emotional interest in the patient's wellbeing and recovery. In practice this meant that if two persons were in some way emotionally attached to each other, although not bound by blood or marriage, and if they were recognised by all three groups, patient, nurse and 'relative' to be 'related' in this way, they were included in the study.

Two main aims were formulated for the study. These were firstly, to determine the content of the interaction between nurses and patients' relatives in a general hospital and to relate the expectations and perceptions of these two groups to their verbal interaction. Secondly, to develop a grounded substantive theory which would account for the

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1. It is, however, recognised that only qualified nurses are legally entitled to be called 'nurse'.

2. A State Registered Nurse trains for three years and is qualified for further promotion. A State Enrolled Nurse trains for two years and continues to work under the supervision of an SRN.

format of the different nurse-relative encounters paying particular attention to nurse and relative roles.

In this way it was hoped that the findings would further our understanding of nursing practice, and the role of the family in illness, as well as contributing to other broader areas of knowledge including face-to-face work, triadic relationships, and the role of the professional in the organisation.

The study was carried out in one hospital group only. It is therefore not necessarily geographically representative of all nurse-relative interaction. However, in defence of the method it can be said that firstly because the forms of encounter observed and described in subsequent chapters occurred, even if only in one locality, they are part of what constitutes the totality of the nurse-relative relationship. Secondly, it has both 'opened up' a previously unexplored area, and developed the tools for further study in other areas. The import of the findings and the quality of the theory derived from them must be assessed in part by the extent to which they are seen to be useful, applicable and comprehensible by those working in similar situations outside the particular hospital studied.

The accounts of the way in which the study was carried out and of the findings are presented in the following way.

The problem to be considered is defined by a review of the literature in Chapter 2. This review directs attention to the available evidence concerning the relationship between nurses and relatives, and also directs attention to other studies which have implications for the present study.

The methodology employed both to collect and to analyse the data

is fully described in Chapter 3. As well as describing the methodology some attention is also paid here to the problems which arose during the course of the study and to their possible implications.

Although the research is presented in the traditional mode employed in social science - that is a short description of the phenomenon to be addressed, followed by the state of knowledge which exists about the phenomenon, and concluding with a description of the researcher's logical construction of the data gathered during the empirical phase of the study - it should be noted that the method of presentation bears no resemblance to the actual process of the researcher's conceptualisation. It has been pointed out that conceptualisation of the research experience rarely occurs in this orderly fashion (Batey 1977), and that in reality it is a back and forth interactive process. This traditional method of presentation has been described as "writing for substance" (Barbera-Stein 1979), and tends to treat aspects of the research experience as irrelevant to the analytical focus of the paper.

Because the social context of the research is not portrayed the reader can be left with the impression that the researcher is "a highly autonomous individual who has controlled the manufacture of a bounded project to the extent that the substantive contentions are warranted adequately" (Barbera-Stein, 1979, p. 3).

In order to counter-balance this impression, the discussion in Chapter 4 focusses on the social context of the research process, in particular the analytical model employed.

The discussion in Chapter 5 focusses on the setting in which the relationship between nurses and patients' relatives takes place, that is the hospital as an organisation. The hospital as an organisation has responded to environmental change, particularly during the last twenty

years, and some attention is given to these changes. Special attention is paid to the changes which have taken place in paediatric wards and also to the way that 'visiting times' have been extended in response to pressure from the consumer.

The 'entry behaviour' of both nurses and relatives is considered in Chapter 6. A detailed description of the tactics used by both groups will be discussed at this point, for these strategies were found to be a particularly significant part of the relationship with implications for nursing practice.

The different forms of encounter which make up the nurse-relative relationship are discussed in subsequent chapters focussing first of all on encounters in which the relative seeks to gather information in Chapter 7. It has already been indicated above that 'lack of information' is a common cause for complaint by relatives as well as by patients. The difficulties that occur in this form of the relationship are considered in some detail at this point.

Other forms of encounter which are discussed concern occasions on which the nurse acts as an announcer, counsellor and teacher. These are considered in Chapters 8, 9 and 10. It will be shown that there are guidelines for the nurse laid down by hospital policy which direct him/her towards the role of 'announcer', but that the roles of teacher and counsellor are self-imposed. The implications of this will be considered, highlighting the particular problems encountered by the nurse carrying out a self-imposed role. In other encounters the relative acts as a surrogate patient and as an agent of the patient. Although these are not major parts of the nurse-relative relationship, they are considered both as part of the whole and also as special encounter forms in their own right in Chapter 11.

After looking at the different encounter forms, some consideration is given to the special situations which occur when nurses interact with the relatives of the dying patient in Chapter 12.

This aspect of the relationship is considered in the context of the work of others, particularly that of Glaser and Strauss (1965, 1967) who have already made a significant contribution to an understanding of the relationship between the nurse, the dying patient and the relatives.

From a consideration of the relationship between the nurse and the relatives of the dying patient the discussion moves in Chapter 13 to a description of the way in which the nurses and relatives are socialised into their respective roles. The preparation of the nurse during training for this role will be reviewed at this point.

The findings of the study are discussed in Chapter 14 highlighting the socio-structural constraints on the relationship. The Chapter ends in a brief discussion of the implications for nursing practice.

CHAPTER 2

THE NURSE-RELATIVE RELATIONSHIP: THE PROBLEM DEFINED

Introduction

Central to this thesis is a discussion concerning the relationship between nurses and patients' relatives. A number of studies have drawn attention to, and helped to clarify certain aspects which may affect this relationship. These studies will be discussed in this chapter.

The concept of 'relationship' is an elusive one, and "notoriously difficult to define" (McIntosh 1977). However, it is possible to identify those relationships which are role-specific (Denzin 1970). The relationship between nurses and patients' relatives is one such relationship. It has also been indicated by Beales (1976) that any social relationship is an on-going process of cognitive construction but that each of the participants may have a different set of criteria by which human relationships are identified. This will affect the participants' choice of behaviours considered to be appropriate to any relationship. Identifying and explaining the rules of conduct which make up the relationship between nurses and patients' relatives is the main task of this study, but in order to begin to understand these rules some account must also be taken of the 'space' in which the relationship takes place.

We shall begin this discussion therefore by an examination of the studies which have drawn attention to the social position of the nurse within the hospital organisation. This will be followed by a review of the studies which have directed our attention to the social position of the relative vis-a-vis the hospital, and also to those studies which,

while not focussing explicitly on the relative, lead to some understanding of the role of 'client'. Finally, the studies which have led to our present understanding of the actual relationship between these two roles will be considered.

I The Social Position of the Nurse within the Hospital

a) The hospital as an organisation

Before focussing on the social position of the nurse, some attention should briefly be given to the hospital as an organisation in which nursing activities concerning the relatives are carried out.

Many studies undertaken during the last few years have helped to illuminate our understanding of the hospital as an organisation, both in this country and in America.[1] The earlier studies focussed on the organisation itself and tended to ignore the environment of which the hospital was a part. These studies took little account of the way in which the environment could shape and influence the ideas and beliefs of the people working within the hospital. This is remedied in later studies and the effect of the environment on the organisation is now better understood.[2] The effects of the environment on the hospital have been described by Wilson (1965):

> "(hospitals) faithfully mirror our attitudes to life and death, illness and health: faithfully reveal in mud and wattle, or bricks and concrete what man believes about himself, how he understands life, suffering and death; and how he responds to illness, whether by curing, banishing, or seeking to probe its causes." (p. 92)

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1. American studies include those by Agyris, C. (1956), Friedson, E. (1963), Rosengren & Lefton (1969). British studies include those by Wilson (1971), Rowbottom (1973) and Green (1974). An excellent account of the development of the British Hospital is found in Abel Smith (1964
2. The literature relating to this notion is reviewed by Aldrich and Pfeffer (1976). The reader's attention is also directed to Thompson, J. (1967), Mott (1972), Karpik (1978) and Lammers & Hickson, (1979) for a full discussion concerning this issue.

But, as previously indicated, the hospital does more than just reflect the environment, it is also constantly reshaped by it.

Although it is necessary to acknowledge the relationship between the environment and the organisation, it has been pointed out that such an acknowledgement can create difficulties for the analyst. Karpik (1978) has drawn attention to this conceptual difficulty by stating that the interplay between the environment and the organisation is both a problem and a reality, "a reality because it concerns reciprocal relations between the internal and the external, and a problem which ill lends itself to analysis." (p. 15).

One of the consequences of the interplay between the environment and the organisation was identified by Jacobs (1979). She pointed out that the characteristics of an individual hospital, which include the physical situation of the hospital in relation to its catchment area, and the 'open-ness' of the hospital system to the world outside, and its staff, can contribute to the creation and maintenance of a distinctive and pre-dominating value system. She also pointed out that within the hospital, stability among the staff can increase the likelihood that a distinctive ideology, once established, would persist, the staff acting as 'culture bearers'. This factor cannot be ignored if an understanding of the social position of the nurse is to be reached.

One further point concerning the interplay between the hospital and the environment should also be made. Not only is the hospital shaped and influenced by the environment, but in turn the hospital itself shapes and influences the environment for:

> "On their return home, patients share their experience of hospital life with their families, neighbours and colleagues. Such experiences mould public opinion."
>
> (Wilson 1975, p. 94)

Finally it should be noted that as well as working within an organisation which is shaped by, and itself influences the environment, the nurse also works within an organisation that is subject to change as a result of the negotiations taking place within it:

> "The hospital may be visualised as a place where numerous agreements are continually being terminated or forgotten, but also as continually being established, renewed, received, revolved and revived."
>
> (Strauss 1963, p. 164)

In this way the social order of the hospital is constantly revised. The "combination of rules, policies, agreements, understandings, facts, contracts and other working arrangements that currently obtain , "is" the hospital at any given time and constitutes its social order."[1] (p. 164)

Most of the nursing activity with which this study is concerned takes place within a ward, but we shall not consider this setting separately from the hospital of which it is an integral part, except to note that all the organisational factors already discussed need to be taken into account in any consideration of this setting.

Having briefly considered the hospital as an organisation, we should now turn our attention to the social position of the nurse within such an organisation.

b) The social position of the nurse within the hierarchy

The social position of the nurse is 'peculiar' in that he/she functions in relation to two formal tiers of authority within the hospital.

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1. The concept of 'negotiated order' has been criticised (Day and Day 1977), and Strauss himself has indicated that it is possible for adherents of this theoretical position to emphasise the co-operative, rather than the co-ercive side of human activity and to over-emphasise the freedom of certain persons or groups to negotiate, thereby overlooking the fact that others operate under possible restraints.

The nurse functions in relation to both 'professional authority' and in relation to the authority of the administration. This complex of bureaucratic and professional authority has clear implications for the nurse who is "caught between two superiors, administrative and medical. The latter is not her bureaucratic senior ... (but) she is subject to the orders of the physician involved ... by virtue of his superior knowledge and responsibility." (Friedson 1970, p. 118).

One further problem has been pointed out by Devine (1978) which makes the social position of the nurse even more complicated. Nursing managers and educators have developed the ideology of the 'professional' nurse, with indispensable knowledge, who also demands autonomous decision making authority. Such an ideology is both conflicting and ambiguous, for as subordinates they are expected to render obedience to their superiors, yet as professionals they are led to believe that they are autonomous:

> "Within the hospital the nurse is often confused as to which authority she owes primary obedience ... (he/she) serves both a medical and administrative authority, yet attempts to function as an autonomous professional resulting in conflicting perspectives." (p. 292)

Susser and Watson (1971) have reported that nurses are much more sensitive to this dual demand than either doctors or administrators because they have to deal with the problem almost daily unlike the other two groups who only occasionally impinge one on the other during their day-to-day work.

c) The nurse-doctor relationship

The social position of the nurse vis-a-vis the doctor is of some importance to the present study and should be examined in more detail. This is a relationship which is not yet fully understood, although a number of studies have highlighted significant features.

Sheahan (1972) has pointed out that some doctors now pay lip service

to the idea that nurses are also professionals and an 'equal' member of the health team, but she has also indicated that underlying the structure of all doctor-nurse relationships is the question of power and "power clearly lies on the physician side of the nurse-doctor relationship". The power of the doctor enables him to define what happens in the clinical situation. Dodd (1974) indicated that the power of the doctor is in the first instance socially conferred and continually re-affirmed by patients seeking care and attention. The symbolic significance of this act gives the doctor his authority. She found that although the doctors in hospital allowed others to share in this symbolic act, "the extent to which other actor groups are included or excluded from the defining process depends exclusively on the interpretation and definition given by the consultant" (p. 614). In this way the nurse is always the agent of the physician in carrying out treatment and patient care.

The nurse's association with the doctor, however, allows him/her to re-affirm her 'professional' status in two ways. In the first instance Friedson (1970) has indicated that although she is the agent of the doctor she is able to bargain firstly with the doctor by utilising her first-hand knowledge of what goes on in the ward, and secondly with the patient, utilising her access to the doctor. This places the nurse in a significant position for while she may serve as a troubled focus of conflicting perspectives, "she may also very well hold the balance of power in determining the outcome of bargaining among patient and staff" (p. 121).

Although nursing care may be said to be subsidiary to medical care it is also complementary to medical care. This duality places the nurse in a controlled intermediary position between the doctor and the patient. In this way Dodd (1974) has indicated that he/she is able to experience the situational rewards of participation and the transitional rewards of social significance.

The intermediary position of the nurse also means that she carries out the doctor's wishes even if he/she may privately disagree with them. McIntosh (1975) found that the nurses in the cancer wards which he studied accepted the doctor's decisions and values without any apparent conflict, while Faulkner (1980) found that although not all the nurses in her study accepted the doctor's decision "in such an wholehearted way" they did in fact abide by such decisions (p. 94).

Sources of conflict in the doctor-nurse relationship have been identified in a number of studies. Stein (1969) found that 92.6% of the nurses in his study of conflicts in nursing stated that there was a problem with regard to communication between the two professions, and that 62% of the nurses reported difficulties concerning the authority of the doctor. Robinson (1972) pointed out that some conflict exists between nurses and physicians in critical care units, and that some doctors expressed sexist attitudes towards nurses. These findings were later confirmed by Weinman (1978). Finally Selmanoff (1968) pointed out that conflict between these two groups can arise because the autonomy of the doctor enables him to disregard the same rules which constrain nursing practice so that the nurse may have to manage his "illegitimate demands".[1]

The 'professional' status of the nurse is, however, re-affirmed by the responsibility she accepts for the co-ordination of the doctor's orders:

> "She must determine which orders are to be executed immediately, and which ones later; to which patients to devote more time and to which less; when understaffed which orders to perform to the fullest; where to economise and where, if necessary, to omit the performance of ordered procedures."
>
> (Mauksh 1966, p. 128)

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1. In a review of the literature concerning this relationship up until 1970, Bates (1970) has indicated that there is now a growing recognition of the importance of physician-nurse relations to patient care and that attempts should be made to resolve some of the problems.

To prevent the consequences of mistakes occurring in regard to this task, nurses have developed rules and procedures to govern nursing practice. Some of these rules are incorporated into hospital policy, some only apply to specific situations and originate from the nursing staff in that area. Rules are a form of communication which specify the obligations of the worker to do particular things in a definite way (Gouldner 1954). Although the rules may provide a framework for work control and minimise the possibility of mistakes, it has been pointed out that nurses can become preoccupied with rules and procedures to the detriment of patient care (Lees 1979).

It has also been indicated that in spite of the rules designed to minimise mistakes, the notion of 'making a mistake' is perceived by nurses as an area of concern and conflict in patient care, Stein (1969) finding that 86.1% of the nurses questioned about areas of concern in nursing practice listed "making mistakes".

Fretwell (1978) has, in addition, pointed out that "rules by their very nature ... have denied the nurse an environment in which learning and enquiry could flourish" (p. 58).

Although rules and procedures may to some extent protect the nurse from the consequences of making decisions in regard to the co-ordination of tasks, they do not totally alleviate the "strain and isolation of a role in which the sister (nurse) alone represents the continuity of social organisation to the patient, and is forced to bridge the discontinuity of other peoples services" (Pembrey 1980, p. 153).

d) Nursing as an occupation

We have noted so far the way in which the hierarchical structure of the hospital constrains the role of the nurse and thereby reduces her responsibility for decision making. We should now consider briefly other

characteristics of nursing as an occupation.

In 1954 Lyle Saunders, in pointing out the changes taking place within the nursing profession, identified the characteristics of nursing as an occupation. He pointed out that first of all nursing is highly diversified in that the 'nurse' carries out a number of different tasks in a variety of settings. Secondly, as has already been indicated, nursing carries with it an ambiguous status for many of the decisions regarding the manner in which nursing work is done are made by people outside the profession. Thirdly, nursing remains socially isolated from other hospital personnel, and "teamwork" exists only in relation to the specific care-of-the-patient situation and does not become generalised across all personal and social aspects of the hospital organisation. Fourthly, nursing is conservative:

> "Conservatism, dependability, stability, caution are characteristics that nurses are encouraged to develop during their period of professional socialisation; attributes such as imagination, resourcefulness, progressiveness and a liking for change are discouraged."
>
> (p. 1021)

Fifthly, nurses are organised with most of their work played out in an institutional setting. This sets limits to the behaviour of the nurse, which must fit in with the general scheme of the organisation of the hospital. Finally, Lyle Saunders has indicated that within recent years, due to the increase in the mechanical and technical aspects of therapy the social distance between nurse and patient has increased.

As well as being constrained within the institutional boundary it should be noted that the nurse is also positioned at the hospital-environment boundary dealing as she does with patient and public, and therefore she cannot distance herself from the effects of the ultimate decisions, made by the medical or administrat-

ive staff (including those made by nurses further up the nursing hierarchy) which concern boundary management.

The role of the nurse in relation to management of the hospital-environment boundary has been discussed by Lees (1980) who drew attention to yet another aspect of the nurse's social position. Because she is situated at the "crossing point" between hospital and environment the nurse accepts the patient "on behalf of" the family. In this way she becomes a 'container'[1] for all the family's anxieties, and also "for their demands, indeed the demand of society at large, which says we want the best". Conversely, the nurse also accepts the management of the patient "on behalf of" the hospital, and in this way she becomes a 'container' "for all the anxieties caused by an organisation with limited resources, saying in effect, all you can get is this". In this way the nurse experiences the full impact of managing the hospital/family boundary (pp. 333-334).

e) The ward sister

The discussion so far has focussed on the relationship of 'nurse' vis-a-vis the doctor and management. Some consideration should now be given to the 'ward sister', and her specific relationships within the hospital hierarchy.

Attention has already been drawn to the power of the doctor which constrains the autonomy of all nurses to some degree, but the ward sister, unlike other nurses, possesses some autonomy, unaffected by her relationship with the doctor, by virtue of her office as 'chief executive'. Turner (1971) has pointed out that because of the combination of power and autonomy inherent in this position, the chief executive "holds a peculiar

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1. The term 'container' is used as described by Bion (1962).

significance, relative to the culture of his own organisation", which gives him "considerable leverage in the dissemination of his own views about the way in which his portion of the organisation should function" (p. 107). In keeping with this view, Dodd (1974) found that the ward sister was the key figure who determined the roles of the nurses subordinate to her, and Fretwell (1978) noted that the ward sister, although she was at the centre of a communicative network negotiating with and on behalf of patients, doctors, nurses and relatives, controlled other nurses by deciding what information she should relay to them.

The recent study by Pembrey (1980) focussed on the planning, or management, skills of the ward sister. This study identified one particular feature concerning the ward sister role which distinguishes this role from other nursing roles. The ward sister is part of the management structure of the hospital, but the nature of the work requires her to work closely with the primary work force. This causes confusion in both theory and practice. However, in common with other studies concerning this role, Pembrey pointed out that the ward sister remains at the "centre of the negotiated order of the care of the patient", and that it is the "combination of continuity in the patient area together with direct authority in relation to patients and nurses which makes the role unique and so important in nursing" (p. 239).

The importance of the ward sister as a key figure concerning the interpersonal relationships which take place within the social world, for which she is responsible, is recognised in the syllabus of training drawn up for the first experimental course for the training of general nurses as ward sisters (Kings Fund, 1979). The objectives defined for this course include the ability to "demonstrate knowledge, appreciation and skills in relationships, communications and personal management"(p. 4).

Having identified the 'unique' role of the ward sister, some consideration should now be given to the relationship between the ward sister and the doctor. The same constraints which apply to the 'nurse-doctor relationship' would appear at first to apply to the 'ward-sister - doctor relationship' and the findings of Dodd (1974) concerning the definition of what goes on in the clinical situation apply equally to the ward sister as to other nurse groups. Yet the ward sister, by virtue of her 'office', has a relationship with the doctor which is different to that of other nurses. Dodd has pointed out that the ward sister performs as 'consort' to the consultant, acting 'as him' or 'for him', and that this form of behaviour is accepted by other groups. If there are to be changes, however, she also noted that it was not the ward sister who changed the doctor (consultant), but it was the doctor who changed her. Stein (1968) has indicated that the omnipotence of the doctor is challenged and accepted by him through the use of 'doctor-nurse games'. In this way he receives sub-rosa recommendations from the senior nurse, i.e. ward sister, and then makes them appear to be initiated by himself. Thus open disagreement is avoided, and the sister earns the title of 'damn good nurse'. "She is respected by everyone and appropriately enjoys her position." The reward for a well played game is a doctor-nurse team that operates efficiently (p. 102).

f) The organisation of Nursing Practice

It has been shown that nursing practice takes place within a work environment (Pembrey 1980) which is subject to disruption. Disruption of nursing work is due to the increasing open-ness of the ward to other hospital staff and visitors. Historically the hospital ward was 'closed' for parts of the day to all 'outsiders'. But it can be demonstrated (Goddard 1953) that the hospital ward has changed from a comparatively closed system to an open system. This environmental instability to

some extent determines the appropriate form of management and work organisation. The ward sister by virtue of her position develops a routine which "encompasses her priorities and rules" (Fretwell 1978) thereby setting limits to the behaviour and operations which take place within her section of the organisation. Although the routine may be developed in response to the instability of the environment, Strong (1979) has indicated that although routinisation renders a working compromise eventually this becomes "not merely a solution but the solution".

> "It becomes the way things are, and since we idealise our lives the way things ought to be, at least for those who do well out of it. In other words these solutions become objectified and even reified." (p. 84)

The routine comprises two aspects, the 'temporal', which tells the nurse when to do things, and the 'motor', which tells her how they should be done (Fretwell 1978). The routine of many wards is task-orientated rather than patient-orientated, and "getting the work done" is the primary focus. A task-orientated routine reduces nursing practice to a series of tasks which can be carried out by any of a number of nurses on the ward at any one time. Task allocation is efficient although as Brown (1966) has indicated, it is bought at a very high price when viewed in terms of its failure to satisfy many nurses and patients. McGhee (1961) found that many patients disliked "the pointless rigidity of the routine" which was predominantly task allocated (pp. 39-40).

Although the routine is disliked by patients, Coser (1962) has pointed out that doctors as well as administrators praise the "efficient organiser" so that the attention of the nurse is geared towards "running things smoothly" in a way which will minimise disturbances (p. 76). It can also be said to be functional for the

junior nurse working on the ward for it "lessens the strain (and) protects the nurse from the whims of a supervisor or doctor" (Davis, 1966, p. 83).

Yet an examination of the nursing journals, particularly the American journals during the late 1950's and 1960's, indicates a growing 'professional awareness' of the rigidity and inflexibility of the routine, although as Storlie (1965) pointed out "the care of the patient is too often given priority in lip service only" and that "in reality hospital routine and function are the prime concerns" (p. 337).

There are, however, indications that some positive action is now being taken to 'de-routinise' nursing practice. One of the ways by which this may happen is by the introduction of the Nursing Process into the practice of nursing. This is a system of nursing which is designed to focus on the needs of the individual patient thereby restructuring nursing practice away from a system of task allocation and a rigid routine. The Nursing Process has been defined as "an interactive, problem-solving, decision-making procedure for assessing, identifying, selecting and implementing approaches and evaluating results in relation to care of the ill or potentially ill person" (Jones 1977, p. 13). Although the Nursing Process has been utilised as a model of nursing care in North America for over a decade, it is only since the mid-1970's that this method of producing an orderly and systematic model of care has been a topic of interest and concern to nurses in this country. As well as being a topic of concern steps have been taken towards a national implementation programme within the last two or three years. This is in response to the incorporation of this model of care into the syllabus of training for Nurses by the General Nursing Council.

This change is of particular significance to the present study for when it is fully implemented many aspects of nursing practice focussing around the nurse-patient relationship will change, and because of this the nurse-relative relationship could also alter during the next few years.

It has been indicated so far that the nurse has a well-defined place in the social structure of the hospital. This social position is ambiguous in that she is a 'professional' with responsibility for co-ordination of care, yet she is constrained by the decisions made by both the doctor and the administrator. Some attention has also been drawn to the conflicts which can occur because of this position, particularly with the doctor, although it has been shown that nurses abide by the doctor's decisions even if they disagree with them.

Some attention has been drawn to the highly routinised nature of nursing work, which sets limits to nurse behaviour. There are, however, indications that there may be changes in nursing practice due to the implementation of the Nursing Process. This could have far reaching implications for the autonomy of the nurse practitioner.

It would appear therefore that although the social position of the nurse is well-defined within the limits set by other relationships rules and policies, it is by no means 'fixed' but is subject to negotiation and change.

We shall return to the role of the nurse vis-a-vis the relative later in the chapter, but for the present we shall turn our attention to the social position of the relative within the structure of the hospital.

II The Social Position of the Relative within the Hospital

We shall consider the social position of the relative by discussing

three different groups of studies. Firstly we shall consider the studies which have described the social position of the client[1] within any organisation. Secondly, we shall consider those studies which have focussed on the social position of the client in the 'medical' setting. Finally, we shall consider the few studies which have centred on the relative as a 'client' vis-a-vis the nurse as a professional.

a) The 'client'

Many of the studies which have drawn attention to the social position of the client have identified the advantages held by the professional. Firstly, Marwell and Schmitt (1967) have pointed out that part of the professional's training will have included the acquisition of 'compliance-gaining skills', while Davis (1978) has indicated that client techniques for countering these skills are limited depending as they do upon information about the strategies of the professional. Secondly, Sjoberg (1966) and others have found that clients are also disadvantaged in two other ways, firstly they do not know the rules of the game, secondly, they rarely have access to 'pull' when necessary. Thirdly it has been shown that not all sub-groups of society have the same facility for performing effectively in the professional-client relationship within an organisation. Miller (1978) amongst others found that some clients know less about their rights than others and feel uncomfortable in impersonal situations in which they have to deal with the complexities of bureaucratic settings, while Danet and Hartman (1972) and McKinley (1975), have found that different groups of clients have different levels of expertise.

Other studies, Friedson (1970), Kadushin (1967), Hughes (1977) and others, have indicated that 'professionals' establish social distance

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1. A 'client has been defined as "an individual who has contact with a bureaucratic organisation in connection with his own personal interests and obligations" (Katz and Danet 1973) p. 668.

between themselves and their clients, and that this is justified both by the knowledge gap[1] between these groups and also by the societal mandate given to the professional group.

It has also been pointed out that the knowledge of resources and the criteria affecting their use also gives the professional the most power in the relationship:

> "The existence of such a power axis meant that the individual's ability to obtain the decision he required was limited ... most interaction took place along this axis and affected the content and outcome of the meetings."
>
> (Danet and Hartman, 1972 p. 167)

The power and the authority of the professional is further maintained by a client-classificatory system which identifies very few actual or potential clients as peers of the expert (Hall 1975).

Lefton and Rosengren (1966) have indicated that these two concepts, 'social distance' and 'authority', are more easily maintained if the contact is limited in time, and if it is supported by a system in which the expert is an 'embedded' member and the client a relatively powerless stranger.

The position of the client which emerges from the studies considered so far is that of an 'outsider', unsupported by a system inside the organisation, yet supposedly 'served' by that organisation. The 'service' offered, however, which is designed for the 'benefit' of the client, has been shown by Roth (1972) to operate in such a way that the beneficiary has little control over his or her fate. In addition to this the power

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1. The 'knowledge' held by the professional, which enables him to keep the client in ignorance, has also been shown by Moore and Turin (1949) to be advantageous to the privileged position of the professional, for it decreases competition from other specialities and provides the protection of traditional values which assists in the maintenance of power.

of the professional has been shown to be maintained by a number of factors related to the 'knowledge' acquired during the process of professional socialisation.

b) The client in the medical setting

We should now turn our attention to the studies which have increased our understanding of the social position of the 'client in the medical setting'.

Some of the studies have focussed on the interactive process between professional and client, drawing attention to both the verbal interaction and to the 'performance' of these two groups in 'medical' encounters. A number of studies concerning the doctor and the patient have been analysed from this perspective, starting with the work of Balint (1964). One of the latest studies concerning the doctor-patient relationship, that by Byrne and Long (1977) shows that most of the interaction which takes place between these two groups within a general practice surgery is 'doctor-centred', the doctor using closed questions, concentrating on the patient's responses to such questions, and brushing aside hints of other problems.

Some of the studies concerning nurse-patient relationships have found that nurses too counter those questions posed by the patient which they prefer not to answer (Faulkner, 1978, Wood, 1979, and MacLeod Clark 1980). In this way the nurse-patient relationship is similar to the doctor-patient relationship and can be described as 'nurse-centred'. If such descriptions are accurate, then by implication the patient, (or the client) is placed in an inferior position.

The findings which have resulted from these studies have been very useful in that they have broadened our understanding of the

nurse-patient and doctor-patient relationship. These findings have therefore been very useful for teaching student nurses and doctors. However, this analytical perspective, while providing such insights, fails to take account of a further issue, which affects the behaviour of the professional and client in the medical setting, that of the negotiation which can take place between these two groups.

Negotiation has been defined as:

> "a process in which the client offers definitions of the situation to which the interrogator responds. After a series of offers and responses a definition of the situation acceptable to both client and interrogator is reached."
>
> (Scheff, 1968 p. 6)

The importance of negotiation within professional-client encounters has been identified by Friedson (1970), who has pointed out that the "professional and lay worlds are always, if only laterally, in conflict, and it is this factor which produces the necessity for some sort of bargaining" (p. 322). Gibson (1977) has, however, indicated that not all the interactions which take place in a medical setting fulfil the conditions which make them amenable to the kinds of negotiations described by Scheff, for the interaction between these two groups may be related to very specific narrow goals, the accomplishment of which is routine and which does not therefore lend itself to protracted discussion. In addition, she also pointed out that staff may be in such a position of power over the patient that they are able to make decisions without consultation.

By taking account of the effect of the social structure on negotiation, McIntosh (1977) was able to show how the doctor's ideology concerning the management of 'uncertainty' constrained the interaction which took place with patients wanting information about their diagnosis

and prognosis. He found that 'telling' in this situation, which was threatening to both client and the professional, became routinised. Routinisation ensured consistency in the sort of information which the patient might receive, and it also absolved the doctor from having to take decisions in individual cases. In addition to these factors, routinisation ensured that conflict between members of staff over what patients should be told was limited. In such instances the routinisation of information-giving is functional for the professional but it sets limits to the amount of negotiation possible between professional and client.

Other studies using this perspective to consider 'medical' relationships are those by Roth (1963) and Hall, Pill and Clough (1980). These studies have focussed on the client's ability to negotiate within the medical setting, Roth found that patients with tuberculosis were able to obtain, and then to use, information pertinent to their case to bargain or to negotiate with staff over the precise scheduling of events within the hospital. Hall pointed out that in spite of the limits to negotiation already described, even child patients were part of the negotiated order, and were observed to 'negotiate' to their advantage.[1] (p. 148).

The studies which have focussed on the client in the medical setting have drawn attention to the ability, in some situations, of the client to negotiate with the 'advantaged' professional, although as Gibson and McIntosh have indicated, the limits to the amount of negotiation possible may vary from medical setting to medical setting. Such studies have also indicated the necessity to take account of the effect of the social structure on the amount of negotiation if any understanding of a role

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1. Similar findings concerning the client in a non-medical setting are reported by Katz and Danet (1973) who found that the Israeli immigrants whom they studied were also able to influence bureaucratic decisions to be made in their favour.

relationship is to be reached.

Having drawn attention to the concept of negotiation we have implied that the social position of the client is not 'fixed' but is subject to change. The changing role of the client has also received some attention recently and we should at this point briefly consider these studies.

A number of reasons have been identified as to why the gap between the client and the professional may be closing. In the first instance the monopolisation of knowledge is more and more difficult to achieve in modern society (Lapota, 1976). Secondly, the enlargement and fragmentisation of the fields of expertise, as indicated by Ellul (1967) has meant that the professionals no longer "share a common universe of discourse to agree on priorities or to present to the public a common front" (p. 435). This has led to a partial rejection of the experts and their advice. Thirdly, Haug (1975) has indicated that the new knowledge of experts is also disseminated to others by the media, leading to a demystification of the knowledge base from which the professional operates.

Lapota (1976) has also drawn attention to the growth of client organisations which have been formed to improve treatment by different professional groups. One such organisation in this country is the Patients Association established in 1963 to:

> "represent and further the interests of patients"
>
> "give help and advice to individuals".
>
> "acquire and spread information about patients interests"
>
> "promote understanding and good will between patients and everyone in medical practice and related activities".

Lapota has in addition indicated that there are a number of trends which are leading to a change in the position of the client in the

medical setting. Firstly, there is now an attempt by some professional groups to treat the patient as a 'whole person'. In this way the client is encouraged to participate in the diagnostic and treatment planning processes as a member of the team. Secondly, family involvement rather than individual involvement may change the nature of the encounters between the client population and the professionals. We shall return to this notion of the client role as a role in transition later in the chapter.

We should now consider those studies that have focussed specifically on the relative as a client. First of all it should be noted that the relative as a 'client' is only a part of the relative career.[1] We shall begin this section, therefore, by giving some consideration to the role of the family in illness in order to review the whole 'career' of the relative.

c) The role of the family in illness

Although the 'role of the relatives' in illness is recognised in most societies, it is subject to a number of cross-cultural variations. The focus of this discussion is on the 'Western' experience, although some cross-cultural comparisons will be made because of their implications for the present study.

The family may become involved very early on in the potential patient's illness as he attempts to make some sense of his symptoms. The response of the individual and his/her family is related firstly to the severity of the symptoms and secondly to the way in which these symptoms intrude on his/her and their social life. In the first instance symptoms are

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1. The notion of 'career' owes a great deal to the work of Goffman (1961). Goffman describes 'career' as a progression of status passages. At each stage of his/her career the individual alters his/her self image to match his/her changing status. The notion of patient 'career' has been developed by a number of sociologists e.g. Jobling (1977).

fitted into a 'minimally threatening framework', and it is only as certain incongruities are perceived which cannot be rationalised that some further action may be taken (Davis 1965). The decision to take further action may be on the advice of the 'lay-referral group', that is any family members, or non-kin, to whom the potential patient turns for advice (Friedson 1972). This advice may move the complainant towards some agent or agency thought to be competent to deal with the problem. The decision may be deferred but while symptoms persist the potential patient or patient's family cannot easily withdraw from the situation (Robinson 1978).

If the potential patient is a child, or is too ill, or otherwise incapable of making the decision to take such action, the family may make this decision themselves.

The "agency thought to be competent" may be the Accident and Emergency department of a general hospital, and a number of patients arrive in this department accompanied by family members who have assisted in the decision to take such action. The behaviour of some of these relatives has been described by Coffey (1979) who noted that "patients, relatives and friends are liable to demand instant attention ... these demands can be pressed very forcefully in spite of attempts by the staff to reason with them ... in fact they are frequently backed up by threats of personal violence which are sometimes carried out" (p. 348).

In non-Western societies the decision-making role of the family in relation to the patient's treatment continues after the initial consultation with the 'healer', but in Western society scientific and technological change have led to the monopolisation of treatment by the medical profession. Decision-making also continues after the initial consultation but these decisions are taken by the 'professional'. The

patient and his relatives appear to play little part in this process (Friedson 1972).

The role of the family, therefore, alters when the professional takes over. The detailed functions of the family in relation to illness in other societies are well documented (Glaser 1970, Janzen 1978, Ngubane 1977 and Read 1966). The role of the family in such societies has been compared with that of the 'lay referral group', pointing out that unlike the 'lay referral group', which discharges its responsibility (or has its responsibility taken from it) when the professional takes over, the family in these societies "continues its authority and frequently even increases it while the sufferer is in the hands of the specialist" (Janzen 1978, p. 133).

The role of the family after the professional has taken over the management of the patient's treatment is confined to the provision of 'care'. The care of the sick person within any society may be shared but "social norms designate family members as bearing the principal obligation" and in most instances "affection and respect motivate them to act accordingly" (Glaser 1970, p. 87). The resources of the family in Western society may be affected by economic and social factors which can restrict the possibilities of successful home care at all social levels, (Susser and Watson 1971). Isaacs (1971) carried out a survey among the families of patients admitted to a geriatric ward because the family were unable to provide the necessary care for the patient, and identified a number of such factors. In the first instance, Isaacs found that many of the relatives who could have cared for the patient were themselves elderly. Secondly, a number of relatives would have been willing and able to undertake this task but because of a 'pre-occupation', defined as "an alternative commitment which could not be disregarded without meeting severe hardship or an absolute impediment",

were unable to carry it out. The 'preoccupation' was found to relate to either the potential helper's own state of health or other family commitments, or because the potential helper was unable to surrender his bread-winning role. Thirdly, some relatives faced a 'dilemma' in that they could only care for the patient by "sacrificing aspects of their own life with potentially harmful consequences", i.e. some harm befalling their own spouse or children. Finally, some relatives perceived that the integrity of their own family life could be threatened by the involvement needed and so decided not to undertake this task (p.282-86)

In spite of the difficulties large numbers of patients are nursed at home often for long periods of time, in most instances by their spouse, or if there is no spouse, another female relative (Cartwright, Hockey and Anderson, 1973).

It has already been pointed out that specialisation of medical care restricts the role of the family to that of 'care', but this aspect can be further restricted if the patient needs to be admitted to hospital. Hospitalisation in Western society 'amputates' the patient from his family, for the family is regarded by the hospital staff as "an amenity for the patient", rather than as "organically involved in the health/sickness situation" (Wilson p. 26).

This 'amputation' is also peculiar to Western society. In most non-Western societies it is expected that the patient will be kept at home and cared for until the illness is resolved, either by the patient's recovery or by his death. "Only rarely does any establishment resembling a hospital appear in primitive society, and it assists rather than replaces care by the family" (Glaser 1970, p. 88). During the last few years a number of 'Westernised' hospitals have been established, mainly by missionary societies, in various parts of the world. In order for

the hospitalisation to become acceptable to patients and their families in those societies in which such hospitals were outside of the traditional medical system, these hospitals have had to incorporate family members into the organisation. In this way they are able to continue to 'care' for the patient.

> "The patients come with their whole families who bring their own food and their livestock. They camp outside the hospital until their relative is well again. They help nurse the patients, wash them and their clothes and cook their meals."
>
> (Guichard 1975, p. 56)

In some instances the family continues to maintain control of the patient's treatment, by making a decision to remove him/her from the hospital back into the care of a 'traditional healer' if this was thought to be in the patient's best interest (Janzen 1978).

It has been shown that in Western society, because of the prevailing medical system, the role of the family in illness is confined mainly to 'care'. It has also been shown that due to the social and economic constraints found in industrial society some families may be unable to provide the 'care' its family members may need. Finally, reference was made to the way in which hospitalisation can itself disrupt the care which could be given by the family.

Cross-cultural comparisons were made because of their implications for this study, although in addition to this they help to accentuate the environmental influences on family roles. Their importance to this study lies in the fact that a growing number of people admitted to hospital in this country originate from other cultures. The families of these patients may well have different expectations than the families of patients socialised in Western society. No data concerning different expectations was found, but it will be shown later in the text that

this aspect could not be ignored.

We have dealt in some detail with the role of the relative in illness to highlight the fact that the role of the relative in the hospital organisation may be only part of the 'career' of the relative, a career which is itself culture bound. We should now consider those studies which have described the effect of hospitalisation on the family.

d) The effect of hospitalisation on the family

A small number of studies have shown that illness not only affects the individual, but that it also affects the whole family. In the first instance the patient's illness may alter the family structure and its functioning, secondly, the illness may also affect other family members psychologically.

The family structure may be affected by the patient's illness because the material economy of the family can become unbalanced. One of the earliest studies in this area, Koos (1945), showed how the illness of the husband could lead to radical alterations for the worse in the family's standard of living. Susser and Watson (1971) pointed out that in Western society at the present time both husband and wife may be wage-earners "dependent on each other for economic and social support".

Other studies have set out to investigate the "reciprocal relationships between the psycho-social circumstances of the family unit and the occurrence of 'critical' incidents such as death, hospitalisation ..." (Meyerowitz 1967 p249). Hansen and Hill (1964) have refined the variables within the family which could precipitate such a crisis in response to 'stressor events'. These variables were subjected to further detailed individual analysis by Burr (1973) who incorporated his findings into a theoretical model. The model incorporates a number of factors, as well

as the suddenness or severity of the event. These factors include:

1) the family's externalisation of blame for the incident,
2) the family's adaptability and integration,
3) the type of kin group and community of which the family was a part,
4) the marital adjustment,
5) the family's previous successful experience with similar types of stress.

No studies have been located which have set out to examine the applicability of this model to the family of the hospitalised patient.

A few studies have focussed on the implications of the full psycho-social effects of hospitalisation for the patient's family. One of the first studies to give any attention to the family's psycho-social adjustment to the hospitalisation of one of its members was that of Davis (1965). Davis studied fourteen families of patients admitted to hospital with poliomyelitis. He found, in addition to the variables identified above by Burr, which could bring about a crisis within a family, that the adjustment of each family in illness is also related to the normal role of the patient within that family. Because of this the "central functions of family life, breadwinning, child-care, housekeeping, sex and recreation" were less disrupted by the admission of a child to hospital than would have been the case if a parent had been admitted (p. 176).

Other studies which have considered the different effects of hospitalisation on the family include those by Endress (1971) and Bellamy (1971). Bellamy carried out a survey which focussed specifically on the relatives of patients admitted to a psychiatric hospital and found that for 40% of relatives the patient's admission came as a shock and caused "sadness, worry and alarm". He also found

that 35% felt relieved that the problem had come to a head. The relatives of patients admitted to psychiatric hospitals appear to have received more attention than any other group of relatives. Baggott (1971) indicated that the families of patients admitted to hospital for psychiatric care could experience two particular problems. Firstly, there was the perceived stigma experienced by some families, and secondly, there could be considerable anxiety related to the patient's future readjustment to life at home following his discharge.

Other groups of relatives who have received some attention include the relatives of patients with cancer, the spouse of the patient admitted to hospital following a myocardial infarction, and the relatives of the dying patient. We shall briefly describe the studies relating to the first two and pay more attention to the studies concerning the relatives of the dying patient.

The condition of cancer is associated with acute family stress. Maguire (1975) has shown that breast cancer not only causes "considerable psychological and social problems" in the patient, but that "many of the husbands are also adversely affected". Maguire, Tait and Brooke (1980) have also cited a number of studies concerning cancer and the family indicating that a substantial proportion of cancer patients and their relatives develop psychiatric problems as a consequence of the disease and treatment. Jamison, Wellisch and Pasnau (1978) carried out research into the psycho-social aspects of mastectomy from both the woman's and man's perspective, concluding that throughout the hospitalisation period and after "the man is anything but a detached observer" (p. 545).

Most of the wives of patients admitted to a coronary care unit, following a myocardial infarction were found by Skelton and Dominian (1973) to experience numbness and panic in the immediate period

following hospitalisation, followed by feelings of loss, depression and guilt. Their findings were based on the patients' own perception of their emotional response. Dyche (1979) concluded after looking at the problems experienced by the wives of patients admitted to hospital that "the social effects of myocardial infarction are lasting and affect most aspects of life" (p. 63).

The emotional responses listed above vary in intensity as they affect different family members, and are usually most acutely experienced by the patient's spouse. The way in which other family members, particularly the patient's children, support the spouse, has been described by McKinley (1971) and Dyche (1979). However, it has also been suggested that young children in the family may exacerbate the problems of the spouse and therefore increase the family's difficulty in coping with the patient's hospitalisation (Finlayson and McEwan 1977).

We have seen that hospitalisation can seriously disrupt the family structure, although most of the studies listed have focussed on specific groups of relatives rather than the relatives of patients admitted to 'general' wards. We should now consider the effects of the death of the patient on the family.

e) Death and the family

A large number of studies have focussed on the notion of death and the family. These must be considered for it appears that it is within this context that many nurses develop a relationship with the patient's relatives.

Attention has been drawn to the way in which Western society has created a cultural system which depersonalises, specialises and fragments death and dying (Benoliel 1967). Supporting this assertion Benoliel

refers to Blauner who has suggested that this system protects society from the disruptive impact of death by "segregating the dying from the living, and by developing bureaucratic procedures for managing death and dying as routine social matters". Because of this system many families facing the death of one of its members for the first time may be ill-prepared for the effects, problems and choices which may face them.

The effects of the dying process on the family vary as a function of innumerable factors:

> "The nature of the terminal condition, personality of all involved persons, prior history of family relationships, the importance of the dying person to each individual family member, the ability of all concerned to establish the communication that is most satisfying to everyone and the rapidity with which death occurs."
>
> (Kalish 1979, p. 228)

These factors determining the amount of disruption are similar to those identified by Burr in relation to other stressor events described on page 36. The amount of disruption within the family, is also related to the former role of the dying person within the family, "when death removes an individual whose family roles are still very important, his death is more socially disruptive than the loss of a less socially relevant person" (Kalish p. 231).

The problems which the family have to confront first of all may relate to the setting in which 'dying' takes place. The family of the patient who is dying may have to decide 'where' the dying should take place.

In some cultures it is believed that the patient must be taken home to die so that the appropriate rituals and ceremonies can be carried out. 'Home' may be the place in which the dying person has recently lived or it may be his home village or some other appropriate

place (Read, 1966).

In British society many deaths (Hinton, [1972] suggests about one in three) take place in institutions. Dying in an institution is socially acceptable, so that the decision concerning the setting in which the patient will remain during this process is made in the light of other factors. Some of these factors have already been discussed when reviewing the care of the ill patient at home, principally the human and economic factors. There is also the problem of time. It may not be possible to estimate how long the dying process will take. If a prolonged period of time is estimated this may place too much of a strain on the available 'brunt bearer', many of whom are elderly themselves. Nearly one-fifth of cancer patients who die at home are nursed by a 'brunt bearer' who is over the age of seventy (Journal of the Royal College of General Practitioners, 1978).

There may also be a problem of space. Some segregation of the dying still takes place within the home, and if this is not possible the presence of the dying patient may be too pervasive and would dominate too much the lives that must go on while he dies (Glaser and Strauss 1968). Glaser and Strauss found that the decision made by the family as to whether the dying should take place at home or in hospital is therefore related to the management of the temporal life of the family and friends who are present in the home or who are easily available to carry out the tasks associated with care.

There may be advantages for the relatives, as well as for the patient if this process takes place in the home. Kalish (1979) has pointed out that although the 'brunt bearer' may become physically exhausted she retains control of the information, of the physical space and of the emotional contacts in relation to the patient and others.

The relatives of the patients admitted to hospital, or remaining in hospital, to die, no longer have control of the situation, nor in most instances do they play an active part in patient care.

Some kinds of hospital wards are better able to manage the dying process, but this will depend on whether the prevailing ideology is one of 'care' or 'cure'.

The present day acute hospital ward is not, because of the ideology towards cure, necessarily very well equipped to cope with death, which appears to represent failure of the cure process (Shivnan 1979). The process of dying in an acute hospital ward has been graphically discussed by Glaser and Strauss (1965) and Sudnow (1967).

The work of Glaser and Strauss and that of Sudnow, who all concentrated on the relationships taking place with and around the dying patient, has been of some influence on this study. Further reference will therefore be made to this influence and its application to the study below in the chapter concerning the dying patient.

The needs of the relatives of patients dying in an acute ward have been identified by Hampe (1975) who found that the majority of the relatives she questioned expressed a need to talk about their feelings, express their grief and receive comfort from the staff. There are at least two reasons put forward why these needs may not be met within the acute ward setting: the busyness of the staff and their lack of preparation for such demands.

Murray Parkes (1978) looked at the way the surviving spouses of terminal patients had perceived the care in the hospital setting which was given to the patient and to themselves. A number complained that the ward staff were always 'too busy' to see them, and that the staff

had ignored the stress which the relatives were experiencing. Parkes concluded that although most respondents were satisfied with the care given "there were many who were not".

There is also some indication that nurses working in acute wards are not well prepared for the task of coping with the dying process including the care of the patients' relatives (Birch 1979, Whitfield 1980).

Care of the dying has improved in many other settings and during the last ten years the growth of the hospice movement has meant that less people have needed to die in acute wards.

A leading article in one of this country's nursing journals recently pointed out that although the person dying at home or in a hospice had "benefitted enormously from the health teams' awareness of the patient's needs and the commitment made to his whole family", patients dying in hospital were still a problem for the staff.

> "Death in Hospital is invariably protected by circumnavigation of the subject, distortion of the truth and physical barriers to conceal the fact ... basically we (writing as a nurse) cannot cope with death as adequately as with complicated surgery."
>
> (Canham, 1980, p. 1153)

The improvements which have taken place in other areas are due to a better understanding of the patients' and relatives' needs during the last twenty or thirty years.

Fazakerly (1978) found in his examination of the nursing textbooks published this century that relatives of the dying patient have, throughout the period, been identified as having special needs which could be helped by the nurse. He also found that although these books identified the needs of the dying they were not specific concerning the 'practical shape' of the nurse's role relating to this problem. Finally, he found

that not only were the textbooks inadequate, but also that nurses were ill-prepared for this task partly because of their training. He looked at the syllabuses of nurse training issued during this period by the General Nursing Council and found that these "avoided the realities of death and dying by focussing attention upon the routine procedures"(p27). In this way they failed to prepare the student nurse to cope with the "psychological trauma which often accompany these events". Birch (1978) also found that this was an event for which nurses believed that they had received insufficient preparation.

Mead (1971) specified the problem:

> "She (the nurse) is never told what to do for grieving relatives; she is never told how to tell visitors that their mother has died or what to do or how to help parents who come into Casualty to find that their small child has died in an accident." (p. 40)

In reply to the argument that this function should be left to the doctor, she pointed out that "mostly they are too busy, or funk it, or they don't know what to do either" (p. 40).

The inadequacy of the textbooks has now to some extent been rectified. Textbooks reflect contemporary knowledge, and during the last few years the emotional needs of dying patients and their relatives have been more fully understood. In the first instance the 'pain' experienced by relatives during the dying process is now better recognised:

> "Family pain is understandably a major factor in the situation. It is the pain of watching ... the pain of parting and loneliness to come - and at times the pain of the old, unresolved tensions which are often exacerbated by illness."
>
> (Saunders 1976, p. 1247)

Secondly, in addition to the 'pain', the concept of 'anticipatory grief' described by Kutscher and Goldberg (1973) as "the mourning which begins before the patient dies" is now slowly gaining recognition by

the nursing and medical profession (Fulton and Fulton, 1972). In the light of this increased 'knowledge' and acceptance of this knowledge by the medical and nursing profession, contemporary nursing "how to do it" books, and other publications now contain more detailed discussions with regard to this subject.

It would appear therefore from the previous discussion that the nurse may experience some difficulty in his/her relationship with the relatives of the dying patient, although there are some indications that there is a growing awareness amongst nurses and other health professionals to come to terms with the problems inherent in this relationship.

It can also be seen from the previous discussion that the patient's illness and subsequent admission to hospital, or death, can precipitate a crisis within the family and affect the homeostasis of the family members. Research into this area is by no means complete, and many questions remain unanswered. However, there is sufficient completed work to indicate that the relative entering a relationship with the nurse in hospital may be experiencing a number of emotions which may possibly affect their perception of any situation.

We have dealt in some detail with the crisis which is inherent in the relative career, indicating that this is still not fully understood, yet it is of some significance to nurses, and therefore to the present study, for as Thompson (1975) has indicated "providers must be aware of the disruption caused by illness". (p. 21).

We should now turn our attention to those studies which have focussed specifically on the relative as a 'client'.

f) The relative as a client

The relative has been identified as a 'client' by virtue of his

association with the patient, although "the position of the family as client is somewhat vague to nurses themselves and is subject to a shifting definition" (Rosenthal, Marshall, Macpherson and French 1980, p. 87).

The relative as a client is geographically located outside the hospital and its work routines. This has implications for the social position of the relative for as Becker (1953) has indicated one of the preoccupations of those who work in service organisations is the "maintenance of their authority definitions over those of clients in order to assure a stable and congenial work setting". This is achieved in part by preventing 'outsiders' from "exerting any authority over the institution's operations" (cited by Rosenthal, 1980, p. 87).

It has been indicated that the client is a 'critical fact' of organisational life (Rosengren and Lefton 1969) and as such is part of the social order. Yet, as Strauss, Schatzman, Ehrlich, Bucher and Sabschin (1964) have indicated, the relative is of another social order to the nurses and other staff working within the hospital, for hospitals comprise two distinct social orders. There are those who regard the organisational property as their own, the staff, and those who are there more or less against their will, the patients and their families:

> "Forced as they are into a direct interface in the contained setting of the hospital, the relations between these two little social orders may be characterised by accommodation at best and open conflict at worst." (p. 124)

It was indicated earlier in the chapter that the role of the client appeared to be in transition. The few studies which focus on the role of the relative support this proposition, although they suggest that the recognition of the relative as a client with a defined role and specific needs is a relatively recent phenomenon.

Until the 1950's the role of the relative in relation to the patient in any ward of a General Hospital in this country was very clearly defined. Relatives were absolved of all responsibility for the patient's care on his admission to hospital. During the period of hospitalisation relatives were allowed to visit the patient, during which time they were "spectators, receivers of good news or bad news, until the day of discharge, when quite suddenly the patient was theirs again" (Wilson 1973, p. 26).

The role of the nurse vis-a-vis the relatives was equally defined. Firstly, she had to ensure that the relatives obeyed the rules concerning access to the patient. Secondly, she had to ensure that the relatives' behaviour during the visiting period was in accord with that laid down by the regulations and, finally, she had to ensure that they were given specified information, e.g. concerning the date of the patient's operation, at the 'correct' time.[1]

The amount of time during which interaction between these two groups could take place was considerably restricted by the visiting rules, and although some interaction could take place outside of these prescribed times, particularly in relation to the relatives of dying patients, the amount of time spent coping with patients' relatives was a very small part of nursing practice. Possibly because of the very specific nature of the interaction which related to the well-defined roles of the groups involved, this aspect of nursing practice received little attention in the literature.

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1. A booklet, 'Rules and Regulations for Ward Sisters' was published and updated at intervals during the first 50 years of the twentieth century at the hospital at which this research was carried out. The rules quoted above are taken from the 1927 edition of this booklet. Similar booklets or lists are found in other hospitals.

One of the first nursing textbooks which drew attention to the needs of relatives was written by Evelyn Pearce (1953). In this book she pointed out the "difficulties", by which she meant the sights, smells and lack of privacy which visitors could experience in the "special atmosphere" of a hospital ward. But she also noted that visitors could regard the nurses "as someone on whom they too can depend for support in much the same way as the patient does". She recognised that many nurses failed to respond to this need and pointed out firmly that "although the visitors are physically well, they too are under severe emotional strain" (p. 69). In spite of such observations it would appear that the recognition of any relative as a client with specific needs did not really occur until the late 1960's and early 1970's, and by 1974 Portman still felt the need to point out that all "relatives are people also and they care very much for the patient. Who cares for the relatives?" (p. 1125).

However, during the last two decades a number of writers have described ways in which the relative has been recognised as a client in some instances and therefore given a different social position within the hospital organisation. Referring to the patient who has had a mastectomy, Jamison, Wellisch and Pasnau (1978) have recommended that in order to help the patient and her husband, health professionals should be trained to understand and deal with marital and sexual counselling. Maguire, Tait and Brooke (1980) have also called for more training for health professionals in interview skills so that the relatives of cancer patients could be helped.

The 'client' needs of the relatives of patients who have an altered body image as a result of surgery are also now well recognised in the medical literature. Downie (1978) indicated that a mastectomy, or severe head and neck surgery could cause the relative to experience a

sense of revulsion and that their need for help should be recognised. Other writers, including Brechman (1977), have suggested that the relatives of patients who have had ileostomies or colostomies formed may also react in this way, and that they need 'time' and 'help' to come to terms with this situation. Because of the altered body image the relatives and patients can also need help with their sexual relationship (Downie 1978, Metz 1978). The form of the 'help' suggested is that of 'counselling', such problems should be "dealt with sympathetically by an expert counsellor" (Downie). Metz goes one step further and suggests that the counselling should be undertaken by a team approach, in which the physician, nurse, 'Reach to Recovery' volunteer[1] and a person who is trained in psychotherapy together treat the patient and her family. Other suggestions have been made concerning the appropriate counsellor, Maguire (1975) suggesting that the appointment of a clinical nurse specialist should be made to carry out this task.[2]

Various other suggestions have been made in the professional literature concerning other approaches to meet relatives' needs. Wellisch, Jamison and Pasnau (1978) have described the way in which they have used family therapy "to aid cancer patients and their families in coping with the difficult and unique psycho-social problems presented by having a cancer diagnosis". Other writers have described the way in which groups have been formed in an attempt to meet the now recognised needs of the relative. Hawker (1964) reported a 'relatives' conference' formed for the relatives of stroke patients to strengthen the links with those "who help the patient towards independence at home". She pointed

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1. Reach to Recovery is one of a number of schemes whereby a patient who has had a mastectomy, assists other mastectomy patients both in practical ways and by helping them to come to terms emotionally.

2. There are at present a very few clinical nurse specialists, although those in post do see this aspect of nursing practice as part of their role (Cox 1979).

out that family members in the past had often been forgotten and left "without information or explanation to continue as best they may" (p1098). A scheme which involves both the patient and his relatives has also been described by Newby (1980). She has pointed out that the relatives of patients who have undergone cardiac surgery are invited with the patient to attend a social gathering to meet the nurses and doctors who care for the patient. The patient and his family are then able to discuss the patient's aftercare over a cup of coffee.

The relatives of patients admitted to psychiatric hospitals have also been invited to join relatives' groups. These 'clubs' have been established in some instances by nurses (Gifford 1966) or by the multi-disciplinary team (Goldmeier, Hollander and Sheehan 1970). The main objective of one such group was "to try and help families to become more aware of the problems of inter-personal relationships" (Monro 1970). He also found that "on the whole relatives were able to give considerable support to each other when they recognised common problems in dealing with various aspects of psychiatric illness and its recurrence"[1]. Masters (1979) has described an eight-week course run for the relatives of patients suffering from senile dementia, the aims of the course were to provide "fellowship, education and information" (p. 4).

While these groups do meet certain relatives' "needs", they do not concern most of the relatives of the patient admitted to the general hospital for they do not set out to meet the needs caused by the patient's hospitalisation. Rather, they set out to meet the needs of family members who need to continue caring for a sick person at home after hospitalisation is complete. The needs of the relatives of the patient in a general hospital are often still ignored although Metz (1978) has indicated that about one-third of the patients, and their spouses, treated in her oncological ward needed this sort of help. It has been suggested that in

1. Personal correspondence with Consultant Psychiatrist who organised such a group.

many instances they are not met because the task of assisting with such problems has not yet been accepted by either the medical or nursing profession. Referring specifically to the sexual problems of the patient and his or her spouse following colostomy, she points out that this "is one area which tends to be neglected ... so a whole sphere of the patient's and family's well-being is neglected. No-one seems to want to take responsibility for this" (Jackson, 1978, personal correspondence).

A few schemes do, however, try and meet the needs of such relatives, although not yet in this country. The American literature indicates that in some areas nursing 'programmes' have been designed to meet the needs of other groups of relatives. One such study, that of Breu and Dracup (1978), has described positive measures which have been instituted in their ward, a coronary care unit, to meet the needs of the spouse. The needs they are attempting to meet are the needs for (a) relief of initial anxiety, (b) information, (c) to be with the patient, (d) to be helpful to the patient, and (e) for support and ventilation.[1] The needs of the relatives of patients facing surgery are also well-recognised in the American literature, and a number of programmes have been set up to 'teach' the relatives pre-operatively. Silva (1978) describes her research relating to one such programme. She concluded her article by stating "We are enthusiastic about providing a systematic and validating pre-operative teaching programme for spouses of surgical patients" (p. 1086).

Before we consider those studies which have focussed specifically on the nurse-relative relationship, one further aspect of the professional client encounter which has particular implications for the social position of the relative should be considered, that of 'territory'.

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1. 'Ventilation' in this context does not refer to the life support machinery which may be necessary in order for the patient to breathe, but to the relatives' need for some form of 'self expression'.

The concept of territory has been used by sociologists in the study of human behaviour, particularly by Whyte (1955) in his study of teen-age groups, and it was also extensively discussed by Goffman (1971). He has described the way that the physical structure can affect the course of any encounter. The architecture of a building has implications for the values of privacy, surveillance and the like. Norms exist to define the areas which are public and private, and norms serve to honour the partition between them.

Mauksh (1966) has pointed out that in the hospital the nurse is the only "functionally organised specialist" to have a specific geographical identity. All the other specialist groups move through the organisation. As a corollary of this territorial status the nurse assumes a "quasi-proprietary aura" about her position. The patient care unit or ward is "hers" and people entering the ward come into "her" territory.

These two findings, that of the specific geographical identity of the nurse, and that of the effect of the physical structure on all encounters appear to have particular implications for the present study of the nurse as a professional interacting with a client who enters "her" territory. The significance of this can perhaps be better understood if the relationship in the hospital is compared with the nurse-relative relationship which takes place in the patient's home, that is, with a district nurse.

In a major study concerning the district nurse, McIntosh (1979) found that the nurse in the patient's home has to fulfil two potentially conflicting roles, that of a guest in the house and that of skilled professional. The nurse needs to be enough of the guest "to enable relatives or patients to maintain the feeling that they are still master

or mistress" and she needs to remain sensitive to the wishes of her hosts. But she also has to attempt to negotiate the appropriate nursing lead. In the home therefore the relative has a well-defined social position, but in hospital this role has no such positive territorial rights.

A number of different aspects of the role of the relative have been considered in this section. We began by looking at the role of the client in broad terms before focussing on the client in the medical setting. Some considerable attention was then given to the role of the family in illness, particularly to the role of the family of the dying patient. These are themes which will be taken up again in subsequent chapters. We then discussed the 'relative' as a client, identifying a number of different ways by which the organisation gives recognition to this status.

Finally we considered the notion of 'territory' for this appears to have some significance to the present study. Most of the studies discussed in this section have highlighted the difficulties inherent in the social position of the relative vis-a-vis the organisation. While the studies in the first section, concerning the nurse, showed this position to be an ambiguous one in that he/she functions in relation to both professional authority and to the authority of the administration, they nevertheless indicated that the social position of the nurse within the organisation is well defined in relation to the social structure. The relative on the other hand has been shown to be an 'outsider' unsupported by the structure of the organisation. There are, however, some indications that this is a role in transition (a finding which also applies to the role of the nurse) and that the 'knowledge' which is increasingly disseminated throughout our society may further change this role.

III The Nature of the Nurse-Relative Relationship

We now come to the final section of this chapter and consider the few studies which have focussed on the nature of the nurse-relative relationship. The number of studies which have considered this relationship are few, and of those studies which have paid attention to this relationship, only three have been located in which this relationship was the prime focus. Some of these studies have considered the attitudes and perceptions of these two groups, others have considered the behaviour of one or other of these groups within the relationship.

We shall begin this section by examining those studies which have identified the expectations and perceptions of nurses and relatives with regard to each other.

The attitudes of the nurse and the relative vis-a-vis the other

Some of the studies concerning the role of the nurse have tried to elicit nurses' attitudes towards relatives/visitors. Anderson (1973) found that 32% of the eighty nurses in three English hospitals that she questioned made negative comments concerning visitors (of whom a large number are inevitably relatives). Some of the nurses in this study believed that visitors stayed too long in the ward, and that they (the relatives) expected too much information and wanted too much of the nurses' time to be spent on them. The student nurses in Anderson's sample, however, appeared to have "a good comprehension of the needs of the visitor and his importance to the patient". Unfortunately, she found that "to the rest of the staff, the visitor was an added task and burden". This was similar to the findings of an American study of nurses carried out by Habenstein and Christ (1963). They found that the 'chief grief' of the staff-nurse in dealing with 'extra-institutional' persons was seen in what was repeatedly referred to as "the relative problem":

> "Attempted solutions to the 'relative problem' have fallen short of their goal. There is some evidence that the relative by displacement becomes a scapegoat in many situations involving frustrations at work."
>
> (p. 161)

The problem of 'the relative' was to some extent contained when visiting hours were restricted. The changes in visiting times have brought this problem to a head (the changes will be fully discussed in Chapter 5):

> "An attitude is still prevalent which regards visiting time as a nuisance in which the nurses are pestered by anxious relatives ... creating barriers such as these does nothing to allay relatives' fears. ... The sight of relatives queuing at the ward entrance is an anachronism. It is archaic to believe that we have the right to deny relatives access to patients."
>
> (Garton, 1979 p. 1747)

The difference in attitudes between the two groups of nurses, student and trained, described above, can be explained to some extent by McGuire's (1966) proposition that most entrants into nursing are 'people oriented', but that as their training proceeds they become predominantly task oriented.

In a more recent study concerning nurse attitudes Miller (1979), while accepting that what a person says may not be what he feels or does, (as demonstrated by La Piere, 1934), nevertheless asserted that, regardless of what is taught in school, trainee nurses will usually adopt attitudes similar to those of established ward staff. In this way it is likely that the students questioned in the above sample would, as they gradually completed their training, also eventually come to see the visitor as "an added task and burden".

As well as perceiving the relatives as "an added task and burden", Cass (1979) has pointed out that the relatives can also be perceived as

"difficult" by the nurses. A "difficult relative" being a relative who fails to accept the staff's plans concerning the patient's discharge and aftercare. (cf. with Peterson, 1967[1]).

A number of studies have also identified the nurses' perception of the relative seeking to interact with the nurse as an unwelcome interruption of nursing practice (Congalton and Najman, 1971, Meyer, 1960 and Anderson 1973). Yet although nurses appear to perceive that the relative can be a cause of interruption to the nursing routine, a study carried out by Hockey (1976) concerning areas of nursing practice for which nurses wanted more time produced only a small number of responses concerning"more time for the relatives".

The studies described above have identified negative attitudes towards the relative amongst many trained nurses, both in this country and in America. This suggests that conflict may be inherent in the nurse-relative relationship.

A mixture of both negative and positive attitudes has been identified among relatives towards nurses, although similar to the studies which have focussed on nurses' attitudes, negative attitudes predominate.

Only a few studies concerning the attitudes of relatives towards nurses have been located. One such study concerns the relatives of stroke patients. The findings of this study are qualified by the authors:

> "Generally warm attitudes towards the nursing staff were expressed. Perhaps 'kind and hardworking', 'tough' but not 'bossy' conceals a failure in communication skills

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1. "A difficult patient is often described as demanding, unco-operative, unresponsive to treatment; unappreciative or generally unlikeable. Actually a difficult patient is one whose needs are not met - emotional, physical or both." (Peterson 1967, p. 523).

> because our patients did not expect nurses to talk much to them or their families and tended to excuse any perceived inadequacy."
>
> (Christie and Lawrence, 1977 p. 50)

A number of relatives, particularly nurses who have "become" relatives, have written articles concerning the process of "being" the relative of a patient in hospital. Some of these articles have also identified the attitudes that relatives may develop towards the nurses caring for the patient. Many of the nurses who have written of their experience of "being" a relative are somewhat critical of the nurses with whom they came into contact during their "relative" experience. D'Addio (1979), Dolan (1967), Fraser (1979), Griffin (1978), Wire (1978) and others have all written from this point of view. D'Addio wrote of her longing for empathy from the nurses; Dolan claimed that the nurses' familiarity with hospital procedures could make them forget that to a relative hospital and illness can be terrifying; Fraser found that looking at nursing through the eyes of a relative was very disturbing and stated that she learnt some harsh facts about the realities of nursing care; Griffin bemoaned the lack of "someone to talk to me - to me"; and Wire described the problems she experienced as a nurse/relative when her husband was classified as a 'difficult' patient. Other nurses who became the relatives of patients admitted to hospital have described the difficulties they encountered, concerning the gathering of information and how this difficulty shaped their attitudes towards the nurse (Jenkins 1978, Bishop 1979(a) and Lovegrove 1979).

The above findings are of some interest for they indicate that nurses who become 'relatives' may experience some form of 'reality shock' as described by Kramer (1974)[1]. It would appear that the role of the

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1. "The total social, physical and emotional response of a person to the unexpected, unwanted, or undesired, and in the most severe degree to the intolerable." (p. 3)

nurse does little to prepare the role incumbent for this other role incumbency.

The 'non-nurses' who have described the 'relative experience' vis-a-vis the nurse have also identified negative attitudes held by the relative. Parker (1978) described the jealousy he felt of the nurse who was both caring for and making decisions concerning his wife, while another relative pointed out how she was given no reassurance by the nurses and "became a very bewildered and frightened person" (Anon 1978).

We should now consider those studies which have identified the expectations of these two groups.

The expectations of the relative

Only one study has been located which has focussed specifically on the relatives' expectations of the nurse. This was a small study carried out by Brislen (1978) in which he attempted to identify the expectations of the relatives of elderly patients in hospital in this country. Brislen found from his study of the 'supporting relatives' of geriatric patients that firstly, the relative expected that the nurse would be a source of information which he/she would be prepared to transmit clearly; secondly, the relative expected the nurse to accept responsibility for keeping him/her informed as required, and finally, the relative expected to be included in the planning of patient care when the patient was not willing or able to do this for himself.

These are important findings, particularly the last one, which are of some significance to this study for they support the indication that the expectations of the 'consumer' using the National Health Service, as well as in other spheres of life is changing. Storch and Simpson (1980) have pointed out that some health care groups are responding to the

change by showing 'concern' for consumer rights. They also point out that although the nursing literature also indicates a growing concern with the changing expectations of the consumer, the actual practice of nursing has not been consistent with this apparent concern.

Some consumer groups in other countries have recognised that a more positive approach to 'patients rights' is necessary. The American Hospital Association statement on a Patients Bill of Rights (A.H.A. 1973) and the Consumers Association of Canada Statement on Consumer Rights in Health Care (C.A.C., 1974) are examples of statements which not only draw attention to this matter, but also give the consumer a basis from which to proceed with a formal complaint if these 'rights' are not met.

In this country consumer rights are protected by the Office of the Health Service Commissioner, the Ombudsman, to whom complaints can be directed for investigation. The reorganisation of the health service in 1972 also provided for the establishment of a Community Health Council in each district to represent everyone in the community including the patient and his family.

Other associations which are independent of the government have also been established. The Patients Association was formed in 1963 and claims to have led or contributed to action in such areas as the appointment of the NHS Ombudsman, improvements in drug safety, reductions in hospital waiting lists, a code of practice and improved hospital visiting hours.

The existence of such consumer protection groups does give the client some recourse outside the organisation which may give support if his/her expectations are not met. This is important for as Susser and Watson (1971) have indicated, dissatisfied clients cannot effect change "through the mechanics of the market place ... only dissatisfied

community groups, resorting to political pressure on the institution, can effect change from without; they are increasingly learning to do so" (p. 189).

Communication in hospital

The expectation concerning information is a notion which has been identified in a number of studies concerning communication in hospital. While none of the major communication studies have focussed specifically on the relatives' expectations, a number of these studies have focussed on the expectations of both the patient and of his family. Mumford and Skipper (1967) found that the patient and his/her family want information concerning the patient's diagnosis, the duration of the illness, the patient's progress, treatment and prognosis. Studies carried out in the 1960's, Barnes (1961), Cartwright (1964) and Raphael (1969), found that the lack of such information from hospital staff was a major complaint of patients and their relatives. Cartwright summarised the situation by pointing out that:

> "While it can be accepted that some patients may have forgotten, not accepted or misunderstood what they were told, and others were really seeking reassurance or even misinformation, there is some evidence of a serious failure of communication between some patients and hospital staff." (p. 86).

The prescriptive literature for nurses points out that the patient and the relatives' 'right to know' is here to stay:

> "Daily we are reminded that patients and their families are more aware of their needs as health care consumers."
>
> (Gilson 1974, p. 5)

In spite of this acknowledgement the situation does not appear to have changed very much for Rayner (1980), a well-known 'agony aunty', has recently written an article in one of the prestigious nursing journals

drawing attention to the fact that many relatives (and patients) write to her to ask for information which should have been given to them in hospital. MacLeod-Clarke (1980) has also pointed out within recent months that the dissatisfaction with communication is now no longer "restricted to private grumbling, for an increasing number of patients and relatives are submitting formal complaints against medical and nursing staff" concerning this matter. (p. 9).

Some attention has been given to the way in which health professionals attempt to control the amount and nature of the information which they share with the 'client', be it either the patient or the relative.[1] Rosenthal and others (1980) have indicated that "information control is fundamental to the maintenance of staff power over patients and families". They argue that this is justified by the health professionals as a way of preventing the management problems which could be created by better informed clients. Other reasons for the restriction of information have also been put forward. Brown (1966), Roth (1963) and Skipper (1965) have all suggested that this restriction masks the professional's short-comings from the scrutiny of their clients, while Davis (1963) and Quint (1965) have suggested that limited communication protects the professional stance of detachment and concern.

"Better communication" with patients' families has been the subject of a number of articles in the nursing press (Williamson 1969, Roberts 1971, Frost 1970, Parfit 1975 among others). But, as Marson (1977) has indicated, as yet "little work of a systematic nature has been done on the development of interpersonal and inter-psychic skills in the trainee nurse". The problem of communication therefore remains one which is generally unresolved within the hospital setting.

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1. The literature concerning the management of information is reviewed by McIntosh (1977).

Coping with relatives as an aspect of nursing practice

Coping with patients' relatives has been shown by Moores and Moult (1979) to occupy only a very small amount of the nurses' time. In their timed study of nursing activities, Moores and Moult found that "dealing with patients' relatives and friends" took up 0.5% of the nurse's day and was rated 39th out of 137 activities arranged in descending order. To set these figures in proportion it should be noted that no one activity took up more than 7% of the nurse's time in any one day, and the form of activity which occupied the highest amount of time was the time spent by the nurse in the kitchen, bathrooms, sluice, etc.

However, it should be noted that Moores and Moult related their 'timings' to all nurses on the ward. Fretwell (1979) looked at six senior sisters' activities on six wards and found that "talking to visitors" ranged from 0.6% - 8.4% of the sisters' time.

It is not, in the light of these figures, surprising therefore that an unplanned activity, which can take up to 8.4% of the nurses' time, should be perceived as 'interruption' as identified by the studies discussed in the section concerning the attitudes of nurses to relatives.

Relative 'behaviour'

A few studies have identified different aspects of the behaviour exhibited by relatives and nurses vis-a-vis each other. Wilson (1971) noted the diffidence with which some relatives approached professional staff, including the nurse. This was also reported by Bellamy (1970) who found that this was related to "not knowing the rules about who to get information from". However, other studies have also noted the 'power' of the relative to adopt certain forms of behaviour which to some extent

compensate for other disadvantages, already described, in the nurse-relative relationship. Glaser and Strauss (1965) have described status forming tactics adopted by the relatives in order to obtain treatment for the patient which is at variance with that prescribed by the staff. Davis (1965) has, in addition, described the behaviour involved in 'shopping around' in which the relative goes from one professional to another in an attempt to improve the quality and quantity of information concerning the patient.

When family members are not able to deal with the stress of hospitalisation, various behaviours indicating crisis may be observed. Hall and Weaver (1974) pointed out that such behaviour may appear to be belligerent towards the staff but that it more properly represents the failure of role expectations.

We should now turn our attention to nurse behaviour.

Nurse behaviour

Most of the nurse behaviour identified vis-a-vis the relative concerns 'visiting', and relates to the nurse's attempts to produce conformity in the relative. Roth (1971) has pointed out that service occupations or organisations cannot select the clients, so that some effort is directed towards "transforming those you do get somewhat closer to the image of the desirable client". (This aspect of behaviour has been described by Gold (1952) between janitors and their 'clientele'). Roth found that in the Accident and Emergency department "visitors are promptly ordered to a waiting room and are reminded of where they belong if they wander into a restricted area" (p. 853). McMillan (1980) has pointed out that in some hospitals the "reception is less than cordial ... the nurses keep guard to make sure that there are only two visitors per patient, that children under 12 are kept out". She continued by pointing

out that the enforcement of such behaviour generates autocratic attitudes on the part of the staff:

> "Rules are rules and must be obeyed without exception. Any deviation from the rules must be stamped out."
>
> (p. 725)

Jacobs (1978) also noted that control was exercised over who could come into the ward, when, and what they could do while they were in it, but that in addition control was also maintained by the lack of facilities for visitors.

The ultimate sanction for non-compliance could be a refusal to allow the relative admission to the ward. Fagerhaugh and Strauss (1977) have drawn attention to this possibility:

> "If families help, or at least they do not hinder the work, they are welcome, but if they are unco-operative the staff will try to control or even banish them."
>
> (p. 12)

Rosenthal et. al. (1980) have described the way in which "problem families", that is non-compliant families were controlled by nurses in a Canadian Hospital. In the first instance they could be given a role as 'worker', in which they could be given definite tasks relating to patient care (the hospital had a strong institutional commitment to family participation). They could also be given the role of 'patient', in which they could become the "legitimate object of the health professionals' attention and skills". In this way "altercasting" (described by Weinstein and Deutschberger, 1963) by imputing roles other than that of 'visitor' to the relatives constrained their conduct. Bond (1980) too observed that relatives were made to conform by the nurses of a radio-therapy ward, although she also noted that nurses tended to avoid the relatives making no effort to obtain detailed information of the kind

of problems they were facing.

Although the picture concerning nurse behaviour is very incomplete, the pre-dominant notion which emerges from these studies is that of 'control', with some aspects of nursing practice seeming to be directed towards obtaining compliance from the relatives.

Conclusion

We have dealt at some length with studies which have helped to illuminate our present understanding of the nurse-relative relationship. These studies concerning this relationship reveal an incomplete picture of the relationship suggesting that much more data is needed before any real understanding of the relationship can be reached.

A number of factors concerning this relationship are, however, of some significance. In the first instance, nurses and relatives provide an interesting contrast with regard to group composition, for nurses are a highly organised group with a well-defined place in the structure of the organisation. Relatives on the other hand, while they share some common characteristics, have little contact with each other and are 'outsiders' in the organisation.

Secondly, relatives and nurses are not invariably well-disposed towards each other. Thirdly, there appears to be a failure of role expectations particularly concerning 'information'. Finally, there are some indications that nurses attempt to control certain aspects of relative behaviour.

These, and other themes which have emerged and have been fully discussed in the text will be taken up again in later chapters.

CHAPTER 3

METHODOLOGY

The discussion of earlier research in the previous chapter has indicated that the relationship between nurses and patients' relatives in a general hospital is a largely unexplored area. It was therefore decided to use the Naturalistic approach for the project so that the social processes which were the focus of the study could be observed and discussed with the participants as and when such processes occurred within their natural setting. The Naturalistic technique is well documented (Denzin 1968, Schatzman and Strauss 1973), and is a methodology which encompasses three principles:

1. the researcher enters the field of his enquiry as a participant observer for a period of intense social interaction with the subjects of the study,
2. the researcher creates much of his method in the field, developing strategies and operations at any stage of the fieldwork for obtaining answers to questions which arise as a result of his investigations, but which allow for data to be unobtrusively and systematically collected,
3. the discovery process does not need to be related to any one theory but leaves the researcher free to think about any of the pertinent theories and assumptions pertaining to his subject matter.

The Field of Enquiry

The examination of the relationship which exists between nurses and patients' relatives was carried out in five wards and departments of one District General Hospital.[1] The hospital was situated on the

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1. The hospital will be referred to as St. Davids in the text.

outskirts of a provincial city and served a population which was both urban and rural. By restricting the research to one hospital the overall organisational policy remained constant allowing variations in behaviour which could be related to individual ward organisation to be identified. The wards in which the observation took place were a medical ward, a gynaecological ward, a geriatric ward, a Coronary Care Unit and the Accident and Emergency department.

The Researcher

The researcher was an experienced nurse who had, prior to the commencement of the study, been actively involved in nurse education.

Obtaining Access

A number of difficulties were encountered in gaining access to the field. These are described in some detail for they are relevant to the study in a number of different ways. In the first instance, the difficulties encountered in the initial negotiations extended the time needed to complete the field work and consequently the project. The problem of 'time' will be fully discussed later in this chapter but is noted at this point, for this extension was unanticipated and occurred in spite of the co-operation of all the people involved in the negotiations. The problem occurred because at the same time as the initial letter requesting permission to carry out the study was received by the District Nursing Officer some intimation of an industrial dispute, part of a national dispute, was also received. The negotiations proceeded but it was indicated from the outset that the project could possibly be held in abeyance if the potential dispute materialised. The industrial dispute eventually caused a two-month delay in the negotiation process.

A further delay occurred with regard to the problem of confident-

iality. This problem was raised initially by the Divisional Nursing Officer and her team of senior nurses, who referred the matter to the District Management Team. The Team asked for a further statement concerning this matter and then referred the problem to the Ethical Committee. After some deliberation the Ethical Committee asked for a further statement concerning 'confidentiality' and also for reassurance that no pressure would be placed on individual nurses to co-operate. They finally requested that the consultants of all the patients whose relatives would be involved in the project should be contacted and their permission obtained. Permission was only given for the negotiations to proceed at ward level after the researcher had agreed to all of these requests.

This final request from the Ethical Committee with regard to the permission of the consultant placed a second constraint on the research, for in a small number of cases this was refused.

One further problem was encountered. After permission had been obtained from the Ethical Committee a number of ward sisters were asked by the Divisional Nursing Officer to attend a meeting at which the researcher was invited to outline her research proposal. This meeting was initially a fairly traumatic one for the researcher, for it appeared to her that most of the sisters invited to the meeting were against the proposed methodology. It seemed that 'observation' was perceived by them as a threat. In addition to this some of the ward sisters had discussed the matter with some of the doctors on their ward and it was reported at this meeting that "they don't like it either". (In the light of later findings this early reference to the collusion between consultant and ward sister is of some interest). Three further objections were also raised, firstly that the nurses were under pressure because of the work-load, and this form of research would take up

valuable nursing time; secondly, that the presence of an observer could prevent relatives from giving the nurses information with regard to the patient; and finally, that much of the interaction which took place between nurses and patients' relatives was of a confidential nature.

In order to counter these arguments the researcher referred to her own experience as a ward sister, indicating that she could appreciate the matters raised, but that this past experience should help her to overcome these difficulties. It was also stressed that the consultants concerned would be approached by the researcher herself and that at this stage it was nursing permission which was being sought.

Eventually, after reassurances had again been given in regard to confidentiality[1] some of the ward sisters agreed to consider the proposal. Each of these sisters were then seen individually and specific problems discussed. From this group of ward sisters five wards which matched the original request were selected. The five wards and units originally requested were selected in terms of the 'task' of the ward, for although the social structure of each unit is to some extent determined by the organisational structure, it was thought that it would be possible to identify other aspects in the social structure which are directly related to the 'task' and patient population of named wards.

All of the ward sisters who agreed to take part in the study were adamant that the researcher be identified as a nurse researcher by a name badge and if possible by some form of uniform. They disagreed concerning the nature of the uniform so the researcher agreed to comply with the wishes of each individual ward sister with regard to this symbol. In the end ordinary clothes were worn on two wards, a white overall on

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1. Rainwater and Pitman (1967) have pointed out that the researcher uses the promise of confidentiality as an inducement to informants, but that this promise places a dual responsibility on him. Firstly, he is bound by the right, the privacy of the informant, and secondly, he is bound by the fact that he made this commitment.

two wards and a voluntary worker's overall on one ward.

One methodological problem occurred at the beginning of the field work as a direct result of these final negotiations, for in spite of the co-operation of everyone encountered 'in the field' a feeling of being 'on trial' was experienced by the researcher. This had to be overcome before the desired relationship could be established.

In retrospect some of the problems encountered initially were because the researcher did not give the people from whom permission was required precise details of the activities which would take place during each observation period. Yet this was not possible for one of the principles of the naturalistic approach to a problem is that the researcher creates much of his/her method in the field in response to questions which arise as a result of the investigation.

Participant Observation

Participant observation as a method is well documented (Bruyn 1966, Junker 1960 and Gold 1969). Four different roles are possible within the boundaries of this method: 1) the complete participant; 2) the participant as observer; 3) the observer as participant; and, 4) the complete observer, although as Junker has indicated "the role of complete observer is more imaginary than real".

The role of complete participant can raise both moral and practical problems, 'moral' because this method may be difficult to defend ethically, and 'practical' because although the participant observer may gain a more complete experience of the subjects socio-cultural milieu, he looses much of his objectivity in the process. Byerly (1964) and Pearsall (1965) have pointed out that most researchers tend to vacillate between the 'observer as participant' and the 'participant as observer'. For the observer as participant, observation takes precedence.

Although this role can be limited in opportunities for obtaining information because of the superficial relationships she forms with her subjects, the risk of over-involvement is removed.

The participant as observer is, by virtue of her closer interpersonal relationships with her subjects, able to obtain a wider range of information from multiple sources. However, this role contains a risk of the field worker's over-involvement with her informants at the expense of data collection.

Becker (1958) has described the task of the participant observer:

> "The participant observer gathers data by participating in the daily life of the group or organisation he studies. He watches the people he is studying to see what situations they ordinarily meet and how they behave in them. He enters into conversations with some or all of the participants in these situations and discovers their interpretations of the events he has observed." (p. 652).

Three steps have been identified within this process: "registering, interpreting and recording" (Schwartz and Schwartz 1955). Success in this role depends on the ability to negotiate satisfactory relationships within the setting in which it takes place. The researcher must find some role which is acceptable to the people she is observing but which will also "allow both intimate observation of certain parts of their behaviour, and reporting in ways useful to social science but not harmful to those observed" (Hughes 1960, cited by Baker, 1978, p. 65).

Before focussing on the actual methods used it is necessary to consider the influence of the observer, for as Weick (1968) has indicated "observers are perceptible as well as perceptive". Some consideration must therefore be given to the possibility that this presence may alter the course of a natural event. Because all action is oriented in some way to the social context the presence of an observer must to some extent change that situation, but as Becker (1969) has emphasised

the "daily business of life has to get done" and continues in spite of the observer's presence:

> "The people the field worker observes are ordinarily constrained to act as they would have in his absence by the very social constraints whose effects interest him; he therefore has little chance, compared to the practitioners of other methods, to influence what they do, for more potent forces are operating." (p. 43).

In addition to this the relationship which was to be observed was in many ways a 'public' one, taking place in the presence of others, nurses, doctors, patients etc.

It is also necessary to consider the notion of bias for as Schwartz and Schwartz (1955) have indicated, this is a universal phenomenon. The observer can, however, by specifying his own biases, limit some of the distortion of his observations. This requires continual introspection as part of the research process, for the need to "recognise and use one's inner conflicts and biases is an essential part of the data being collected and analysed" (Quint 1967, p.110). Byerly (1968) has indicated that "conscientiously recorded notes" allow the researcher to reflect on the roles played and on how the researcher's own behaviour may have affected the response elicited. Reflection also enables the researcher to consider how in turn the responses elicited have affected her feelings and subsequent attempts to obtain further information.

Methods Used to Collect Data

Each ward was studied for a period of three weeks. This three week period was followed by an interval of 3-4 weeks to allow preliminary analysis of the data collected.

Data was collected from each ward and department during daily four-hour periods for eighteen days of the three week period. The

daily four hour periods were arranged to cover the full day-time span of duty, but concentrated on those periods in which most relatives visited the wards. Some time was also spent with the night staff on some of the wards.

The first few days in each ward focused on a number of specific activities. Firstly, data was collected with regard to the physical structure of the ward, for as Hall (1966) has pointed out, "Fixed-feature space is one of the basic ways of organising the activities of individuals and groups; it includes material manifestations as well as the hidden internalised designs that govern behaviour as man moves about this earth." (p. 97) Secondly, permission was obtained from all the nurses working in the ward to observe any interaction with relatives in which they might be involved.

A number of discussions have focused on the notion of 'informed consent' by which the participants choose whether or not to take part in an investigation after being informed of facts which could influence their decision.[1] This principle is based on both cultural values and legal considerations and there is also a 'common-sense' justification in that potentially harmful research is minimised. It can also improve the quality of the researcher/subject relationship making the research experience beneficial for both.

Diener and Grandall (1978) pointed out that when field studies do not significantly affect subjects lives, informed consent can be methodologically undesirable. Therefore, if anyone other than the nurses, patients and relatives taking part in the study asked questions about the role of the researcher these were answered truthfully, but no effort was made to specify her purpose.

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1. This literature is reviewed in Diener and Grandall, 1978.

Vidich (1955) has pointed out that each respondent forms an image of the respondent and will place her into a 'meaningful context'. This 'meaningful context' will determine her social position and will determine to some degree what she is likely to see. The respondents' perception of the researcher as a 'nurse' may have been an advantage during this early period, although it was recognised by the researcher that it was necessary to avoid committing allegiance to one segment of the group to be studied as far as this was possible.

It was also recognised from the outset that the position of the researcher was an ambivalent one, for it was necessary to 'woo the society' to 'live' in it, yet it was necessary to 'deceive the society' to study it. Enough information must be given to potential respondents to fulfil the ethical requirements implicit in 'permission seeking', yet too much information could be a cause of distortion. Levine (1976) has indicated that there are eleven types of information which need to be given about the research, the purpose, the participant's role, the reason for the choice of subject, the procedures to be employed, any risks or discomforts, any benefits and, if applicable, any alternative procedures. The researcher should also offer to answer any questions, and should state that the subject can withdraw at any time. Finally, if this is applicable, the researcher should state that further information will be given following the experiment. This information was fed back to the ward sisters who took part in the study before any of the findings were published.

As well as taking note of the physical structure and obtaining permission from participants, notes were also made of the routine activities within the ward setting, recording observations about the way in which they were performed.

Places were also chosen during this period from which the inter-

action taking place between nurses and patient's relatives could be observed without intruding on the situation. Recordings of the interaction observed were also made during these first two to three days, so that nurses were used to seeing the researcher with a notebook. These preliminary recordings were not, however, used as material in the analysis, for it was believed that until the nurses were accustomed to the presence of the researcher, they might find it difficult to behave 'normally'.

Notes were only made at the time of the interaction if this could be carried out without intruding on the situation, for example, if the interaction was taking place within earshot but far enough away from the participants for them not to realise that this was being done. In other instances, as soon as the encounter was completed, the researcher withdrew to record as accurately as possible the interaction observed.

The use of a tape-recorder had been considered as a possible aid to the collection of this form of data, but this idea was abandoned after some consideration. Tape-recorders and video-recorders are an essential tool for the collection of interaction data which is to be analysed in great detail as an end product, but the focus of this study was also on the organisational factors which could affect the interaction patterns. Therefore, while the collection of interaction data was essential it was only part of the overall methodological approach. It was also known from a previous study (Fox 1976) that most interactions between nurses and patients were of short duration (less than 30 seconds) and from previous experience it was considered that nurse-relative interactions would be similar. It was therefore believed that there would be little actual data loss due to the inability of the researcher to recall the format of the interaction. In most instances the interactions observed were in fact of very short duration, although no effort

was made to time them.

During this initial period the researcher also introduced herself to a number of relatives, and, where this was appropriate, to the patients concerned, seeking their permission for her presence during any encounters they might have with nurses. None of the nurses who were consulted refused to co-operate, although as it will be indicated later some were initially uneasy about giving their consent. Two of the relatives initially refused permission, but both later approached the researcher indicating that they had changed their minds.

After three or four days 'acclimatisation' the data collection began in earnest. During each period of observation, after obtaining the consent of those involved, notes were made of all the nursing activity which took place in which relatives were involved. Such activity included the interaction which took place between nurses and patients' relatives, the interaction between nurses and their colleagues concerning relatives and the verbal reports given to nurses coming on duty, in which references to the patients' relatives could be made. It was accepted by the researcher that communication between nurses and relatives also takes place on the non-verbal level. However, except for very obvious non-verbal behaviour no attempt was made to collect non-verbal behaviour for the researcher had no experience in the correct and accurate interpretation of such data, and the use of a video-recorder allowing for later interpretation was not practical.

Most of the interaction which takes place between nurses and relatives occurs in a 'public' area, that is, in the corridor, ward or at the nurses station. This means that it is easily observed without apparent intrusion, for the observer is just one of the 'crowd'. In order to obtain this form of data much of the time was spent sitting near the nurses station. Other observation places were also required,

and at the beginning of the field work the problem of choosing the most important place to be at any particular time was difficult. This became easier as more information was collected and the main foci of the research established, although it was never entirely resolved.

At times the relative was invited 'backstage' by the nurse. This only occurred if the nurse perceived the relatives' enquiry to be of some import, or if she wished to make an announcement.[1] In such instances it was necessary for the researcher also to go 'backstage'. While it is believed that little distortion occurred due to the observer's presence in the 'public' area, it is necessary to consider the possible distortion that the researcher caused by her presence in the 'private' area. This problem has been discussed by Kratz (1975) who argued that the answer to the question of distortion lies in the "exact numbers involved in small-scale interaction, the type of transaction, on the participants in the transaction and on the locale in which the interaction takes place." (p. 53). In order to avoid the introduction of a third party, that of the researcher, into this form of encounter, and thereby alter a dyadic situation into a triadic one, the researcher in such instances was introduced as a 'colleague', who was watching the nurse, and the usual permission sought. While this ensured that the relative response was likely not to be altered, the infrequency of these occasions did not allow the nurse to 'forget' the researcher's presence and it is likely that in such instances, therefore, the situation was distorted. But, it should be emphasised, such occasions were not very frequent. Notes were not taken in these situations, but an account was made of such encounters immediately after they had taken place.

It has already been indicated that some data was collected by

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1. Announceable events will be discussed in Chapter 8.

listening to reports given to nurses coming on duty. From this data it was possible to reach some understanding of the way nurses perceived certain relatives, and also of the way in which decisions were made concerning who would be the 'announcer' if an announcement had to be made.

As well as noting the interactions with regard to relatives some discussion concerning aspects of the interaction observed was initiated with the nurses as and when the opportunity occurred. The researcher was also 'fed' pieces of information which the nurses thought might be useful. All such pieces of information were acknowledged gratefully, although their reliability was privately regarded as unestablished.

Three other methods of data collection were used. Firstly, the available documentation produced by the organisation as policy documents were examined, as well as the procedure books and the patients' daily records which were maintained by the nurses. Secondly, all the nurses on each ward were interviewed. Thirdly, a number of relatives were interviewed over the period of time during which they were visiting the hospital.

These multiple sampling strategies allowed for data to be triangulated as described by Zelditch (1962).

Becker and Geer (1957) have indicated the advantages to the researcher of using both 'observation' and 'interviews' - pointing out that it is essential to learn the language of the people being interviewed, and that this can only be verified by observation. They also indicated that there are matters which interviewees are unwilling to discuss at interview, and that interviewees can see themselves to be 'distorting lenses'. The combination of methods allows the researcher to monitor such discrepancies. Monitoring a process over a period of

time also sensitises the researcher to any change in perspective.

Fifty-four nurses were interviewed. Each interview covered the same ground, although not necessarily in the same order, with the different participants, by the use of a topic list of twenty-four different aspects of nursing practice vis-a-vis relatives. Key phrases were noted down at each interview and an account was then written up immediately afterwards. These interviews took place wherever a reasonably private place could be located, the treatment rooms, sisters' office etc., and lasted between 15 and 30 minutes. Arranging and carrying out the interviews with nurses caused few problems, but this task was not so easy in regard to relatives.

It has already been indicated that the researcher talked to nurses about matters raised by her observations, including those in which they interacted with the relatives. She also discussed matters arising out of those individual pieces of observed interaction with the patients' relatives, but, in addition to this, information was required which would help to provide some insight into the meanings given to the experience of being a relative of a patient in hospital by the relatives themselves, in particular concerning that part of the relative experience in which they had some contact with nurses. It was planned to obtain such information by carrying out a series of short unstructured interviews with a small number of relatives in each ward, while the patient was still in hospital, in which the relative would be encouraged to formulate his or her own replies to questions which were related to the relatives' retrospective view of his or her experiences. This information would be linked to the observed temporal sequence of relative behaviour in the ward setting. There were two reasons for the choice of a series of interviews with relatives in preference to the one in-depth interview chosen for collecting information from individual nurses:

1. It would allow for the possible identification of any relatives' attitudes which changed as a result of consequent experiences.

2. It was hoped that this method would encourage the development of a relationship between the researcher and the relative. (Relationships with all the participants in the research will be discussed later.)

This aspect of the research was not introduced to the relatives until other strategies for collecting data were established, although of course some contact was made with relatives during this early period in connection with the collection of other forms of data.

It was believed that relatives might be reluctant to take part in this aspect of the research but in fact the opposite was found, and the relatives approached appeared very eager to talk about their on-going experiences. (This of itself may indicate an unmet need in relatives). However, as previously indicated, this aspect of the research created a number of specific problems (Hawker 1979).

In the first instance there were limitations placed on the collection of this data by the way in which relatives occupy themselves on the ward. Secondly, there was some difficulty experienced in maintaining continuity between the researcher and the relatives. Finally, there was some difficulty experienced in regard to the 'space' in which such interviews could be carried out.

The Limitations Placed on the Collection of Data by the Way in Which Relatives Occupy Their Time on the Ward.

One of the principles of the naturalistic technique is that data collection must not be intrusive. The time the relative spends with

the patient is often very precious to both of them and it had been anticipated that relatives, and the patients whom they were visiting, might be reluctant to share some of this time with the researcher. The researcher, therefore, had to remain very sensitive to this, and she tried as often as she could to use the opportunities which occurred, when the relative had for some reason or other to leave the patient's bedside, to carry out one of the interviews. This was less of a problem on the wards where visiting was unrestricted as the relatives in these wards often had to leave the bedside so that some form of nursing activity could take place, but in those wards where visiting was restricted, nursing activity concerning actual patient-care lessened considerably during these periods. If such an opportunity did not occur it was necessary to devise some alternative means for initiating the interview. In some instances the researcher would wait and see if any other visitors arrived for the patient and would then feel free to ask the relative if they were prepared to talk with her on that day. She would occasionally see the relative and patient together but tried on most occasions to see the relative alone as it was found that a number of relatives were reluctant to say very much in front of the patient. An arrangement could also be made to see the relative on their way out of the hospital but this was only convenient if the relative had no other pressing engagements, as the amount of time a relative plans to stay with the patient is related to other daily activities.

If none of these opportunities arose and the relative and patient were totally engaged in conversation throughout the visiting period, the researcher would wait until the next day when in most instances an opportunity as described above would arise. If it looked as if this was unlikely, only then would she interrupt the patient and relative to make an arrangement.

In order to avoid interrupting a lively relationship between patient and relative the researcher had to spend a lot of time just looking for opportunities. The number of relatives involved in this aspect of the research was limited to three at any one time to keep the situation within manageable proportions.

A similar series of interviews with patients or nurses would be far less of a problem as there are a number of times during each day when patients are not involved in any sort of activity. It is also possible, although perhaps more difficult, for nurses to arrange their activity so that the research process does not intrude on other aspects of nursing practice.

There was a further minor problem relating to time. Some relatives, especially those who were the relatives of patients who were unable to respond normally to their visitors because of their physical condition, were only too glad to talk to someone during the visiting period. The difficulty here was to find ways of terminating the interview when the events and experiences in which the researcher was interested had been fully discussed. Most interviews lasted for about ten minutes, but one, the longest, with the relative of a terminally ill, unconscious patient, lasted for two hours.

In the first few interviews the researcher had to take the initiative in introducing those subjects in which she was interested, but most relatives soon became aware of her interest, and later interviews were less structured and allowed for gentle probing into the meaning of the event for the relative. The first few interviews were also the interviews in which a relationship based on trust was built, but such a relationship takes time, and the most productive interviews were those with whom the relationship had built up over most of the observation

period, i.e. up to two-and-a-half weeks, and the least productive were those with relatives of patients who were in hospital for only a few days. (Some data was collected in this way from relatives of patients who were only in for 48 hours, but this provides little insight into the meaning of the events described.)

The Difficulty of Maintaining Continuity

Closely related to the problem of time was the problem of maintaining continuity. The patients' relatives are an elusive group. No-one can ever be sure when they will be in the ward. Although the four hour periods on the ward were most heavily concentrated on those times when most of the relatives were in the ward, it was possible for a relative to visit a patient several times without being in the ward at the same time as the researcher. This was because the observations were also related to other aspects of the research, while the relative was only able to visit the patient when not engaged in other activity outside the hospital. It was not absolutely necessary to see each relative every day as has already been pointed out, but some effort was made to avoid too long a gap between events which might be significant for the relative and the discussion of such events.

If too much time had elapsed since an event which was then discussed, the researcher had to be aware of the changes which might have taken place in the reporting of such an event.

If the researcher missed seeing a relative for any length of time, she would try and alter her observation schedule to be there when the relative was next expected on the ward, but this was not always possible, and there was some data loss because of this problem. Fortunately, a number of relatives were very co-operative and would tell the researcher of their visiting plans for the following day, and some would also look

for her when they arrived on the ward, so that in their own way they helped to maintain continuity.

The Lack of Space in Which to Talk to Relatives

During the course of the research, the researcher interviewed a number of people from different disciplines within the hospital. All of these interviews took place within some sort of office space to which that person could lay claim,the nurses' office, coroner's office in the mortuary, social worker's office, etc. She also talked to a number of patients who, although they did not have any office space, did have some 'bed-space' which belonged only to them. While the bed-space did not afford very much privacy, it did not interfere with other peoples' use of space. However, there was some difficulty with regard to the space in which a 'spaceless' researcher could interview 'spaceless' relatives, not only once but several times.

Only one ward had a visitors room and this solved the problem on that ward, but in all the other wards a space had to be created before any of the interviews were initiated. The space used could vary from day-to-day or even within the same observation period. Interviews took place in empty side-wards, in the day room, in waiting areas outside the ward, or even, in desperation, in the corridor. Interviews in all of these places were unfortunately likely to be interrupted by other people wishing to use the space. The researcher was therefore concerned about the lack of privacy in these various settings, none of which met the criteria set out as the ideal environment in the 'how-to-do-it' research books. It says a good deal about the relatives taking part in this aspect of the research that they were willing to tolerate these conditions.

Comparative analysis of the data collected in these many different

settings indicates that the effect of the different settings appears less than had been anticipated. It seems that the main advantage of the visitors room was that the relatives relaxed more quickly. The disadvantage was that the combination of comfortable armchairs and the quiet atmosphere tended to prolong the interviews with some relatives, i.e. those of patients not able to respond normally, many of whom were happy to talk about other issues not related to the research, and it seemed more difficult to terminate these interviews. The least satisfactory location appeared to be the corridor, possibly because this was the location in which there was the most distraction.

The methods described so far were carried out on all the wards in which the observation took place, but there were also a number of strategies which were used in connection with specific wards. These will be described below in the context of each ward and unit.

The Medical Ward

The medical ward was a mixed ward of twenty-two beds served by two consultants, and managed by one ward sister. During the observation period on this ward the researcher sat at the desk usually occupied by the ward clerk, who was on holiday at the time. From this position it was possible to monitor most of the telephone calls into the ward, and some effort was made to focus on this aspect of the interaction which takes place between nurses and patients' relatives.

The Coronary Care Unit

The Coronary Care Unit comprised six beds served by six consultants and was managed by three ward sisters working a duty system of internal rotation[1]. No additional strategies were employed in this unit at the

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1. Internal rotation means that one of the three sisters is on night duty for a period of a week before being replaced by another etc.

time, but after examining the data, a letter was sent to ten other coronary care units in order to follow-up an aspect of behaviour identified (this will be described in the text).

The Gynaecological Ward

The gynaecological ward was managed by two ward sisters and comprised 40 beds. It was served by three consultants. While on this ward a survey using a simple questionnaire was carried out among patients with young families at home, in order to collect information with regard to the effect of the patients' hospitalisation on the family.

The Geriatric Ward

The geriatric ward comprised thirty beds, was served by one consultant, and was managed by one ward sister. During the observation period the ward sister was away, due to illness, and the ward was managed by her deputy, a staff nurse of some experience, who shortly after the observation period was appointed to a sister's post. During the period of observation, the researcher attended the multi-disciplinary meetings, held weekly to discuss the patients, during which discussions in regard to the patients' family figured prominently. She also attended two 'stroke relatives meetings', convened by the physiotherapy department and supported by the nursing staff, which were designed to teach the relatives of 'stroke' patients some aspect of their care.

Accident and Emergency Department

At the request of the four sisters and the nursing officer who managed this department, the observation took place at two different times of the year, one two-week period during the winter, and one during the summer. This was because during the summer the work-load

was normally increased by the influx of holiday-makers into the surrounding area. No additional strategies were used in this area.

Although the settings varied in different ways, as Lofland (1971) has indicated "they are alike in that they provide for those involved a similarity of circumstance of action". It was possible, therefore, using the methods described, to identify phenomena which arose out of the general features of the settings, and which could be observed 'across the board'. But it was also possible to identify phenomena which seemed to arise out of the more specific features of each setting.

However, collecting data is only one part of a 'multiplex process' in which analysis, research design and 'write-ups' are all carried on simultaneously, continually influencing and impinging upon one another (McCall and Simmons, 1969). Bailyn (1977) has indicated that continuous analysis is important for two reasons, firstly it allows the data collected to be sufficiently complex, without overwhelming the researcher, who is able to control its cognitive complexity. Secondly, it enables links to be made between the data and existing concepts, thus indicating where more data is needed.

The method of collecting data already described resulted in a mass of notes at the end of each period of observation. Some attempt was made during each three week period of observation to begin the preliminary analysis. In the very first instance a number of questions as suggested by Spier (1973) were asked of the data in order to determine any major categories. In this way the 'routine' kind of interactions were identified, some possible constraints noted, special terms used identified, and the difference between front and back-stage behaviour established. Data concerning individual nurses' behaviour was examined for indications of special entitlements, privileges and

qualifications which defined spheres of rightful behaviour for them but not for others. The data was also examined for possible patterns of deference, and for the way in which responsibility was delegated and enacted by those in positions with duties and obligations towards others. This preliminary examination of the data guided the researcher to further particular observations, and questionning of the people observed. Some attempt was also made during this period to define particular categories by the constant comparative method. At the end of the three week observation period this process was completed before the next three week period of observation began.

During these intervening periods the implications of the developing categories were considered as well as their relationship to other categories. Categories were developed from the data by the 'constant comparative method' suggested by Glaser and Strauss (1967). Glaser and Strauss also indicated that these 'reflective periods', as well as giving the researcher a break from data collection, allow him/her to think uninterruptedly about the field experience, and to 'reflect' systematically about his/her data in accordance with his/her basic analytical categories, and to consider the interplay between the two.

As categories were identified from the data, their properties were defined in the light of the existing data, and then each category title was written on a 5"x8" index card. Further examples found in the data were then compared with the original until the category was 'saturated' (Glaser and Strauss, 1967). In this way it was possible to identify the typical and routine applications of the phenomenon as well as the range of its applicability and the way this varied systematically in use.

Many of the original 233 categories generated from the data clustered into recognisable concepts.

However, it should be pointed out that not all the categories were systematically followed through as the field work progressed, for their significance was not immediately apparent, and it was only later that some propositions were precisely formulated. In this instance these propositions were tested against the existing data.

Neither should it be assumed that following the last 'reflective period', everything fell into place. The final 'ah-ha!' did not occur until much later in the process, and there are also some 'loose ends' which could be followed further. The analytical model will be further discussed in Chapter 4.

Before focussing on the 'relationships' in which the researcher was engaged it is necessary to take note of some of the practical problems encountered during the data collection and analysis.

1. Some difficulty was encountered by the researcher in regard to her new role within a hospital ward. Pearsall (1965) and Byerly (1969) have indicated the advantages of the nurse carrying out research in a familiar environment, in that she avoids 'culture shock'. They have also pointed out the disadvantages which the nurse may have in this situation: in the first instance she may be so familiar with the environment that she overlooks the familiar, and secondly, she may not initially be able to avoid over-identification with the nurse group. Thirdly, she may experience some difficulty in the re-orientation from being actively involved in patient-care to a passive role as far as patient-care is concerned. This in fact was less difficult than some of the other aspects for the researcher, possibly because of her previous experience of 'watching' student and pupil nurses when practising as a clinical teacher. Some attempt was made at first on each of the wards in which the observation took place to refrain from 'lending a hand' in order to concentrate totally on the observation.

However as the researcher became more familiar with her surroundings she was able to utilise 'participation' in the routine as a source of data. But as soon as the researcher indicated her willingness to participate she also found that she had to define exactly what she would and would not do, or she would rapidly have been perceived as a 'nurse' on the ward, for example, an 'extra pair of hands', and not as a researcher.[1]

2. It has already been pointed out that the consultants' permission to observe interaction involving 'their' relatives was refused by two consultants, both of whom attended the coronary care unit. It was necessary, therefore, on this ward to establish first of all if the relative could by this criterion be approached for permission. As this was only a small unit this was not a major problem but it did create a practical hindrance.

3. There were also problems experienced with regard to confidentiality. Because the researcher was identified as a 'nurse' some of the relatives asked questions of her, during the course of their interviews, concerning the patients' condition. In such instances the researcher had to deceive the relative by pleading ignorance.

4. One further problem occurred, which unavoidably caused distortion of the situation under observation. A number of relatives in all the wards, entering the ward for the first time, approached the researcher looking for information. As a matter of courtesy the only response available to the researcher was to direct them to the most likely source of information, for example, the ward sister, but this obviously distorted the 'initiation behaviour' pattern.

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1. Byerly and Pearsall also indicated that the situation could arise in the ward when the nurse as researcher had to choose between intervention and non-intervention by making a nursing judgement. No such situation arose.

5. It is also thought that some distortion may have occurred in the data collected by interview because the researcher was perceived as a nurse by both relatives and nurses. Although some relatives were critical of the nurses this was in most instances qualified by a statement such as "they're so busy" or by some reference to their "kindness" in other areas. This may have been because the respondent perceived the researcher as one of the group she was criticising.[1] The nurses also at times appeared to be exhibiting 'researcher pleasing' behaviour. However, because of the other sources of data it was possible to monitor such discrepancies as suggested by Becker and Geer (1957).

6. Some consideration should briefly be given to the amount of time which participant observation as a method requires compared with other methods. Every part of the process is time-consuming. Whyte (1979) has pointed out how long it takes for the researcher to 'break through' the superficialities of conversation among strangers. It is possible that this is easier in a hospital ward than in some other settings, for the social structure of the ward is designed to constantly incorporate 'strangers' into the system, albeit 'strangers' in well-defined social positions, such as patients, student nurses, unlike that of the researcher. However, a period of time was still necessary for the researcher to define a position for herself within that structure.

   Jackson (1975) has also indicated that it takes time and practice for the novice to become comfortable with the process.

   Finally the analysis itself takes time.

   We should now turn our attention to the matter of relationships.

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1. This was not unlike the findings of Nehring and Geach (1973) who found that patients were reluctant to comment on their care under any conditions no matter what methods were used to try to obtain this information.

Building relationships with the groups within the setting is also an important part of the research process. Whyte (1979) has indicated that "success in the field depends less on the mastery of certain techniques than on the ability to build a mutually supportive relationship with his subjects". However, although relationships are very important it is equally important to prevent over-rapport with any of the subjects for too close a relationship may prevent some lines of enquiry being pursued. "The question for the participant observer is not merely that of developing rapport, but what kind and quality of rapport are desirable". (p.60).

The hospital is a highly structured setting, in both social and territorial terms, and in order to gain access to this setting the researcher has to be socially located. Each group within the hospital has its territory and also its social location. In such an organised setting the unlabelled, unlocated person is either a transient (like the relatives and other visitors) or an unlicensed intruder, both of which are unsuitable roles for the researcher. Labelling the researcher as a 'nurse' undoubtedly had advantages in terms of contacts with other members of the group, but as has already been indicated this may have disadvantages vis-a-vis other groups, and in some instances with the group with whom she was identified. It seems likely that because of the structured nature of the relationships induced by labelling, some classes of information may be inaccessible to a researcher who is labelled as a nurse. It was essential therefore that a supportive relationship was established with relatives and nurses in order to minimise the consequences of labelling.

As previously reported, the researcher talked with a number of relatives each day, usually in the ward, but attempts were also made, where this was appropriate, to enter "the relative world" outside the

ward, by waiting in the waiting room, standing outside the ward doors, waiting for visiting time to begin, drinking tea in the hospital canteen, travelling on the hospital bus.

In the same way the researcher accompanied the nurses to meals, drank coffee with them, played backgammon with the night staff during their break and accepted an invitation to a leaving party for one of the permanent staff on one of the wards.

Mistakes were made, for example, a relationship with two first-year students perceptibly changed after they discovered that the researcher had been a clinical teacher - "Now we shall think that you're watching to see if we do it wrong." This was unfortunate, but is part of the learning process of the researcher.

The attempt by nurses and others to place the nurse into a meaningful context has been described by Fretwell (1979) and Baker (1978). The experience of the researcher was similar. A number of nurses were interested in the researcher's future plans, and her past. This may be, as suggested by Baker, because other nurses were anxious to place her in the nursing hierarchy, and in that way try and discover her relationship with nurse managers.

It was essential that the researcher was perceived as 'trustworthy' and was not perceived as 'reporting back' to the management. If questions were asked the researcher made it clear that she had no contact with the management, and in fact this was true for the management made no attempt to maintain any links.

Some effort was made by a few nurses to use the researcher as a 'sympathetic ear' and as an audience for complaints about the 'duty rota' and the staff shortage. The researcher in such instances attempted to

refrain from making a judgemental response.

The nurses' perception of the task of the researcher is also of some interest. A number of nurses regarded the apparent 'inactivity' of the research as 'boring'.

> "I couldn't just sit there watching like that, I'd have to be doing something."

They were, however, anxious to know what 'notes' were being taken.

> "I wish I knew what you were writing down."
>
> "One day I'll steal that little book."

One doctor actually asked to see what had just been written. This request was granted for he had been party to the conversation just recorded so no breach of confidentiality took place, and it was thought that this would indicate that no subjective criticisms were being recorded.

The doctors' attitude to the research was also of some interest. Most were unfamiliar with the methodology employed and some tended to be scornful, "too much memory loss and bias", "not possible to do a good piece of research that way". On the other hand, a number of them were very anxious to give their unsolicited views concerning patients' relatives.

The unfamiliarity with the research methodology also appeared to create a threat for some nurses on some of the wards. This had already been indicated at the first meeting with the sisters. As the researcher was leaving the various wards at the end of the observation period, a number of nurses indicated their immediate reaction to hearing that the research was to take place in 'their' ward.

> "We were all a bit put out when we heard you were coming - we thought you'd be grabbing us every time we talked to a relative - I for one was very unhappy about that."
>
> (SRN)

> "When I heard what you wanted to do, I thought, not with me she doesn't. I'm not going to have someone follow me around."
>
> (SRN)

The nurses' perception of the research as a threat, and the 'boring' nature of the task is not surprising in view of Oleson and Whittaker's finding that many participants have "fallacious images of what sociological researchers do". Part of the researcher's task would therefore seem to be that of teacher.

One further comment should be made about relationships between the researcher and others. Byerly (1960) indicated that some nurses may attempt to keep the researcher at a distance by joking, teasing behaviour. This was not encountered with nurses, but was a fairly common behaviour pattern adopted by the doctors toward the researcher.

It was not possible to measure how successful the researcher was in regard to relationships. This can only be judged by the incidents she was permitted to watch and the conversations in which she participated "indicating success in negotiating an acceptable role, being both trustworthy and unobtrusive." (Baker 1978).

Conclusion

The methodology employed allowed the researcher to progress from collecting a kaleidoscope of subjective impressions to the collection of data which was used to test out propcsitions which had arisen from the data. It is possible therefore to indicate in the ensuing chapters the 'fit' between the different components of this complex process.

No attempt was made to measure the amount of satisfaction or dissatisfaction with any aspect of the nurse-relative relationship, for as Mauksh (1973) has pointed out, such studies have been acknowledged as "being largely useless". He also indicated that repeated findings of the 'satisfied' patient "must beg the question of concept and methodology", and that since these studies merely tap a segment of a stream of negotiated relationships, it is not surprising that the usual response of patients tends to bear witness to their effort to succeed in the interaction game rather than being any indication of either the real experience or to its quality.

Data has instead been used to illuminate the different aspects of the nurse-patient relationship, highlighting the significance of the social structure in which this relationship develops.

The discussion in this chapter has focussed on the methodology employed in this study. Some consideration has been given to the way in which the data was collected, and also to the way in which the collection of data was perceived by both the researcher and others concerned in the process. Before we go on to consider the different aspects of the nurse-relative relationship we should now pay some attention to the analytical model employed. This will be considered in the next chapter.

CHAPTER 4

THE ANALYTICAL MODEL

Some brief reference was made in the previous chapter, as part of the description of the methodology employed, to the way in which the data was analysed. Further attention must now be given to the analytical model itself and to the relationship of this model to the theoretical perspective of this thesis.

The discussion will be concerned with three separate issues which are themselves inter-related. Although these issues are not easily divisible because of their relatedness some division must be made in order to reach an understanding of the way in which each issue plays a part in the social context of this research.

Firstly, as indicated in Chapter 3, the research procedures used in this study were procedures which produced descriptive data. These procedures and the data produced reflect the researcher's attempt to capture the 'whole' setting as opposed to focussing on isolated variables or hypotheses. In this way the research methodology can be described as 'qualitative'.

The two different approaches to the collection of social data, qualitative and quantitative, both of which are well documented, each have their devotees among sociologists, most of whom are willing to accept that both methods, albeit with certain reservations, play a useful part in extending the frontiers of sociological knowledge. However, there are also within each camp critics of the alternative method employed by colleagues in the opposite camp. Although a detailed description of the qualitative versus quantitative argument, which has existed among sociologists for many years, is not appropriate at this point, some reference should be made to the specific arguments made

against the qualitative method and to their implications for the present study.

Secondly, further consideration should be given to the use of grounded theory as described by Glaser and Strauss, for their work, and the work of others who have themselves been influenced by these two sociologists also has major implications for this piece of research.

Finally, some attention should be paid to the cognitive process implicit in the analysis of qualitative data.

It is hoped that this discussion will help the reader both to understand the logic of the data analysis utilised in this study, and also to establish the quality of the theory generated in this way.

The Qualitative Method

During the period 1920-1930 two great methodological issues sharply divided sociologists. These issues, which, as already indicated, still to some extent exist today, centred on the merits of case studies versus statistics and also on the concept of subjective interpretation. A compromise was eventually reached by which it was generally acknowledged that case studies could be usefully carried out but that as a method this was not as impressive or as advantageous as the statistical method. Similarly subjective data, such as motives and intentions, were held to be relevant only insofar as they were classifiable and countable. In this way such data could be used as the basis for a theoretical interpretation of statistical relationships between this and other data.

McCall and Simmons, after summarising the situation briefly described above in 1969 noted that at that time these arguments for and against the various methodologies, in particular the credibility of subjective data, were still to be found in the literature relating to

participant observation. Much more recently, in a review article, Roos (1979) has attempted to present the substance of the arguments which exist at present in a critique of the recent literature describing the use of qualitative methodology in some recent studies. The main substance of the argument at the present time appears to be not so much about the merits of the methods themselves but more about the quality of the theory, and its general applicability, which each method can generate.

The present preoccupation with the quality of the theory is of some relevance to the present study and will be discussed more extensively later in the chapter. At present we shall focus briefly on the lesser argument which also still persists, concerning the credibility of the data collected by this methodological approach.

The techniques employed to collect qualitative data are of necessity non-standardised. The main advantage of non-standardisation is that the direction of the enquiry can be altered, in response to the data collected, to more fruitful areas of investigation. In this way the field situation can be exploited to the full. Although this is a major advantage, it should also be noted that non-standardisation may possibly inhibit the formulation of variables and hinder the understanding of the relationship between them. While accepting this rider it should also be noted that this "lack of formulation is not an inherent shortcoming of the method, but it is a frequent concomitant" (Dean, Eichhorn and Dean, 1969, p. 21). However, because of this lack of formulation arguments have been levelled against the proponents of these methods that the data is not necessarily reliable or valid[1] and therefore credible.

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1. It is accepted that reliability and validity are issues which affect not only the credibility of qualitative analysis but are also a problem in any form of data collection. Attention has already been drawn to the method of "triangulation" of data in Chapter 3 by which to some extent these problems are overcome. (See p. 77).

The blame for the continued existence of this argument may possibly be levelled at some of the researchers themselves who have employed these techniques in the past. It is likely that in some instances too much emphasis has been placed on the methodological issues such as gaining access, interviewing, handling reciprocities and so on rather than on the intellectual work of analysis and the way in which the credibility of the findings are established. Sieber (1976) has suggested that this exaggerated emphasis on the "non-intellective aspects" of field work leads to the suspicion that the human relations orientation of people working in the field takes precedence over scientific concerns. This is not to say that rigorous methods of data collection and analysis, which themselves help to reassure others of the reliability and validity of the data as well as the credibility of the researcher and the research findings, have not been carried out, only that they have not always been described in sufficient detail. It is possible that this lack of detail has led to suspicions that are hard to allay.

In order to overcome this deficiency Merton, as far back as 1957, asked that the sociological fraternity should include in their publications a detailed account of the way in which qualitative analyses actually developed:

> "Only when a considerable body of such reports are available will it be possible to codify methods of qualitative analysis with something of the clarity with which quantitative methods have been articulated."
> (p. 390)

There are of course some publications which partly deal with this issue (for example Hammond, 1964) but this still remains a relatively undocumented area.

In addition to this lack of detail from researchers themselves, one further point concerning the analysis may also have created some

suspicion about qualitative methodology. The texts which describe the analytical methods which can be employed in the handling of qualitative data are ambiguous concerning when the analysis should take place. In some texts the analysis is described as on-going (Glaser and Strauss, 1967), while in others it is described as either an on-going process or as an activity which can take place after the collection of data (Bogdan and Taylor, 1975, Schatzman and Strauss, 1973). Yet in the former the analysis appears to play an integral part in establishing the credibility of the findings. Credibility is established in the former by noting the consistency of the observation, and by constant comparison of the data as the fieldwork takes place. There may or may not be any significance in the timing of the analysis but attention has been drawn to this inconsistency by Seiber (1975) who has indicated that this and other ambiguities in the analytical tools employed have led to the notion of qualitative analysts adopting "random behaviour patterns - or worse, haphazard behaviour patterns" (p. 3).

However, in support of the qualitative method some of the shortcomings of the quantitative method should also be indicated. It has already been suggested that by focussing on predetermined variables and looking for their relationships, some part of the area under study may be missed. In addition to this Roth (1966) has indicated the tedium and the inaccuracy which can be associated with trying to make data fit into pre-determined categories. Roth used this assertion in his argument concerning the use of 'hired hands' as data collectors, but the assertion stands even when the motivation of the individual researcher is high and can lead to inaccuracies in the analysis which are hard to detect. Yet they are to some extent detectable because of in-built controls.

The methods and the in-built controls used to collect quantitative data are well documented and have thus been laid open to the normal

canons of criticism. It is to be hoped that more detailed descriptions of the way in which qualitative data is collected and the analytical model employed will further the on-going discussion of these methods. Such discussion may be fruitful both in refining the methods themselves and also in further establishing the credibility of the findings based on qualitative data collection.

We should now return to the discussion of the main thrust of the argument levelled against qualitative methodology at the present time, which questions the quality of the theory generated from qualitative data and the general applicability of this theory. As this aspect is so closely interlinked with the other final themes to be discussed in this chapter, that of the cognitive process implicit in the analysis, it will be considered firstly as a methodology in this part of the chapter, and then in relation to the cognitive process in the next section of the chapter.

The Use of Grounded Theory

The role of any researcher is two-fold. Firstly, data needs to be collected using methods which are reliable and valid and secondly, the researcher needs to generate an explanation of the collected data. It seems reasonable in this discussion of the social context of the research to focus at this point on the theoretical perspective which underpins this thesis, that of 'grounded theory'.

The use of grounded theory as an approach to the handling of qualitative data was first described by Glaser and Strauss (1968). By this term they meant "the discovery of theory from data". The use of this approach allows the researcher to develop theory relating to the substantive area being studied, and encourages the application of the individual's creative intelligence in doing so.

The number of studies using this approach has grown steadily during the last fourteen years, including a number of studies carried out by nurses (for example Melia, 1979, Ogier, 1975).

The method employed to handle the data in this study deviates somewhat from the method described by Glaser and Strauss, although the influence of these two sociologists has been of some impact on the present study. The actual methodology employed to handle the data collected for the present study owes much to the work of Turner (1981) who has identified advantages of this approach. Firstly, it promotes the development of theoretical accounts and explanations which conform closely to the situations being observed. In this way it is likely to be intelligible to, and usable by, those in the situations studied. Because of this it is also open to comment and correction by them. Secondly, the theories are likely to be complex. This complexity bears some resemblance to the complex phenomena studied and this quality is likely to enhance its appeal and utility. Finally, it has one further advantage in that the researcher is directed immediately to the creative core of the research process. This facilitates the direct application of both the intellect and the imagination to the interpretive process.

Before we consider these advantages and relate them to the present study we should also consider some of the reservations that have been expressed concerning grounded theory. Brown (1973) and Trend (1978) have pointed out many of the dangers inherent in this approach, although both appear to recognise the value of qualitative methodology in certain areas of interest to sociologists. It would seem from their comments that the grounded theory approach is likely to be of maximum use when applied to the data obtained from the observation of face-to-face interactions, from semi-structured or unstructured interviews, from

case-study material or from certain kinds of documentary sources. By the same token it is least useful when dealing with large-scale structural features of social phenomena (Turner, 1981).

The general application of the method as described by Glaser and Strauss (1968) was discussed in Chapter 3, in which it was noted that 233 categories were generated from the data. These categories were labelled according to the one essential property which appeared best to describe each phenomenon. By the constant comparison of each category with the other data it was possible to 'saturate' each category. It was at this stage that a definition of each saturated category could be produced. The definition produced helped both to sensitise the researcher to recognise further instances of the phenomenon and to stimulate further cognitive activity.

An actual example of the way this was done in the present fieldwork may be helpful at this stage of the discussion. On the very first day of the fieldwork it was noted that an upset relative asked the nurse for advice concerning what she should do about informing her brother in Australia that their father's death was imminent. This incident led to the generalisation of several categories including those of 'relative asking for advice' and 'nurse giving advice'. Throughout the first period of fieldwork many other examples of these forms of behaviour were observed. This was a fairly easily recognisable aspect of behaviour and each of these two categories was very soon saturated. From the category of 'relative asking for advice' a definition was produced indicating that the phenomenon being observed was one in which the relative could have certain expectations of the nurse from whom she was asking for advice. This theoretical proposition led to questions being asked of all the relatives interviewed concerning their expectations of the nurse. In relation to this definition other categories of

behaviour which also related to the relatives' expectations of the nurse, not only that of 'advice-giver', were considered. From this exploitation and link-up with other categories, it became clear as the fieldwork and consequent analysis progressed, that this was a proposition of some theoretical importance in the present study. In this particular instance the linkages made with other categories relating to relatives' expectations indicated that in many instances the nurse, because of the relative's expectation, was cast by the relative into the role of 'expert'. This led to further refinements and linkages between categories all followed through in the fieldwork, so it was possible to readily identify the existence of the relationship suggested. As the fieldwork further progressed it was possible to identify the actual conditions in which the relationship, as postulated from the data, held.

The links to existing theory were in this instance readily apparent. These links will be made clear in the ensuing chapters. An attempt was made to exploit and link all the emerging categories in this way. From this very brief description it can be seen that the theory generated is grounded in the data.

However, as already indicated in Chapter 3, while each category was exploited and linked as described above, not all the categories generated propositions so readily. It was only during the final part of the analysis that the significance of some of the categories generated was realised. Also, as indicated in Chapter 3, there were some loose ends which could be followed further. However, the fact that everything does not fall into place does not detract from the effectiveness of the analytical model, for as Glaser and Strauss and others have indicated, although one of the advantages is the closeness of fit between theory and data, the emerging theory is likely to be too complex, if it faithfully represents the complex situation under study, to fall into a

set of simple logical propositions which express its essence. In addition, if the theory accurately reflects that portion of the world which has been studied, other people are likely to recognise this account of their world and in that way help to confirm the theoretical explanation of the processes within it.

Glaser and Strauss concluded their discussion of the use of grounded theory by suggesting that in order to determine the limits of the propositions developed in the emerging theory, an active search should be made for confirming and disconfirming instances. In this way emerging theoretical statements can be related to one single social phenomenon. An example of this can be seen in the way all the propositions generated by Glaser and Strauss (1965) focussed on 'dying'. This stage has not been followed through in the present research. This omission may well be a disadvantage but the complex world of the nurse and the relative in the general hospital does not, as described in this thesis, immediately appear to lend itself to this analytical activity.

The Implications of the Cognitive Process Implicit in the Analysis of Qualitative Data.

We have so far focussed on the mechanics of analysis using the 'grounded theory' approach to the handling of data, although some implicit reference has been made to the cognitive process of the researcher involved in the analysis. We should now consider in more detail this aspect of the social context of the research.

In any social enquiry there is an interaction between the researcher and the social world. In this interaction it is important for the researcher to both recognise and respect the 'quality' of the properties of the world which is being studied. Research analysis is the process by which the researcher is able to tease out these qualities in order

to gain a fuller understanding of them.

During the analysis the researcher becomes aware of the infinite range of characteristics found in any phenomenon and attempts to choose the 'right' facts to solve his research problem however elusive these facts might be. Bailyn (1977), Glaser (1978) and Turner (1981) have drawn attention to the centrality of the cognitive process in some aspects of the research process and to the importance of recognising the effect of this process in the handling of qualitative data. They have indicated in particular the subconscious perceptual processes which influence what is observed and how this is constrained by the information handling capacity of the human brain.

A number of writers have considered the cognitive issues central to theory production[1] but only Bailyn (1977) has suggested that in order to be maximumly useful data must be maintained at a 'proper' level of complexity, neither too simple nor too complex. She has suggested that the data collected needs to be sufficiently complex for if it is too simple it will not provide the researcher with input capable of affecting existent views about the phenomenon being studied. However, she has also indicated that while the data collected must be complex enough to stimulate, if it is too complex it can overwhelm the researcher. Controlling the complexity of the data therefore would appear to be a major analytical activity.

Related to this activity is the notion that the process of analysis is to be understood as proceeding by a continual interplay between concepts and data (p. 101). She has pointed out that when research is viewed in this way analysis is continuous, in that it occurs in all of

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1. See Turner, 1981, p. 229.

the phases of the research process from the initial collecting of the data to the final writing of the findings. Some indication has already been given in the example quoted earlier in the chapter of the way this part of the research process in this study began from the very first day of the fieldwork.

In order to fully follow through these two principles the researcher, during the collection phase of the research, needs to collect the kind of data which will permit the research to proceed in an orderly fashion. After collecting the data, it is then analysed and during the first phase of the analysis, which is perhaps the most creative phase, the researcher needs to transform the data so that it both guides and reflects his/her evolving conceptions. Research results should then be presented in a way which allows them to be assessed by others in the context of this evolving process, which has been made explicit in the text.

Although the process as described in this way appears to be sequential with each phase preceding the next logically, Bailyn has indicated, and it was certainly found to be the case in the present study, that data collection and data analysis are closely intertwined and are not necessarily either perceived or carried out in this logical way. The close intertwining of these activities also leads to some backward examination of the data in the light of emerging conceptualisation.

The analytical process is a time-consuming activity for it is necessary to work slowly and sequentially through the data in order to maximise its cognitive yield.

The final phase of the interplay between the researcher and the data occurs in the presentation of the results. This requires a certain amount of openness by the researcher so that the findings are open to the scrutiny of others. This is particularly necessary in an exploratory

study such as this one. In this way, by documenting the way in which the findings were interpreted, the reader is stimulated to consider their validity.

We began this part of the discussion by looking at the way in which some argument still persists among sociologists concerning the quality of the theory generated from qualitative data. In order to support the 'quality' of the theory generated by the data collected for the present study some attention was paid to the notion of grounded theory and its use in, and applicability to, this work. Finally, reference was made to the cognitive process of the researcher which is implicit in the analytical process.

We should now begin to consider the findings concerning the nurse-relative relationship beginning with an examination of the context in which the relationship took place.

CHAPTER 5

THE CONTEXT

Introduction

Social action in any situation is constrained by the ideas available to the actors involved, and by the conditions under which they act, the former in part determining what they choose to do, the latter in part determining what they are able to do (Robinson 1978). Before looking at the nurse-relative relationship as an on-going social process, it is necessary therefore to examine the 'conditions', or contextual factors, which determine the potential for action of these two groups.

The hospital is an organisation in which various groups of people, with their own priorities and perspectives, come together in some health related activity. Strauss with others (1964) has indicated that in order to understand what the hospital 'is' on any given day, one must have a comprehensive grasp of the rules, policies, agreements, understandings, facts, contracts and other working arrangements that currently obtain concerning the various groups which come together within this setting.

Nurses and relatives, as social actors, have traditionally been constrained by rules. The rules served, to some extent, to define the relationship between them, for they codified the desired relative behaviour, and gave the nurse the legitimate authority to enforce such behaviour.

We shall begin, therefore, by looking at the 'traditional' rules which constrained the nurse-relative relationship. Although they are defined as 'traditional', these rules and the way in which they defined the relationship between these two groups, are within the 'working memory' of many nurses employed at St. Davids hospital at the present time.

Attention will also be drawn, in this first section, to the way in which the rules were enforced by both nurses and doctors, and to the small amount of data available which gives some indication of the role of the nurse in the 'traditional' relationship.

This will be followed by a discussion of the factors which led to the intra-organisational changes of the 1960's resulting in a re-definition of the nurse-relative relationship.

The discussion in the final section will focus once again on the rules and policies of the hospital, taking note of the way in which they are stretched, negotiated, argued or ignored by nurses and relatives at the present time.

I THE 'TRADITIONAL' RULES

Before the establishment of the Voluntary Hospitals most sick people were nursed at home: "it was there the Doctor found the resources he needed for his patients: relatives to provide nursing care, food and shelter" (Burling, Lentz and Wilson, 1956, p.8). As soon as the hospital took over the task of providing shelter, food and care for the patient, it also had to devise a method of coping with the patients' relatives who were bereft of their traditional role, but who retained an interest in his welfare. From the establishment of the Voluntary Hospitals in the eighteenth-century until the present time, rules have been devised by the administrators of each hospital in an attempt to 'manage' this problem.

St. Davids hospital was established as a Voluntary Hospital during the early part of the eighteenth-century. The first 'Rules of the House' drawn up in the hospital studied reflect the values held by the governing body concerning the 'correct' mode of behaviour for all those who became

a part of the organisation, either permanently as employees, or temporarily as patients and relatives. The founders of an organisation inscribe in the rules their preferences and premises about what the organisation can and should be (Lammers and Hickson, 1979), and an examination of these early 'Rules and Regulations' indicates that the Governors believed that the behaviour of both employees and patients should be strictly controlled.

A Visitor was appointed by the Governors to visit the hospital each day to ensure that the rules were not being broken. The appointment of such a Visitor was in keeping with practice in other eighteenth-century hospitals (Brockbank 1952).

Failure to comply with the rules was regarded as a serious matter. During the first decade, following the opening of St. Davids, 15% of the patients were dismissed for 'irregularity'. The first Matron was also summarily dismissed for allowing 'a poor woman' to remain in the wards when she had not been admitted 'in the manner prescribed by the rules'. The Governors refused to recognise the woman as a patient, and both she and the Matron were forced to leave the hospital immediately.[1]

The rules which attempted to control the relatives relate both to the amount of access to the patient which was allowed and to their expected behaviour during the visiting period.

"Access Rules"

Although permission to visit the patient had to be obtained by the relative before he was allowed into the hospital, there appear to

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1. The information for this section is taken from the Minutes of the Governors Meeting, assorted pamphlets and local newspapers. Detailed references are not given because of issues of confidentiality relating to the field work.

have been no set times during which visiting was allowed or prohibited until the nineteenth-century. The fact that permission to visit the patient was needed was indicated on a brass plate, fixed to the outside door, inscribed as follows:

> "No Stranger to be admitted without leave from the APOTHECARY or MATRON or by a written order of a GOVERNOR".

(Notices with instructions relating to access are still posted on the ward doors in the hospital at the present time, the wording of such notices indicating the expected behaviour of the relative in accordance with hospital policy.)

The rules were ordered to be hung up in the wards, and "such other parts of the House as the Weekly Board shall think proper", and they were read to the inmates once a day.

The need for permission to visit was common practice in the Voluntary Hospitals in other parts of the country, some of which began, towards the end of the century, also to restrict the time allowed for visiting. The Court of Committees at Guy's Hospital had decided in 1778 that "the intercourse between patients and their relatives be limited to certain hours" (Cameron 1954).

The Governors of St. Davids did not decide to restrict 'visiting' to specified times until 1825, when it was stipulated that 'visiting' should be restricted to Sunday afternoons only. No reason was given for this decision.

The rule restricting the relatives' access to one day only appears to have had an unforeseen consequence, for it is recorded that on the first Sunday afternoon following the enforcement of the new regulations, the relatives waiting for verbal permission, before

being allowed into the hospital, formed 'a great tumult' and could not be controlled by the hospital porter.

In order to prevent a recurrence of the "difficulties caused" (these are not actually specified) the Governors decided to ask the local Mayor "for the means during a further Sunday or two to prevent any further disturbances". The Mayor responded by promising to send two 'Staff-Bearers' to the hospital to control the visitors! No account of any further trouble is recorded, although it was reported to the Governors that the new brass plate, inscribed with the revised visiting regulations, was "wilfully defaced" within a few days of its erection.

Visiting was restricted to Sundays only until 1832, when the hospital was closed to all visitors for six months because of an outbreak of cholera in the area.

When the hospital re-opened its doors to visitors the following year, the times allowed for access were extended:

> "Persons visiting their friends in the Wards shall be restricted to the following days and hours: Strangers from the country on Tuesday and Friday from 10-12 and from 2-4, and those within the Parliamentary boundary of ..... to the same days from 2-4; and on Sundays persons from the country only may be admitted from 1-2. No person from the country shall remain for more than half an hour, nor any person from the town for more than a quarter of an hour."

The difficulty of implementing these new regulations is immediately obvious, and it is not surprising that they were altered

once again, within a very short time, to Tuesday, Friday and Sunday afternoons for both town and country residents. This pattern of visiting remained unchanged for many years.

From the time of the hospital's foundation, in the eighteenth-century, until the end of the nineteenth-century, the task of managing the patients' relatives appears to have been shared between the doctor and the matron. We have seen so far that either of these role-occupants could give permission for access. It would appear that, certainly by the latter half of the nineteenth-century, representatives of both these occupational groups were also concerned with the 'correct' administration of the rules drawn up by the Board of Governors.

When the new visiting times were implemented in 1833, it was also decided to restrict the number of visitors to two per patient. This rule, relating to number of visitors, while it remained part of official policy, does not seem to have been strictly enforced over the years, for in 1871, both the House-Surgeon and a newly-appointed Matron complained to the Governors concerning this matter. Their reasons for restricting numbers are, for the first time, legitimated in terms of 'good patient care'. (This concept is discussed in more detail on page).

> "There is no limit to the number of visitors whom any one person may receive, and that in consequence the wards are sometimes much too crowded to the discomfort and injury of the sick."
>
> (Letter from House-Surgeon)

> "Could any limit be made to the number of visitors to each patient? Frequently one patient has seven visitors in three-quarters-of-an-hour. It does much harm to the patient."
>
> (Letter from Matron)

The Governors responded to these requests by stipulating that all patients should be issued with two tickets to be used by their relatives at visiting times, and that no visitor was to be allowed to enter the hospital without such a ticket. This system was further developed a few years later by the issue of pink tickets to the relatives of seriously ill patients, who were given special visiting privileges.

By 1892 new 'Rules and Regulations' for staff placed the responsibility for enforcing the rules of visiting on the ward sister who was instructed to:

"... See that all visitors withdrew at the appointed time"

"... Not allow more than two visitors at the bedside of each patient, nor any visitor to remain beyond the appointed time without special permission".

The role of the ward sister had undergone a number of changes during the previous two decades, following the introduction of nursing training throughout the county (this began in the hospital in which the research took place in 1888), and the ward sister of the 1890's had far more authority for the organisation of her ward than that held by her predecessors.

However, although the ward sister was required to enforce the rules, permission for a relative to visit a patient outside the stipulated time[1] remained the prerogative of the Matron, Doctor or Administrator until well into this century. The 'Revised Statutues and Rules' of 1922 make the position quite clear:

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1. The 'stipulated time' was until the 1960's decided by the Governors or by the Hospital Management Committee.

> "Persons visiting their friends in the Wards shall be restricted to such days and hours as may be fixed by the Committee from time to time. At other times they can only be admitted by the special permission of one of the Resident Medical Officers, Matron, Secretary, or by an order in writing from the Physician or Surgeon attending the patient with reference to whom such admission is required ... The nature of the hours and days shall be affixed to the doors of the Hospital".

The situation in relation to access and the control of numbers by tickets remained unchanged throughout the first half of the twentieth-century, except for the relatives of private patients and Military Officers admitted during the two World Wars, who were not controlled in this way.

It has been shown so far that rules were drawn up by the Governors, and used to control the relatives' access to the ward. From the few available sources it would appear that the application of the rules was carried out by both the doctor and the matron/ward sister.

We shall now direct our attention to the rules concerning the expected 'behaviour' of the relative within the hospital during visiting times.

'Behaviour' Rules

Rules relating to the expected behaviour of the relatives were mainly concerned with the issue of food. The provision of food for the patient was the responsibility of the hospital, but was the cause of some difficulty between the organisation and the relatives for many

years, in the hospital studied.[1]

The first set of 'Rules and Regulations' drawn up when the hospital was established stipulated that:

> "No liquors or provisions of any sort be brought into the House to the patients from their friends or any others whomsoever".

This rule was frequently abused at the hospital in which the research took place, and in 1830 the Governors produced a rule which was designed to prevent this abuse. They ordered that:

> "A chain be placed across the foredoor within forming a lobby into which lobby not more than ...[2] be admitted from the door. That from the lobby no person be admitted to visit any patient of any ward without the Porter or his female assistant be satisfied that the stranger be not the bearer of any food or liquor whatsoever. That if any provisions be detected the same be delivered to the Matron, the stranger dismissed from the Hospital and the patient warned that his ever receiving any such provision will be followed by his being at once expelled."

There is no evidence to show when this form of 'search' was abandoned, but later regulations stipulated that nurses should search the patients' lockers after visiting times to "see that they are clean and tidy and contain nothing contrary to the rules".

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1. Not all of the Voluntary Hospitals restricted the relatives in this way, and in some hospitals the relatives were actively encouraged to bring in food (Dainton 1961).

2. The actual number is not specified in the Minutes.

The House-Surgeon also appears to have played a part in trying to prevent the relatives from bringing in food according to a report in the local newspaper in 1889, when the whole issue of food was raised. The newspaper report referred to evidence received at an inquest into the death of one of the patients. Part of the evidence offered by the patient's mother referred to this matter:

> "She knew he (the patient) had an appetite, but they would not allow him what he wanted. He did not say what he had been denied. He asked witness to bring him in some sweets, but the Nurse said they were not allowed. A sponge cake or two had been taken to him, but he was not permitted to eat them."

In reply the House-Surgeon said that:

> "The rules of the institution did not permit such things being taken to patients, and he had to act almost as a detective at times to prevent things being smuggled in."

The problem of supervising relatives with regard to food and drink was recognised in the last decade of the nineteenth-century by a writer of nursing textbooks, Miss Eva Lückes, the matron of the London Hospital.

> "That difficult matter for supervision every visiting day, the bringing in of all sorts of unwholesome provisions to patients whose conditions sometimes makes the viands a source of positive danger."
>
> (Lückes p. 83) [1]

Realising that the supervision of provisions was a delicate problem Miss Lückes advised her nurse readers that "tact and discretion will go a long way towards keeping the peace, and soothing the injured feelings that the well advised prohibition is apt to create". Miss Lückes also reminded nurses that "great firmness is essential for only those experienced in such matters can form any conception of the amount and variety of the food which relatives bring into the Hospital at this time" (p. 83). [1]

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1. Both of these quotes are from her book for ward sisters, which is undated.

The original attempt to control the bringing in of food or liquor by the relatives may have related to the Governors' fear that bribery of the staff would take place using these commodities. There is plenty of evidence to show that bribery was a problem in all Voluntary Hospitals including the hospital in which the research took place, and as late as 1871, the House-Surgeon reported to the Governors that nurses were "still receiving gifts of money and provisions from patients and their friends". With the changing social composition of the ward, and with nurses increasingly drawn from the middle-class bribery was likely to be less.

As well as the 'fear of bribery' it was also believed that the 'correct diet' played an important part in the patients' treatment (Lückes) although this became of less importance as time went on. In spite of these changes the regulation remained until at least the outbreak of the Second World War; legitimated in common with the rules concerning access as being 'for the good of the patient'.

Coser (1964) has drawn attention to the way in which the ideology of 'for the good of the patient' is an element in hospital life which is functional for the 'professionals' involved because it serves to strengthen the common norm. But she has also indicated that the patient does not necessarily benefit from this 'pseudo-consensus' for 'the patient' may "often turn out to be a disembodied abstraction, often involved but less often actually perceived"(p. 34). In this way the individual patient tends to remain an 'object' or a case to be 'managed'.

The picture which has emerged so far is of a rule-bound relationship. The rules clearly defined the behaviour of the relative, and the task of the nurse in ensuring that the rules were carried out. In

this way the rules were functional for the nurse, firstly because they provided a framework of control, and secondly, they gave her legitimate authority within this framework.

Legitimate authority refers to the right of an individual to direct the action of another by virtue of his objective, impersonal position in a social system (Rosenberg and Pearlin 1962). It is the essential underpinning of most formal organisations and is usually supported by implicit coercion.

It has also been shown that certainly in the early days, following the establishment of St. David's, the rules were supported by sanctions which could be, and were, applied if the rules were broken.

The 'Traditional' Role of the Nurse

There is little empirical evidence concerning the 'traditional' role of the nurse in relation to visitors, but it is possible to reach some understanding of this by looking at nursing textbooks and autobiographies.

Eva Lückes drew attention, in two different nursing textbooks, one for ward sisters and one for nurses (dates unknown), to the problem of the 'patients' friend'.

1. "The patients' friends are generally less attractive than the patients themselves, as the latter call out on sympathies by claiming our help, whereas the former sometimes continue to make themselves very troublesome indeed."

   Book for ward sisters (p. 142)

2. "It is not uncommon to hear nurses explain that the patients' friends are infinitely more trouble than the patient himself and sometimes unfortunately this is true."

   Book for nurses (p. 15)

However, the middle-class nurse was gently reminded by Matron Lückes that because good manners were paramount to the nurse, she should always be polite to visitors even though they "may be of no special consequence" (p. 16).

Other groups of nurses, apart from 'general' nurses, were also given specific instructions concerning the 'correct' attitude towards relatives. A midwifery textbook published early in the twentieth-century advised the nurse how to cope with 'granny' after the husband of the patient had been dispatched from the scene:

> "As to Granny, she is undoubtedly the hardest nut to crack of the lot. I think one's attitude towards her should be one of beaming, childlike amiability and good comradeship. If she is rude, don't hear it, frayed nerves are not conducive to good manners. If she darkly hints at better methods, one's best armour is that of an impenetrable stupidity. If she engages in personal reminiscence, indulge her to the full, only turn her off the deaths of her friends, and on to the situations she held as a girl, and the prizes her children took at school. It is all, I quite admit, a most tremendous strain; so probably are the crises of the administrator's life. If, as is often the case, one is becoming anxious oneself, and not quite sure when or whether to send for the doctor (Granny will never forgive you if you incur an unnecessary fee on her son's behalf, and, indeed, it is no light matter), to tie one's smile in a bow behind, so that it can't shift, and maintain an unruffled aspect, is one of the hardest things I know. To do all that not only needs character, but makes it, and we are all of us bigger women than we were before, every time we succeed."
>
> (Gregory p. 54)

The ward sister was singled out by Miss Lückes as having special responsibilities towards the relatives. She was instructed by Miss Lückes to see "as much as she can of the patients' friends on visiting days, giving them all, as far as possible, a chance of speaking to her <u>if they wish it</u>", (my underlining). The onus which is still placed on the relative to initiate interaction "if they wish it" will be taken up later in the thesis.

It would appear that the "availability of the ward sister" was partly to enable her to cope with any complaints which the relatives might wish to make.

> "If they (the relatives) have a grievance, real or imaginary, they are much more likely to complain, and so make a remedy or explanation possible, than if they feel there is no connection between them and the sister, as they naturally will do, if she fails to display any interest in them."
> Book for ward sisters (p.143)

Although it seems that relatives were associated with complaining "real or imaginary" this form of behaviour was firmly denounced by the editor of a local newspaper as unreasonable behaviour (in 1911).

> "Patients and friends of patients are too often on the pounce. A little grumble, the complaint of an overwrought person is taken and twisted until one might imagine that hospital staff are callous torturers."

Complaints, as a feature of the interaction between nurses and relatives also figure in the detailed instructions to ward sisters at St. Davids published throughout the first half of the twentieth-century. The ward sister was not expected to deal with these herself, but was instructed that "complaints from patients or visitors should be reported to Matron at once".

The ward sister was also advised by the writers that tact, discrimination, and "the knowledge of how best to deal with them (the relatives) which comes by experience, can teach the sister the wisest and kindest manner of replying to their anxious and innumerable questions". The 'knowledge' and 'experience' of nurses coping with patients' relatives are themes which will recur in later chapters.

The only relatives who were identified as being in need of special attention were the relatives of dying patients:

> "The nurse must do her utmost to measure their (the relatives) grief by what it is to them, and endeavour to let her sympathy take whatever practical shape the circumstances may indicate."
>
> (Lückes, Book for nurses, p. 211)

A number of autobiographical accounts indicate that 'relatives' were perceived as 'troublesome' well into this century. A V.A.D. working in a military hospital during the First World War records her perception of the sisters' view of relatives:

> "On the whole the Sisters loathe relations. They look into the ward and see the mothers and sisters and wives camped around the beds, and go back into the bunks feeling that the ward does not belong to them.
>
> The eldest Sister said to me yesterday: 'Shut the door nurse, there's Captain Fellow's father. I don't want him fussing round'.
>
> On that we discussed relations, and it seemed to me that it was inevitable that a Sister should be the only buffer between them and their pressing anxieties.
>
> 'No, a relation is the last straw ... you don't understand!' she said.
>
> I don't understand; but I am not specialised."
>
> (Bagnold p. 76)

An account of 'visiting' in the 1930's by Prentis (1977) is in a similar vein:

> "Sunday was visiting day and a lot of preparation had to be made for it. Clean nightdresses were put on, hair brushed, sheets smoothed, lockers tidied, stools put out for the visitors to sit on ...
>
> The time allowed was two hours, but this was cut considerably by Lavender (the Ward Sister) standing on guard outside the ward door keeping everybody waiting while she vetted each visitor for their right to enter. However near and dear they were to the patient they had to stand while she made a quick appraisal of their age - nobody was admitted under the age of sixteen - their relationship to the patient ... but above all the physical condition they were in. This was checked assiduously."
>
> (p. 60)

The last check was to prevent anyone who had been drinking alcohol from entering. Prentis goes on to describe how the nurses were all

kept 'busy' in the ward during this period to watch for any signs of visitors 'misbehaving':

> "Should one of them be wicked enough to rest his backside for a moment on the clean white counterpane put on specially for the day, or be undisciplined enough to smuggle in a portion of forbidden food, the spies (nurses) fell over themselves to report the culprit to sister."
>
> (p. 61)

The visitor was then threatened with expulsion if it "ever happened again".

Although the evidence is sparse it would seem from these accounts that the traditional role of the nurse vis-a-vis the relatives was not one which all nurses, including the writers quoted, accepted happily.

We should now turn our attention to the factors which led to a re-definition of the traditional relationship.

II THE FACTORS LEADING TO A RE-DEFINITION OF THE 'TRADITIONAL' RELATIONSHIP

The role of the nurse and the policy relating to the expected behaviour of the relatives remained relatively unchanged until the early 1960's. We should now therefore consider the factors which led to the intra-organisational changes which re-defined the traditional nurse-relative relationship.

During the 1920's most Voluntary Hospitals were compelled, through financial necessity, to introduce a contributory system, whereby each patient paid something towards his treatment and care. Patients as a group, therefore, began to be "more critical and demanding" (Abel Smith 1964). This change in patient attitude led to some discussion concerning consumer preferences in the hospital and medical journals. However, in spite of this discussion, very little action was taken in order

to meet the new consumer demands, except in the private wards where, for a price, the patient could avoid "the martyrdom of rules and regulations - for instance about visiting hours - which governed the public wards" (Bransen and Heinemann 1971, p.223).

The factors which led to change did not emerge until after the Second World War.

After the establishment of the National Health Service, Government concern with public relations increased. Before nationalisation of the Health Service, little attention was paid to 'public relations' between the hospital and the community except with regard to fund-raising. From the beginning of the National Health Service the Ministry of Health stressed the importance of good public relations (M.O.H. Circular 36/48, 15th March, 1948).

In an attempt to meet the Ministry's requirement a document was drawn up by the Institute of Hospital Administrators (1951), in which the patients' family were given some importance:

> "Relatives and friends comprise the next large class of the public which is brought into contact with the hospital service at fairly close quarters, and their treatment when visiting the sick is a factor which cannot be neglected."
>
> (p. 79)

Although the emphasis was placed on the role of the relative as a 'visitor' documents such as these drew attention to the increased status of the relative vis-a-vis the hospital.

The establishment of the National Health Service itself reflects the changed expectation of British society towards the treatment of illness and the impetus towards the reform caused by the practical and psychological pressure of war.

Also as a consequence of the National Health Service the patient population in most hospitals was no longer divided into 'public' and 'private'.[1] All sections of the population were admitted to the 'general' hospital, resulting in a more articulate formulation of the changing societal expectations, leading eventually to the formation of consumer groups.

One area of consumer interest which appears to have had a significant impact on the nurse-relative relationship is to do with children in hospital. Developments in this area can be traced to the work of Bowlby and Pugh in the early 1950's. They defined and discussed the possible ill-effects of the separation of young children from their parents.

As a result of this work a Committee was set up in 1956, under the chairmanship of Sir Harry Platt, with the following terms of reference:

> "To make a special study of the arrangements made in Hospitals for the welfare of ill children - as distinct from their medical and nursing treatment - and to make suggestions which could be passed on to Hospital authorities."
>
> (p. 1)

A number of recommendations were made by the Platt Committee which were eventually to have effects beyond that of nurse-parent-child relationship. These were:

1. The Committee recommended that 'The authority and responsibility of parents should be more fully recognised'. This was a recommendation which if implemented could totally alter the existing relationship of the hospital staff vis-a-vis the family

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1. Although, of course, 'private' hospitals remained outside the National Health Service.

in at least two ways. Firstly, if the authority and responsibility of the family were to be recognised this implied the possible involvement of the family in administrative decisions. Secondly, this recognition would also lead to changes in nursing care, relieving the nurse of some of the mother-surrogate role.

2. They recommended that there should be 'unrestricted visiting' i.e. visiting at any reasonable hour of the day, during which the mother could undertake some of the routine care of the child, "keeping him occupied and entertained".

3. It was recommended that facilities be provided by the hospitals, including playrooms for other children in the family, and that if necessary financial aid should be available for relatives who needed to make long journeys in order to visit frequently.

4. There was a recommendation that a parent of all children under the age of five should be admitted with the child. The Committee realised the organisational problems this could cause including the problems of teaching student doctors in an area where the parents were often present, but stated that modified teaching techniques could be used and that "one of the most valuable lessons for students is how to deal with a child's relatives" (para. 70 p. 17).

5. It was recommended that information from nursing and medical staff should be available at fixed times known to the parents. It was also recommended that this information should be available even if the parents were not able to visit, from the ward sister, either by letter or telephone. "It is not enough for a parent to be given a formal 'bulletin' by, for instance, a telephone operator" (para. 108 p. 27).

In relation to all of these recommendations hospital staff are advised that "It is better to convert a parent to a point of view, than to overrule him".

The recommendations of the Platt Committee were accepted by the Ministry of Health in 1959, and all hospitals were advised by the Ministry to implement these changes as soon as possible.

In spite of some opposition from doctors and nurses, a number of hospitals did change their policy to incorporate these recommendations. However, not all hospitals changed their policy, and so pressure groups were formed in local areas to press for these changes - led by articulate middle-class parents, mainly mothers. These small groups eventually amalgamated into two National Associations, the National Association for the Welfare of Children in Hospital, and a Welsh group, based at Swansea, known as the Association for the Welfare of Children in Hospital.

The 'recognition of the family', the 'change in nurse role', 'unrestricted visiting', 'facilities for relatives', 'the problem of relatives in the ward while students were being taught', 'the availability of information', were all issues which were eventually discussed with regard to all relatives not only the relatives of children admitted to hospital.

While these changes were taking place in childrens wards, Hospital Management Committees were also beginning to actively respond to the concept of the adult patient as 'consumer'. The problem of keeping the hospital human had been formulated by Titmus (1958) leading eventually to the publication of research carried out by Central Health Services

Council "Inquiry into the In-Patients Day" (1961).

At the beginning of the decade the psychological problems of patients in general hospitals were also the subject of a world-wide study organised by the World Federation of Mental Health, the International Council of Nurses and the International Hospital Federation, whose findings were published in 1961 (Barnes).

During the next two or three years a number of patient surveys were carried out to test the reaction of patients to various aspects of hospital organisation: (Haywood and others (1961), Mcghee (1961) amongst others). Although these surveys highlighted a number of problems, the first real issue to provoke any practical response was that of visiting times. In 1962 a Ministry of Health Circular, (H.M. (62) 39), stated that "visiting should be regarded as an important contribution to the patients' recovery and never as a concession or as an unwelcome interference with hospital routine". The Circular recommended that each hospital should have daily visiting periods, and that it should also look at its visiting times and if necessary extend them to conform with the minimum number recommended by the Ministry. This Circular heralded the debate between open visiting, that is the number of hours during which relatives were free to come and go as they wished, and the traditional restrictions.

In those hospitals where open visiting was proposed and implemented, some opposition was encountered from doctors and nurses. Research into the problems created by open visiting was carried out at Leeds in 1963, after an experimental period of open visiting had been completed. It was found that the doctors objected chiefly because they found it more difficult to work and teach in the wards in the presence of visitors, while the difficulties encountered by the nursing staff included:

"1) keeping a check on the number of visitors at the bedside; 2) stopping visitors smoking; 3) asking visitors to leave for various reasons; and 4) having insufficient time for necessary nursing duties". All of these 'difficulties' can be seen as a threat to the traditional role of the nurse as it has already been, albeit briefly, described. It will also be shown that seventeen years later, these same reasons are being put forward by nurses who still wish to restrict visiting.

The consumers responded much more favourably. The Leeds Survey showed that the relatives were happy that the 'ticket-system' had been abolished, and nearly all found the new hours extremely convenient. The majority of patients were also enthusiastic. The report, however, noted that while two-thirds of the patients said that visitors never tired them, doctors and nurses were inclined to say that open visiting tired patients. An editorial in "The Hospital", commenting on this latter finding stated that "The patient is not necessarily right but neither is it necessarily true that nurses know best". The editorial also noted that not all the difficulties of open visiting derived from staff attitudes, and pinpointed a further problem, "problems of the organisation of ward routine and so on must arise and it is well that they should be understood realistically before a change in practice is introduced" (October 1963, pp. 595-597).

In some areas the change to open visiting appeared to create few problems. Irvine and Smith (1963) reported that "Free visiting has so many advantages that it is now preferred by the nurses ... Free visiting has improved communications between all grades of hospital staff and visitors and has thus led to greater co-operation between them" (p.600). But many hospitals found such changes unsatisfactory and unworkable, and so reverted to their traditional restrictions.

The great disparity between hospitals is shown by the results of a survey carried out by the Patients Association in 1963, which showed that in twenty-two hospitals the number of hours during which visiting was allowed varied from five to forty-two.

Commenting on the above findings, and also on a paper presented by Winifred Prentice at the Annual Conference of Hospital Administrators in 1965, which drew attention to this problem, the Editor of "The Hospital", identified a number of reasons why open visiting did not work in some areas, including the fact that the ward sister was often unwilling to accept the change. Some indication of the 'power' of the ward sister concerning the management of her ward, was given in Chapter 2. It will be shown in the next section of this chapter that in some instances ward sisters were given the power by the organisation to 'choose' the mode of visiting which they wished to implement in their ward. It would appear, therefore, that the 'ward sister' was and is an important factor in this debate.

We have dealt at some length with this issue for two reasons. Firstly because it is a situation which is still not satisfactorily resolved, and secondly, although this is related to the first reason, many nurses still practising at St. Davids were trained prior to the changes and to some extent still retain the attitudes towards relatives which they developed at that time.

Letters appear regularly in the nursing press to illustrate the problem as it appears at the present time:

> "An attitude is still prevalent which regards visiting time as a nuisance in which the nurses are pestered by anxious relatives ... creating barriers such as these does nothing to allay relatives' fears ... The sight of relatives queuing at the ward entrance is an anachronism. It is archaic to believe that we have the right to deny relatives access to patients."
>
> (Garton 1979, p. 1747)

Another recent letter pointed out that a member of a consumer group for the improvement of maternity services "is fighting hard to reverse a total ban on children visiting post-natal wards ... This battle has been in progress since 1974 ... What on earth does one do when hospital staff are utterly determined to keep visitors out". (Beech 1980, p.1389)

Some indication of the variation still found within one hospital, let alone between hospitals, will be found in the next section.

III CONTEMPORARY RULES OF VISITING

We shall now consider the rules, and their application in the wards in which the study was carried out.

The official policy concerning 'visiting' was left open to interpretation at ward level:

> "There shall be minimal restrictions on visiting of patients subject to the general condition that visiting of individual patients may be extended, restricted or excluded by ward sisters, in accordance with the advice of the medical staff, the patient's own wishes or special circumstances within the ward".

A number of further issues were then listed:

1. Visiting for all children should be unrestricted.
2. Visiting for long-stay and chronic patients should be unrestricted between the hours 8.00 a.m. - 8.00 p.m. daily.
3. Visiting of parents and close relatives by children should be permitted and should be arranged through the ward sister.
4. Two visitors only should be permitted at any one time for each adult patient or child.

Individual ward sisters had interpreted these general principles into the specific restrictions which they placed on access within their own wards. This decision was based on their assessment of if, and when, the presence of relatives would create some inconvenience to the orderly running of their ward. Two of the ward sisters interviewed described how they had reached their particular decision in this matter.

> "A few years ago there was a Ministry Circular[1] stating that we had to have the ward open for visitors for so many hours. This was more than we had at that time so we discussed the whole issue of our visiting times. We had discussions about open visiting but decided that we couldn't cope. We had to compromise by allowing visitors every afternoon and evening. It's difficult to open the wards at 2 o'clock with doctors rounds at that time, so we start visiting later."

> "When it was decided that the hours should be changed and that we could choose the hours we liked for our wards, I thought well let's try open visiting, and although some of the other staff don't like it, I'm sure most of the patients do. It's worked out well because most of the visitors still come in the afternoon and evening any way. One thing I do insist on is a rest hour, so the ward is closed for an hour after lunch, the patients need that break."

The relatives, and other visitors, were informed concerning the restrictions placed on visiting times and behaviour by the existence of notices. Most of the wards had a notice concerning the visiting times for that ward posted on the door, or on a wall, near the entrance to the ward. The notices on the doors of the wards in which the observation took place contained the following information:

MEDICAL WARD	Visiting to this ward
	10.00 - 1.00 and 2.30 - 8.00 every day No more than two visitors at one time to each patient. Visiting by children and at other times by arrangement. Please see ward sister.

---

1. (H.M.(62)39) Reference has already been made to this circular on page 129.

Visiting is at the discretion of the ward sister who may need to restrict visitors in the interest of the patients and their treatment. It may be necessary for visitors to wait during the doctor's round or be interrupted while nursing procedures are carried out.
Visitors, No Smoking Please.

CORONARY CARE UNIT

The entrance to the Coronary Care Unit was through the same door as the above medical ward, so that there was an additional notice on the door headed 'Coronary Care Unit' which stated:

Visiting to this ward
As for (medical ward) but please enquire at the desk before entering the unit.

GYNAECOLOGICAL WARD

The notice concerning visiting was within the ward precinct near to the sister's office and could be seen before entering the area in which the patients were situated.

Visiting to this ward
Daily from 3.00 - 4.30 p.m. Mon-Fri.
2.30 - 4.30 weekend. 7.00-8.00 Daily.

The same restrictions which applied to the medical ward were then listed.

GERIATRIC WARD

There was no notice on any of the ward doors in the geriatric unit as the official policy for the unit was open visiting between the hours of 8.00 a.m. and 8.00 p.m. (There was, however, a statement in the

ward policy book (statement No. 15) relating to visiting times: "Patients may be visited at any time but visitors will be encouraged to come between 2.00 p.m. and 8.00 p.m.).

In addition to notices on the ward doors, there were also notices inside the wards which stipulated relative behaviour, for example, "Visitors. Please return chairs when leaving the ward".

These notices were supplemented by similar information in the "patients handbook" concerning access and behaviour. The patients handbook also contained one further instruction:

> "Your friends and relations are specially asked not to visit you if they are unwell themselves, and particularly if they have a cough or a cold or are suffering from diarrhoea".

The patient and his relatives were also given verbal information on admission concerning visiting behaviour. The existence of notices, and other written and verbal information relating to visiting times and expected behaviour during these periods help to confirm the proposition made by Storlie (1975) that "the protocol of visiting is rarely left to chance" (p. 73).

It was assumed by the staff that most visitors would conform with these restrictions, and it was observed by the researcher that most relatives did in fact appear to conform. The observed conformity does not, however, mean that all the visitors seen to conform, privately agreed with these restrictions. Collins (1973) has pointed out that public conformity must be distinguished from private conformity and that it is easier to conform than not to conform. ('Non-conforming' behaviour will be discussed later in the chapter.)

It was found that some of the relatives who were interviewed privately disagreed with the restrictions. One particular relative,

the wife of a patient admitted to hospital while they were both on holiday, pointed out her particular problem concerning access. She stated that she and her husband managed a social club in another part of the country and that their usual working day began in the evening, just at the time when normal visiting ended. This was the time of the day when they would most liked to have been together, as it was very difficult for them to start 'winding down' at that time of the evening and she was left to face a very long, lonely evening on her own. Although she realised that this could be difficult for the other patients in the ward, she privately believed that there should be no official end to visiting time, and resented having to leave the ward at this time.

As well as giving specific instructions, the notices also indicated the power of the staff to further restrict access "in the interests of patients and their treatment", and also during "doctors' rounds", and indicated to the relatives that the restrictions were not absolute but that there could be some relaxation of these rules "by arrangement with the ward sister".

Some attention was given to the ward sister as part of the hospital organisation in Chapter 2, where it was shown that she was the 'key figure' who determined the rules of the people subordinate to her. Before discussing the power of the ward sister as an 'enforcer' or 'relaxer' of the rules, we should note that the authority of the ward sister was recognised by nurses of other grades in this study.

> "When you first go on a ward you learn from the ward sister how she wants things done and then you make sure that you get it done that way."
>
> (SRN)

> "I didn't agree with it but on 'Daffodil Ward' you had to get the visitors out as soon as the bell had gone. I hated having to do it but that's what sister wanted."
>
> (3rd Year Student)

It has already been noted that one of the factors which caused the implementation of open visiting to be unsuccessful throughout the country was the lack of motivation on the part of the ward sister, and that at the hospital in which the research took place the sisters had themselves chosen the times for visiting on their ward.

The ward sister, therefore, is institutionally defined as both maker and enforcer of the rules. In this way she, and the nurses working with her, functioned as 'gatekeepers'. The concept of 'gatekeeper' was first described by Lewin (1947) in his study of organisations, who noted that the travelling of a certain news item through certain communication channels depended on what happened in the 'gate region'. Gate regions are governed either by impartial rules or by 'gatekeepers'. A number of sociologists have found this term useful, including Stimpson and Webb (1975) who used it to describe the nurse or receptionist in a Health Centre who controlled the patients' access to the doctor, and Dodd (1974) who used it to describe the way in which the ward sister controlled access by any personnel into her ward domain.

Lewin pointed out that as the gatekeeper is the person who is 'in power' for making the decisions between 'in and out' it is necessary to try and understand the gatekeeper's system of values as well as other factors which would determine whether the gate was 'opened' or 'closed'.

Many of the nurses interviewed discussed their attitudes to relatives visiting the patient and their attitudes to visiting times, so that it is possible to go some way towards understanding the system of values which lies behind 'gatekeeping'. Two reasons were given for maintaining restricted visiting:

1. "Visitors interfere with the ward routine". This was the most

common reason offered for retaining restrictions. The routinisation of nursing activity (which is discussed elsewhere) led to a belief that there were set times for doing things and that relatives (visitors) needed to attend at a time which would not disrupt the routine. It was also believed that visitors could delay routine tasks:

> "You can't get in and give out the bowls (for the patients to wash) until they've gone."
> (2nd Year Student)

Many nurses pointed out that the physical presence of relatives could hinder the work because they "get in the way". A ward full of visitors obstructed the physical progress of the nurse:

> "I hate doing the daily blood pressures in the day room at the weekends when all the visitors are around. It takes so long to get around all the chairs and clutter they bring with them."
> (SEN)

2. "It's not good for the patients". Some nurses stated that they felt that too long a period of visiting could create a problem for the patient, who might become tired. Visiting could also create problems for other patients without visitors who also could not rest because of the presence of a number of extra people around them, and who might be reluctant to ask for attention:

> "If there are men in a ward some women are reluctant to ask for a bedpan."
> (2nd Year Pupil)

A small number of nurses also mentioned the possibility that nursing treatment could be hurried if there were visitors waiting, and that this could be to the detriment of the patient.

However, the majority of the nurses interviewed (33 out of 54) stated that they believed in the principle of 'open visiting', although with certain modifications, particularly at the patients' mealtimes:

> "It really bugs me to see relatives sitting there gawping while the patient is trying to eat."
> (SRN)

In support of Glaser and Strauss's (1964) findings that 'canons of responsibility' rather than rigid rules were necessary for carrying out complex medical tasks, nurses were unanimously agreed that as 'professionals' they should retain the right to relax or restrict the rules when they believed that it was in the patient's interest.

We should now look at some of the reasons offered by nurses, and some of the observations made which could determine whether the 'gate' was 'open' or 'closed'. We shall first look at the factors which lead to a relaxation of the restrictions, and this will be followed by a description of the factors which lead to the imposition of further restrictions.

Relaxation of Visiting Regulations

The nurses interviewed stated that there were a number of conditions which could lead to a relaxation of the restrictions.

a) Geographical difficulties. Most nurses stated that they allowed extended visiting to those relatives who were only able to visit infrequently because of the distance.

> "It is difficult to tell relatives to go at the end of visiting if they've come a long way, so they can stay as long as they like, although I tell them that they may have to be content to sit at the bedside while the patient rests." (SRN)

It was also observed that the rules were relaxed in this way, in one instance without the relative asking for this privilege. A visitor arrived an hour before visiting on the ward and asked to see one of the patients. He was told that visiting was not for another hour and directed to the day room to wait. About half-an-hour later the staff nurse, who had directed the visitor to the day room, was in the ward and overheard the patient for whom the relative had enquired tell

another patient that her son was going to visit that afternoon from Kent. The staff nurse immediately went to the man and asked if he was the patient's son from Kent (250 miles away from the hospital) and, on hearing that he was, directed him to his mother at once saying, "Why didn't you say you'd come all that way, you wouldn't have had to wait then".

b) Work difficulties. In the ward in which there was only afternoon and evening visiting it was observed that relatives who worked at that time were allowed to visit in the morning. All the nurses also stated that they would accept 'working' as a reason for admission at non-visiting times.

It was also generally agreed among the nurses interviewed that certain categories of patients, the very ill, those receiving terminal care, children and the mentally handicapped should be able to receive visitors at all times.

Further Restriction of Visiting Regulations

Restricting visiting even within the times specified when the ward would normally be open was inevitably justified in terms of 'good patient care', but it was also observed that restricting visitors could at times be in the interests of the ward routine and therefore the nurse. On one occasion, when the ward had been very busy and a small number of patients still needed attention, the nurse in charge advised the rest of the staff to "keep the door closed, and don't let them in until we're ready". The door was kept closed and about twenty relatives/visitors had to wait for 15 minutes. This was the only occasion observed when a restriction was made concerning all visitors; all the other occasions observed referred to the relatives of individual patients.

Sometimes this restriction was made in collusion with the patient.

One of the sisters put a notice on the door of a single ward restricting visitors because "the relatives will smother her (the patient) and she finds it too much".

On another occasion the nurse in charge told the rest of the staff at 'report' that one of the patients had asked her to talk to his wife and ask her to visit less frequently. The patient had had a stroke with some dysarthria[1] and found it very frustrating attempting to cope with his speech disability and his wife's constant questions requiring rapid answers. "Every time she comes she upsets him so I'm going to see the daughter and ask her to try and persuade her mother to come in only every other day".

The patient, of course, has the right to ask the nurse to restrict his visitors to certain times. This is the only time when, if the relative persists in visiting the patient, he can be forcibly ejected. The policy statement concerning this eventuality makes the position quite clear:

"Visitors - Unwelcome

When a patient informs the nursing staff that he or she does not wish to see a relative or visitor the fact should be noted with the date and time in the Kardex (patient's nursing care record). The Medical Officer must be told of this request and his advice noted in the record.

If this visitor calls at the ward, the nursing staff should ask them to wait while the nurse enquires from the patient whether she still feels the same. Should the patient reiterate their original statement, the nurse must tactfully explain the situation to the visitor and if necessary arrange for a medical officer to see the visitor.

---

1. Difficulty in speaking.

Should the visitor insist on seeing the patient they must be courteously but firmly refused entrance. The Administrator and Nursing Officer should be told and the Head Porter asked to send someone to escort the visitor out. If this cannot be achieved or if the situation becomes unpleasant the police must be sent for."

A number of nurses were able to describe occasions when they had had to dissuade a relative from visiting, but this was only observed on one occasion. One of the patients had stated that she did not wish to see a particular relative if he visited the hospital. When he arrived the nurse told him that the patient needed to rest completely and it would be best if he went to see her when she was back at home. The relative then asked if the nurse would go and ask the patient again if that was really what she wanted. After this had been confirmed he left the ward without taking any further action.

If a decision was made by the nurse to restrict visitors to an individual patient, the relative was usually given a reason for this decision:

"I think it would be best if you just stayed for a little while tonight, he's very tired."
(SRN)

"He's very breathless, so I should just say a few words and then go, don't let him talk too much, it will only make him worse."
(SRN)

The relatives of patients admitted for major gynaecological surgery were all advised that on the day of the operation they should only visit for ten minutes and that there should be only one visitor. Some nurses, however, stated that they would prefer to exclude the relatives altogether at such a time (all nurses were asked for their views concerning major surgery - not only those on the 'gynae' ward):

"The post-op patient may get bothered and can be upset by the relatives visiting too soon."

(SRN)

"There's not much point to it because the patient is semi-conscious and it's not good for the relative." (SEN)

"I don't think the relatives should see the patient on the day of the operation. They (the patients) look pretty white and zonked out and it could seem like the end of the world for them (the relatives) to see the drip and the naso-gastric tube."

(2nd Year Pupil)

Children as 'Visitors'

Nurses also functioned as 'gatekeepers' with regard to children who wished to visit a patient. Children were frequently observed visiting in the wards and were only seen to be refused admittance if the patient's condition was such that this was perceived as in his/her best interests by the nurse. The father of an eleven year-old child who asked for permission for the child to visit the patient on the first post-operative day received the following reply:

"I don't think so, not today, but from tomorrow on it should be OK."

- to the child -

"If you like you can go and watch TV in there while dad is with mummy."

The SRN involved in the above encounter later justified her action by saying:

"I don't think it's good for a child to sit there while the patient is still poorly, watching the blood transfusion going in."

Not all nurses appeared to believe that children should be allowed to visit and offered a number of reasons why children as visitors should be restricted. These could be related to the child's age as well as the patient's condition (although no children were observed to be

refused admission because of age).

> "It is important for the patient's morale but it can be dangerous for a baby, they can pick up infection so easily. Toddlers should only be allowed to stay a very short while, they crawl over the bed and floor. I don't like to see kids crawling about on the floor, the ward is not like their sitting room. It can be difficult with children."
>
> (3rd Year Nurse)

> "Not babies or toddlers, really, they soon get bored and can upset the other patients."

> "I don't like too young children in at all really, but it depends on the patient's condition."
>
> (SRN)

> "I only allow children under 12 on rare occasions, but it depends on the circumstances - all rules are flexible."
>
> (SRN)

A number of nurses suggested that 'visiting' can be harmful for babies because of the risk of infection. This is in common with the findings of Jacobs (1978, p. 102), but as she pointed out "this view is now seriously questioned", for a number of studies have indicated that children visiting patients are not as prone to infection as it was hitherto believed.

Some of the statements made by nurses with regard to the visiting of patients by children indicate some evidence of the nurses' dilemma concerning this issue, and the conflict between doing what was best for the patient and what was best for the ward routine.

> "I'm sure its right for the patient to see them, but I don't think its right to see them running around making a noise."
>
> (SRN)

However, although some nurses preferred not to have children as visitors, many of the nurses appeared to enjoy seeing children in the ward, and spent some time talking to, and in some instances playing with them.

The discussion thus far has focused on the way in which the rules were administered with some reference to the system of values which underlies gatekeeping. The 'gatekeeping' described so far can only take place if the relatives accept the situation, but there were some instances observed, and reported, which show that if a relative persists in disobeying the rule, by adopting 'non-conforming behaviour', there is little which can be done to produce conformity. The only possible sanction is to forbid or restrict the relatives' 'visiting privileges'. No such restrictions were enforced during the period of observation, but during the course of the research attention was drawn to the following report in the "Daily Mirror" (August 14th, 1980):

"Hospital Curbs Visit to Mum"

> "A hospital has slapped a visiting curb on an 84-year-old patient ... because they cause 'disruptions' in the ward. (the relatives) have had their daily visits to (the patient) cut down to two a week."

But unless the relative is 'disruptive' it can be difficult to enforce 'compliance'. It was, for example, reported by one of the ward sisters that, just before the period of observation, a situation had arisen in which it had proved impossible to enforce the time limit because a relative refused to acknowledge this as 'legitimate'.

> "I'm not really fussy about them going at eight o'clock but this patient's boy-friend insisted on staying every night until about ten o'clock. He just insisted on staying. It was all right when she was well enough to go and talk to him in the day room, but it disturbed the other patients when she was still confined to bed. Some of the younger nurses were unhappy about it as well."

Further questioning revealed that this relative had been seen by the doctor and night sister as well as the ward sister, but that he could not be persuaded to leave, and so they had no option but to let him stay.

Controlling numbers could also be difficult if the relatives refused to comply with the regulations. This was seen as one of the problems which could occur with the relatives of patients who were from other cultures in which the family role in illness was different from that of Western cultures.

> "Oh yes, we had an Indian patient recently, and all the family came in even when the patient was just back from theatre they were all there. We couldn't persuade them to leave, they just wouldn't listen."
>
> (3rd Year Nurse)

> "They don't take any notice of the nurse asking them to leave, and I have had to get a doctor to assert his authority about this, and that was only partly successful."
>
> (SRN)

One sister had developed a 'coping mechanism' for this eventuality. "I try to put the patient in a side ward and then they can all stay as long and as many as they like. You try to restrict them but you can't." It was also reported that a number of relatives of patients of other cultures negotiated the rules by "failing to understand them".

> "The relatives could speak English but when you asked them to go they 'misunderstood' and just stayed there."
>
> (SRN)

Some relatives appeared to conform but were observed to 'beat the system' by direct action taken when unobserved by nurses. In one such instance observed the father and mother of a small child were refused admission for the child to visit her grandfather, who was seriously ill. They sat in the corridor and then, when there were no nurses in view, walked into the ward, stayed for a few moment at the bedside of the patient, and then walked out again.

Other relatives were observed to negotiate with the ward sister/nurse in order to "work the rules". Two relatives arrived on the ward during 'rest hour' and asked for permission to see the patient. This

was refused at first by the SRN stating:

"I don't mind visitors at any time except between 1.00 and 2.30."

"Could we just look in for five minutes to let him know we're here?"

"I'd rather you didn't, he needs to rest."

"We won't disturb him if he really wants to rest."

"All right then, just for two minutes."

The nurse in this instance justified her refusal first by referring to the rules, then by referring to the patient's condition, before finally acceding to the relatives' request.

In spite of the above examples, as previously indicated most relatives conformed to the rules, although it appears that the relatives' 'co-operation' was based on his/her system of values, not that of the hospital. The relatives' system of values is important for as Goffman (1971) has indicated, rules can only be effective if those to whom they apply believe them to be right and "come to conceive of themselves both in terms of who and what it is that compliance allows them to be and in terms of what deviation implies they have become." (p. 127)

Summary

It has been shown in the preceding account that the present situation concerning access is far less rigid than the traditional situation. It has also been shown that at present the rules are less like commands and more like general understandings. This change came about in response to social change concerning the relatives' expectations. The response of the organisation to the community is necessary for as Davis (1965) has indicated, if the hospital is to maintain effective

ties with the community at large, it must in its functioning be sufficiently imperfect, or flexible, as to allow some of those who use its services to "evade or get around those very rules and policies that in the main govern the organisation's relations with its clientele". (p. 61). In this way some relaxation of the previously rigid rules is functional for the organisation, but it can be argued that the present flexibility is dysfunctional for the nurse.

Traditionally, nursing practice, including the task of managing the patients' relatives, has been severely constrained by rules, which protect the nurse from uninvited responsibilities. Much of present day nursing practice is still constrained by 'procedures' which give the nurse guidance concerning the standards of practice that are necessary. Procedures serve to protect the nurse from responsibility in the same way as the rules traditionally offered him/her protection. If the nurse 'keeps the rules' or 'follows the procedure' she cannot be 'blamed'.

Although the rules which traditionally protected the nurse have to some extent been removed, they have not been replaced by procedures. The present-day nurse is therefore more vulnerable than the traditional nurse, for he/she has neither rules nor procedures to guide his/her behaviour vis-a-vis the relatives. It will be shown in later chapters that these two factors, greater responsibility and less authority, serve to constrain nursing practice vis-a-vis the relatives.

Some attention has also been paid to 'non-conforming behaviour' and to the way in which the relatives successfully negotiate the rules, indicating that the balance of power within the nurse-relative relationship can be a precarious one.

We shall now turn our attention to the way in which the nurse-relative relationship is initiated.

CHAPTER 6

THE NURSE-RELATIVE RELATIONSHIP: ENTRY BEHAVIOUR

Introduction

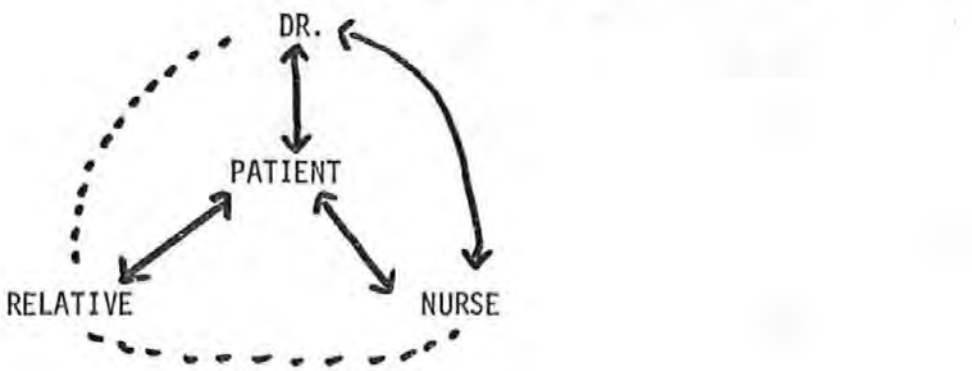
It was established very early on in the field work that there is no single form of the nurse-relative relationship, but that this is a diverse and often fleeting relationship. It was also established that many relatives who visit the ward each day have no verbal contact with any of the nurses caring for the patient. In this chapter we shall be concerned with the way in which encounters between nurses and relatives are initiated and also with the reasons for which such encounters are initiated. In this way we may begin to reach some understanding of firstly, why only some relatives interact with nurses, and, secondly, of the relationship itself, for, as Daubenmire, Searles and Ashton (1978) have indicated, the behaviour of the participants in an encounter, which takes place "whenever two or more persons move together in a bound segment of time and space", not only defines a relationship, but also serves to modify, support and amend it (p. 303). The behaviour of nurses and relatives immediately prior to and at the beginning of any encounter will be classified in this study as 'entry behaviour'.

The 'potential' nurse-relative relationship

The relationship between the nurse and relative is one part of a model which also includes the doctor and the patient. In this model some relationships can be described as 'actual', in that even though no verbal contact may take place between these groups, a relationship based on accountability and responsibility is an inevitable consequence of the patient's admission to hospital. No such relationship is inevitable

concerning the nurse and the relative. This, it will be shown, is a 'potential' relationship, which may in certain circumstances become actual.

The nurse-relative-doctor-patient model



The 'potential' relationship only becomes 'actual' when either the relative or the nurse takes the initiative to interact with the other. We should, therefore, turn our attention to the 'pre-disposing conditions' that will cause one or other of these groups to take the initiative which will lead to an 'actual' relationship.

The 'actual' nurse-relative relationship

As well as establishing very early on in the field work that only a few of the relatives who visited the ward each day had any verbal contact with the nurses caring for the patient, that is, an 'actual' relationship, it also appeared that those interchanges which did take place between these two groups were engineered by one or the other of these groups for a specific reason. It was therefore of some importance to identify the reasons which would cause a nurse or relative to initiate such an encounter. This was established by analysing two hundred different encounters between these two groups. The two hundred encounters selected for this analysis were collected, and analysed, separately in two groups of one hundred encounters.

The two separate 'hundreds' of encounters used for this analysis were collected by taking the first twenty encounters between a nurse and a relative in each ward and unit, which occurred on the fifth day of each observation period. The exercise was repeated with the first twenty encounters which occurred on the fourteenth day of the observation period in each ward and unit. This resulted in two separate groups of encounters which after analysis could be compared with each other, therefore increasing the reliability of the findings.

Each of the encounters was classified in two separate ways. First, it was established whether the nurse or the relative had initiated the encounter, secondly, an attempt was made to establish the reason for the encounter.

Previous research (McIntosh 1978) had suggested that most encounters between the relatives and both nurses and medical staff were relative-initiated. This finding was confirmed, for it was found that of the first 100 encounters analysed 78 were relative-initiated, while in the second 100, 73 were relative-initiated.

The 'collected' encounters were then further examined in order to reach some understanding of the purpose for which each encounter was initiated. The results are shown in Table One (p.152). It was far more difficult to be certain as to 'why' an encounter was initiated than it was to ascertain the initiator. The purpose of each encounter was established by taking note of the first 'stated' purpose in the encounter, although it was realised that this would not, in all instances, be either the main or the only purpose of either the relative or the nurse who had initiated the encounter.1

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1. Attention had been drawn to the possibility of this difficulty during the examination of 'doctor-patient studies' (discussed in Chapter 2) in which a number of authors had pointed out that the real purpose of the consultation was not revealed until the patient was about to leave the surgery when he/she stated "Oh, by the way ..." and then stated his/her reason for consulting the doctor.

Before discussing the findings two points should be made concerning the presentation of the results in Table One.

Firstly, the results are presented as either nurse or relative initiated (described as N or R in the table). Secondly, all the 'reasons' for nurse-relative encounters as described above fell into one or other of 13 different categories except for two described in the table as 'odds'. Each of these two encounters was initiated by a relative. In the first encounter the relative came to the ward to look for a death certificate instead of going, as directed previously, to the General Office; in the second encounter, a relative arrived on a ward for the sole purpose of bringing a box of chocolates to the nurses, the patient having been discharged several days previously.

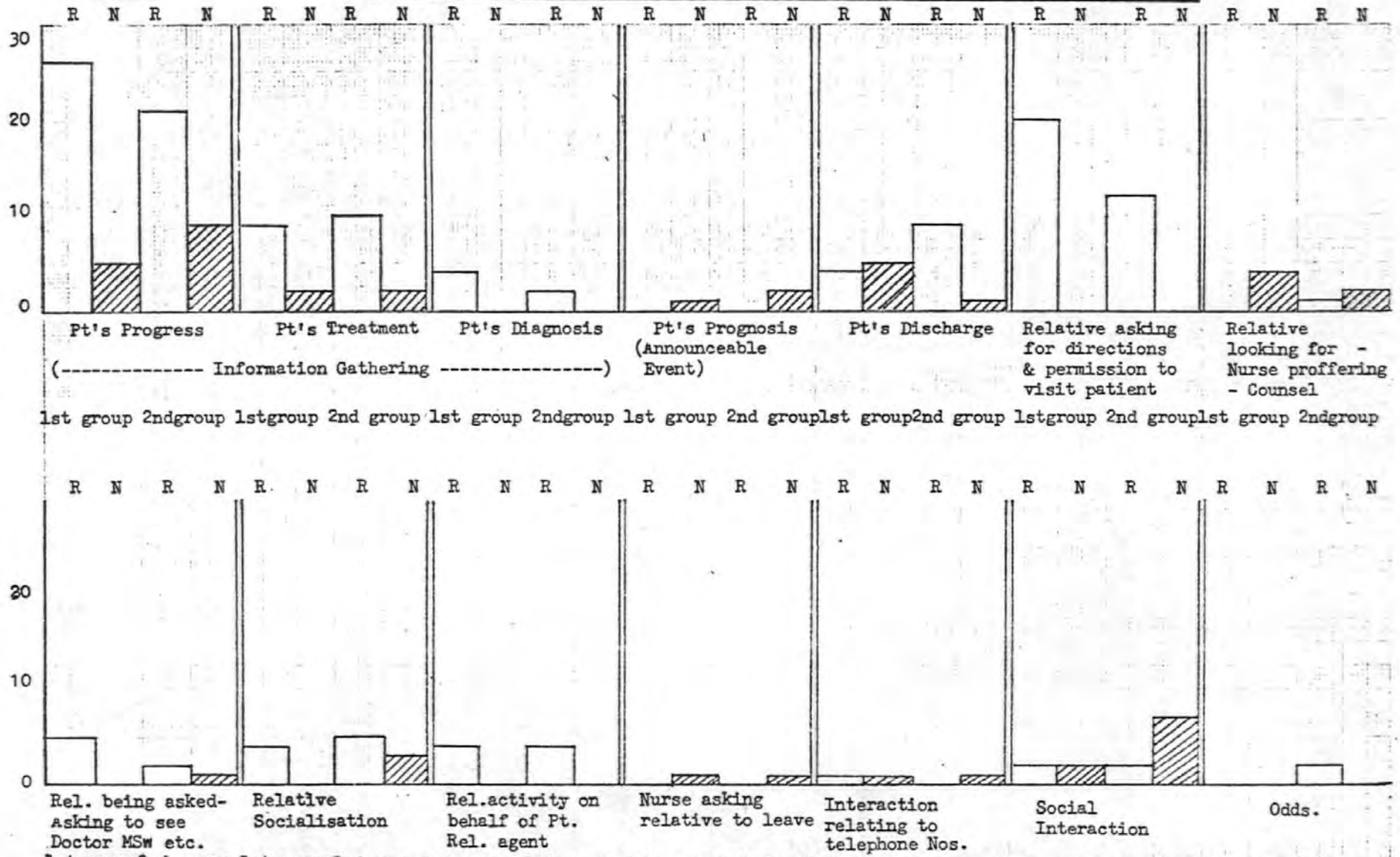
The 13 different categories of nurse-relative encounters classified by 'purpose' concern:

a) the patient's progress
b) the patient's treatment
c) the patient's diagnosis
d) the patient's prognosis
e) permission to visit or directions concerning the patient's location in the ward
f) looking for or proferring counsel
g) relatives being asked or asking to see the doctor or medical social worker
h) relative socialisation
i) relative activity on behalf of the patient
j) the nurse asking the relative to leave the patient
k) interaction relating to telephone numbers
l) 'social' interaction

Most of these different forms of encounter will be discussed in

TABLE ONE

ANALYSIS OF 200 ENCOUNTERS BETWEEN NURSES AND RELATIVES BY 'PURPOSE'



detail in later chapters, focussing on the following notions:

1) the relative as a gatherer of information

2) the nurse as an announcer

3) the nurse as a counsellor

4) the nurse as a teacher

5) the nurse and the relatives of the dying patient.

6) the relative as patient's agent.

We should, however, at this stage of the thesis make a few comments concerning these findings.

1) It was found that the number of different reasons for the encounters which take place between nurses and relatives is comparatively small, and, although this is not represented on the chart, did not vary very much from ward to ward, or from unit to unit. This finding to some extent confirms the proposition made by Strong (1979) that most role encounters in hospital can be described as "institutionalised activity systems" repeated over and over again within different settings and with different participants. It was not surprising in view of the previous findings reported in Chapter 2 to find that most of the encounters between these two groups concerned the patient's illness, and that they were concerned with the patient's progress, treatment, diagnosis and discharge. The ratio of these encounters is reproduced in Table Two.

TABLE TWO

Breakdown of Encounters Relating to Patient's Illness

	1st "100"			2nd "100"			N	%
	Rel.	Nur.		Rel.	Nur.			
Patient's Progress	26	+ 5	31	21	+ 9	30	61	30.5
" Treatment	9	+ 2	11	10	+ 2	12	23	11.5
" Diagnosis	4	+ 0	4	2	+ 0	2	6	3.0
" Prognosis	0	+ 1	1	2	+ 0	2	3	1.5
" Discharge	4	+ 5	9	9	+ 1	10	19	9.5
	43	13	56	44	12	56	112	56%

A number of points should be made concerning the figures in the above table.

(a) Most of the encounters focus on the patient's progress and treatment. It will be shown later in the thesis that many relatives and nurses considered interaction related to the patient's diagnosis and prognosis to be the province of the doctor. This view is reflected in these figures.

(b) Included in the nurse-initiated 'treatment' encounters are those forms of nurse-relative interaction which will be described in the text as 'nurses teaching relatives'.

(c) Many of these encounters, although they were initiated for the purpose stated, included other forms of interchange, particularly the interchange described in the text as 'counselling' (see Note 3 below).

2) The second most frequently occurring form of encounter between nurses and relatives concerns either 'permission' to visit the patient or the actual location of the patient within the ward. This form of encounter is associated with all visitors, not only patients' relatives.

3) A small number of encounters were engineered specifically concerning 'counselling'. It will be shown later in the text that this term is used in a very general sense, defining counselling as a form of interaction, which also includes the 'giving of advice' and 'reassuring'. Such encounters focussed on the relatives' <u>own</u> needs, although of course such needs were almost always related to the patient's illness.

4) Further reference will be made to these points in later chapters. Having established reasons "why" nurses and relatives interact with each other, it was then possible to establish a list of pre-disposing

conditions which could give rise to one or more of the reasons identified. In this way it is possible to predict the circumstances when the 'potential' relationship, which always exists, is likely to become actual.

The analysis of the fieldwork in the current project led to the formulation of the following propositions:

I The relative may initiate an encounter with the nurse if one or more of the following conditions exist:

a) if he/she requires information concerning the patient's illness which he/she is unable to obtain from the patient;

b) if he/she requires information or help relating to his/her own need;

c) if he/she has been appointed by the patient, or has appointed himself to act on the patient's behalf;

d) if he/she requires to see other members of the hospital staff, (thereby using the nurse as an intermediary);

e) if social courtesy makes this difficult to avoid.

II The nurse may initiate interaction with the relative if one or more of the following conditions exist:

a) if the patient's physical or mental condition in some way lessens his ability to carry out the 'normal' patient role in the doctor-patient or nurse-patient relationship (the relative in this instance is asked to act 'on behalf of'the patient);

b) if an 'announceable event' has occurred; (an 'announceable event' is an event of such importance that it is laid down by hospital policy that the information concerning such an event must be shared with the patient's family);

c) if the doctor/nurse needs the relative's consent for a procedure to be carried out on the patient;

d) if nursing or medical practice is impeded by the presence of relatives;

e) if the relative's 'behaviour' is not commensurate with the 'expected' behaviour of relatives;

f) if social courtesy makes this difficult to avoid.

It was confirmed by discussion with both groups that a 'reason' for initiating interaction, except for the occasional 'social' encounter, was considered necessary.

> "No I've never spoken to a nurse. There's been no need. The wife tells me all that's happening and I can see for myself that she's getting on. That's all I need to know."
>
> "Of course I speak to the relatives if I need them for anything, but otherwise I leave it to them. If they want anything they'll ask. They know we're here." (SRN)

The nurse as an expert

It would also appear from the above discussion that in most encounters between nurses and relatives the nurse either adopts or is cast into an 'expert' role.

Hughes (1971) has identified the 'expert' as any person possessing a body of knowledge who is ordained, certified or given a licence or mandate by society for the use of such knowledge. This person is known by at least some members of society as being such an expert. Such a person either seeks out or is sought out by others in order to enter a complementary client role (p. 287-292). The nurse who adopts an expert role seeks out the relative when certain conditions prevail in order to establish a complementary client role. Conversely the relative who perceives a need for 'expert' help relating to a need which is not met by the nurse-patient relationship will seek out the nurse in order to enter a complementary client role.

We shall return again to this notion later in the chapter and in subsequent chapters for it is particularly significant to the argument.

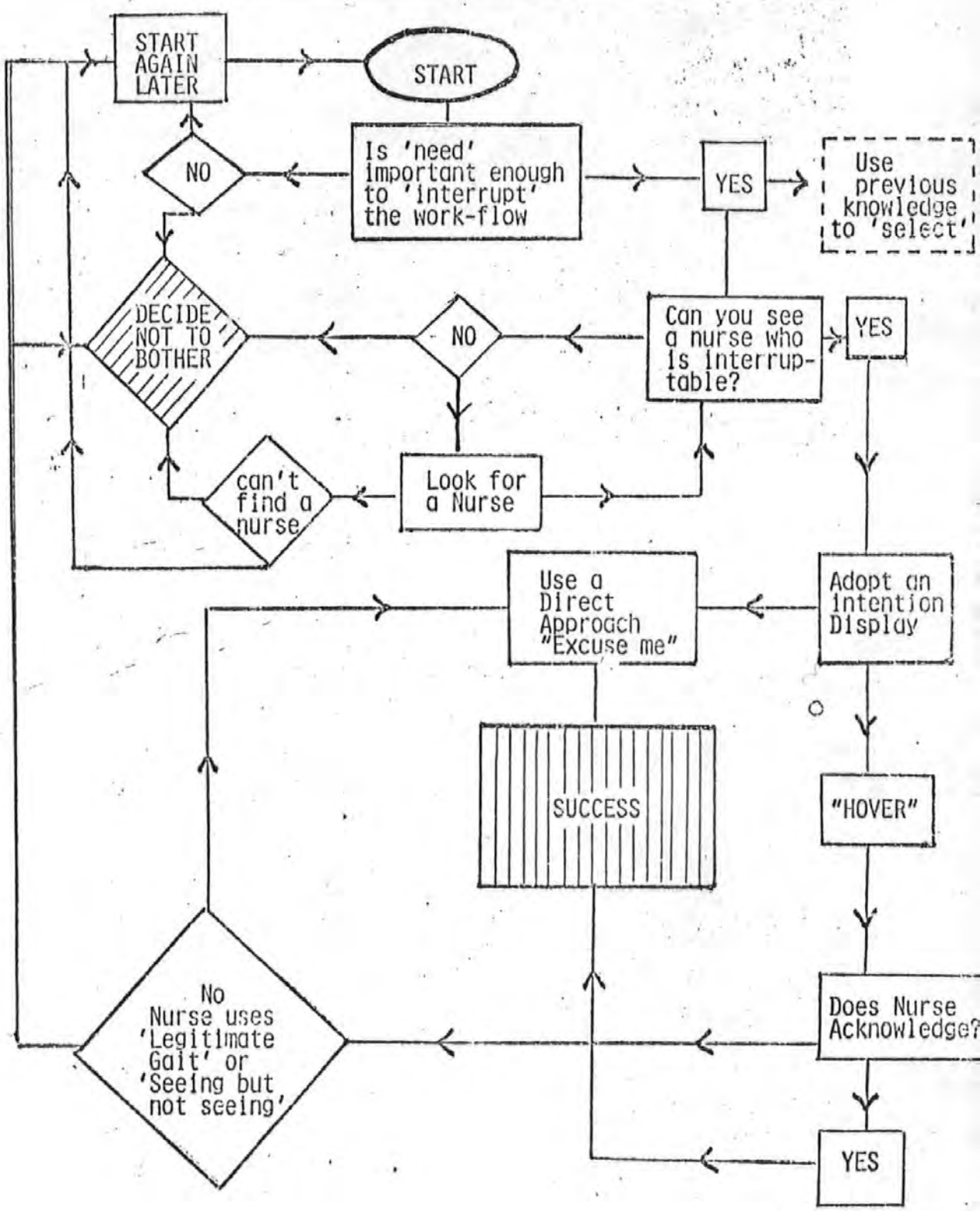
Before turning to the way in which purposeful encounters are initiated, one further point should be made with regard to 'social encounters', for these cannot be classified as expert-client encounters. It was shown in Table One that some encounters could only be described as 'social' in that no specific purpose beyond that of 'being sociable' could be determined. In such instances the interaction between these two groups would appear to serve no specific function in the relationship, but it is possible that such encounters can be functional in two ways. Firstly, in an established relationship, they maintain continuity, and, secondly, if no relationship has been established the initiator of such an encounter lays him/herself 'open' to further interaction. This is a significant point for if such an encounter is initiated by a nurse it indicates behaviour which to some extent deviates from 'normal' nurse entry behaviour, which will now be described.

The Entry Behaviour of Nurses and Relatives

We shall first look at the behaviour of nurses and relatives before, and during, the initiation of an encounter, focussing primarily on the relative as the 'initiator'. This will be followed by a brief examination of entry behaviour when the nurse takes the initiative.

As we have already indicated most of the encounters between nurses and relatives can be described as purposive interchanges. The entry behaviour of the relative therefore begins with the perception of a need to initiate an encounter with the nurse for any of the reasons listed earlier in the chapter. Having perceived a need the relative then has to make a decision concerning the answer to the question, "Is my need important enough to interrupt the work flow?". The response to this question will determine his next course of action. (This is illustrated diagramatically on page 159).

The Relative's Pathway to Success/Failure in the Initiation of Nurse-Relative Encounters (Entry Behaviour)



Before proceeding any further we should pay some attention to the notion of the work flow in this context. It was suggested in Chapter 2 that much of nursing work is routinised and that considerable emphasis is placed on "getting the work done". This notion should be further considered in the present context and related to the concept of "being busy".

"Being Busy"

The relative who wishes to initiate an encounter with a nurse is likely to perceive that he/she is in a situation in which "being busy" is related to nursing practice, for as Congalton and Najman (1971) have indicated "activity is the keynote of the nurse's role". In addition Dodd (1974) has pointed out that "being busy" seems to satisfy the requirement of the on-going organisational reality within the ward where nursing presents itself to its public. "Being busy" however creates a barrier which can deter the relative from making his need known, as well as deterring the nurse from making spontaneous contact or communication with either patients or relatives. The perceived need of the relative needs to appear to be important enough for him/her to 'interrupt' this 'busyness'. In some instances it was found that the relative never reached this decision:

> "I've been wanting to ask someone about mother for the last three nights but they've been so busy that I thought perhaps I'd better leave it."
>
> (Son of patient with 'stroke')

> "Yes, there are one or two things I would like to ask about, but you can't bother them with every little thing can you?"
>
> (Wife of patient with coronary thrombosis)

> "Of course we want to know what's going to happen next week (date of patient's discharge) but you know what it's like here sometimes - I just can't bring myself to ask them when they're so busy."
>
> (Daughter of patient requiring care after discharge)

Dodd found that "being busy" effectively, if not intentionally, deterred the patient from interrupting the routine with 'trivial demands'. It would appear that this also applies to the relatives. In this way it may be, as suggested by Jacobs (1978), that the staff exert a degree of control over ward life.

If the relative decides that his/her need is not important enough to 'interrupt' the work flow he/she can either decide 'not to bother' or he/she can decide to 'try again later'.

If, on the other hand, the relative decides to proceed with the pre-initiation behaviour he/she will then attempt to 'locate' a nurse in order to draw attention to his/her need to interact.

Locating a Nurse

It has already been suggested that the relative wishing to initiate interaction with a nurse is likely to perceive that most nurses are engaged in "being busy". The relative therefore must be prepared to 'interrupt' the activity which surrounds him/her. 'Locating' a nurse, therefore, not only means physically 'locating' a nurse (that is, finding a nurse), but it also means 'locating' a nurse engaged in an activity which is perceived as 'interruptable'.

There is a further aspect of the location process that of 'selection' which is restricted to those relatives whose socialisation includes the ability to distinguish the membership group of each grade of nurse by his/her uniform, and therefore to establish the 'status' of the nurse. The nurse 'selected' in this way is perceived by the relative to be of the appropriate status to 'manage' the ensuing interaction. One other element of selection was also identified. This element of selection was used by some of the relatives of long-stay patients who had had reason to interact

with several different nurses during the patients' stay on the ward. From the relatives' previous experience, in different encounters, some nurses were perceived to be more 'sympathetic' than others, and were therefore 'selected' in preference to others when this was possible. It would appear therefore that the 'favourite nurse' is a phenomenon which is recognised by relatives, as well as by patients:

> "Well if --- is on duty I always ask her. Its funny but although the others are very nice, I always feel more at ease with her."

Having drawn attention to the notion of selection as a part of the location process we should now return to the problems associated with this process.

Although some nursing activity is 'public' in that it is carried out in full view of patients and relatives, many nursing activities take place 'backstage'. It may therefore be difficult to locate a nurse 'working' in the public area. It was common practice during the traditional visiting periods for most of the ward staff to be engaged in backstage activity during these periods. Jacobs (1979) has pointed out that the relative needing a nurse at this time had to 'seek out' the nurse who was "conspicuous by her absence" during visiting time. She has also indicated that "for many this was probably a sufficient deterrent to prevent such interaction". Although this situation no longer exists to the same extent, if the relative is unable to locate a nurse in a public area, it is likely that the interaction which he wishes to initiate may never take place, although this was not possible to observe. This was not possible for, in the few instances in which relatives were observed to have difficulty in locating a nurse, such relatives eventually asked the researcher for assistance with this task, and it was not morally possible to refuse such assistance.

The suggestion has already been made that relatives attempt to 'locate' a nurse whom they perceive as 'interruptable', that is, a nurse engaged in an activity which is considered of less importance than the relatives' need. It was also observed that nurses interacting with the individual patients were rarely interrupted by relatives, although almost every other activity, including those such as medicine rounds, or observation rounds, where fleeting contact was made with a number of patients could be interrupted, after the relative had located a nurse involved in these activities. However, the activity which was most frequently interrupted was that which can loosely be called administration duty, in which the nurse was located either in the 'sister's office' or at the nurses' station, carrying out some activity which involved sitting down and writing. Relatives who were familiar with the nursing routine would in some instances wait for a nurse to go and sit at the desk before they would attempt to initiate interaction:

> "I wait until she (Ward sister) goes in there (office) and then I go and ask."
>
> "I think it's best to wait till they're finished with the patients."

Some attention should now be given to the nurses' perception of the task of "seeing the relatives" as "interruption".[1]

Unlike most other aspects of nursing activity, the task of 'seeing the relatives' cannot be fitted easily into the routine. Many wards still operate a system of task-allocation (or at least partial task allocation) as opposed to patient allocation, in which each nurse is made responsible

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1. The term "seeing the relatives" is used to describe nurse activity with relatives for it is a phrase which has some meaning for nurses. While the different forms of encounter are classified in this study in order to help our understanding of the activity, this is not the way in which they are perceived in the day-to-day work of the nurse. The nurse wishing to initiate an encounter with a relative is most likely to state to colleagues that he/she wishes to "see" the relatives.

for the completion of a number of tasks rather than for the care of a small number of patients. "Seeing the relatives" is not in this way made the responsibility of any one nurse, therefore if a nurse is approached by a relative, taking time to cope with the relative's problem means that she is taking time away from the other tasks for which she is responsible. It is not surprising therefore that the nurse perceives that she has to "make time" to cope with this "intrusion" into her work-flow.

> "There are set jobs to be done at set times and relatives asking questions can interfere with this routine." (SRN)

> "You've got to make time for them, but I suppose it's all part of it, although you can resent it at times." (SEN)

Any interruption of the routine by patients, relatives, other staff, the telephone etc. can be resented by some nurses, and Congalton and Najman (1971) have shown that "interruption" is perceived by nurses as a cause of stress in nursing practice. It has also been further indicated by Lorber (1975) that those patients who "do not interrupt the smoothness of the medical routine are likely to be considered good patients" (p.224).

'Interruption'[1] also appears to be related to the nurses' perception of a 'good' relative. All the nurses in the present study were asked to define a 'good' relative. Most of the nurses defined 'good' relatives in terms of the patient-relative relationships, but some also defined a 'good' or 'difficult' relative in terms of their own relationship with the relative.

'Good' relatives:-

> "visit only in set hours, don't ask too many questions and are not noisy." (SRN)

> "ask questions at the right time and don't keep bothering you." (SEN)

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1. Or more correctly 'non-interruption'.

'Difficult' relatives:-

"don't take any notice if you're busy." (SRN)

"keep coming and asking about the patient every time they come in." (SRN)

Nurses, who had themselves become relatives, appeared to appreciate the difficulties involved in being a 'good' relative, i.e. a relative who did not 'interrupt'.

"We came in to see my father, and my mother wanted to see the sister about his wound. They were having 'report' and I said 'you can't interrupt them now'. 'Why not?' she said, 'they're all sitting down', and she just went in and asked. I felt so embarrassed because I knew what they would be thinking." 1

(3rd Year Nurse)

"I didn't want to keep asking sister how he was but because I was a nurse all the family expected me to know. They don't realise how difficult it is to find the right moment to do this."

(2nd Year Nurse)

Having considered the matter of interruption we should now return to the actual entry behaviour.

Once the relative had located a nurse whom he/she perceived as interruptable he/she adopted an 'intention display'.

The 'Intention Display'

By the use of an 'intention display' (Goffman 1963) the individual adopts a position which others can read or predict by. An intention display adopted by the relative may consist of one or more direct actions,

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1. The problem may have been compounded from the nurse's point of view in this instance because she would appreciate the significance of the 'report'. Report sessions have been described by Zeburavel (1978) as "highly formalized and stylyzed briefing sessions, which consist of a condensed transmission of vital information about patients from one nurse to her relief". He pointed out that reports have a "tremendous moral significance" for nurses and that many nursing activities are suspended while such a session takes place. (p. 79).

- a knock on a door, the use of a phrase such as "excuse me", or a clearing of the throat - all of which are designed to draw some response from the nurse. It is difficult for the nurse to ignore such direct action and the desired interaction is usually initiated.

Many relatives are, however, reluctant to take direct action and attempt to establish interaction by a less direct method. This begins with a 'hovering' movement near to the selected and located nurse. The relative using such a method tries to draw the nurse's attention to his behaviour, hoping that she will respond in such a way that interaction will begin. In many instances this sort of behaviour does result in the desired interaction, but there are also occasions when this behaviour is ignored. The irresolute relative may then retreat back to the bedside of the patient if he is reluctant to take a more positive approach. Of those relatives observed to take this action, some attempted to initiate interaction later on, but others took no further action concerning this matter.

Nurses were aware of this behaviour and even in some instances used the term 'hover'.

"You see them hanging around in the background trying to attract attention." (SEN)

"They hover around and need someone to ask them what they want." (3rd Year Nurse)

Although they were aware of this form of behaviour, nurses were also observed to use 'avoidance tactics' so as not to have to respond to the hovering behaviour which they could see taking place. Two particular avoidance tactics were identified:-

a) the use of a 'legitimate gait'

b) 'seeing' but not 'seeing'.

Legitimate Gait

Some nurses, as well as describing the actions of relatives who were trying to attract attention, also realised that they themselves took positive steps at times to avoid making contact with the relative which would lead to interaction. One enrolled nurse described how she had come to adopt the use of a different way of walking to avoid interaction with relatives when she was busy:

> "When I first came on this ward I thought I was always being stopped by relatives, and then I realised that it was me that stopped for them. Then I noticed that some of the other nurses walked right past them without asking what they wanted. Well I know it's an awful thing to do, but now I also just walk past them looking as if I'm on my way to do something important."

Glaser and Strauss (1965) have described how nurses who wish to avoid contact with the family adopt "a legitimate running gait with which to breeze past family members". This sort of walk and the demeanour of the nurse serve as an intention display for the relatives to interpret as "do not interrupt or disturb me as I am involved in matters of some importance". There may of course be occasions when such an intention display reflects the real situation of the nurse. However, some attention was given, during the course of the study, to the occasions when such a gait (hereafter called a 'legitimate gait') was adopted to avoid relative interaction. It was found that nurses could adopt this strategy even though they were engaged in such tasks as going to make a patient's empty bed, or to fetch a glass of water.

Nurses attempted to justify their use of this intention display in terms of "getting the work done".

> "If you didn't do it you'd never get anything done."
>
> (3rd Year Nurse)

> "Of course you have to do it, otherwise you'd always be stopping."
>
> (SRN)

"If you're rushing around it stops them from bothering you and then you can get on with things."
(SEN)

Portman (tongue in cheek) (1974) has described the nurse's use of this form of behaviour:

"They (relatives) have a habit of stopping you in the corridor with 'can you spare a minute?' when it's obvious by the speed you are travelling that you haven't a second, least of all a whole minute."! (p. 1125)

The 'legitimate gait' was observed to be used on all the wards in which the study was carried out by all grades of nurse.

'Seeing' but not 'seeing'

When a relative hovers near a nurse involved in some sort of static activity, the use of the 'legitimate gait' as an avoidance technique is not possible. The nurse, however, can still avoid interaction, if she wishes, by avoiding eye contact with the relative. This does not mean that the relative is not seen by the nurse. Dodd (1974) observed how the relative could "stand in full view of the sister at her desk seeing and being seen" without any acknowledgement being made of his/her presence until the relative took more positive action. In the same way that nurses recognised that at times they adopted a 'legitimate gait' they also realised that they used the 'seeing' but not 'seeing' strategy to avoid interaction.

"They (the relatives) can see that you're busy but they don't take any notice, they just stand there. I just ignore them till I've finished what I'm doing."
(SEN)

It must be stated that it might be detrimental at times to patient care if the nurse did stop in the middle of some of the activities in which she is engaged, such as checking drugs, in order to cope with the relatives' needs. But this was never put forward as legitimation for either of the avoidance tactics described by the nurses who adopted

these strategies.

When hovering failed to initiate the required interaction the relative had three alternative courses of action. The first, which has already been indicated, was to withdraw and try again either by locating another nurse or by adopting the same behaviour later on in time. The second course of behaviour was to adopt the direct approach, while the third alternative was to decide to abandon the attempt and thereby forego the possibility of obtaining the required information.

One example of the alternative strategies, which were at times necessary, involved the son of a patient who had been admitted as an emergency and who was seriously ill. The relatives, including the son, had been called into the hospital but as yet had received no information apart from the fact that he had collapsed and had therefore had to be admitted. After sitting by the patient's bedside for a period of time (20 minutes) the son decided to try and gather some further information. First of all he hovered near a nurse talking to a doctor, where it appeared that he was 'seen but not seen'. The relative then 'hovered' near a nurse who was putting away linen, where again he was 'seen but not seen'. Finally he decided to use a 'direct approach' 'interrupting' the nurse and the doctor around whom he had originally 'hovered'. Interaction usually proceeded wherever the nurse had been located, in the office, at the nurses' station, in the corridor, day-room etc. On a few occasions the nurse invited the relative to accompany her to another area in the ward, e.g. the office, but this was the exception rather than the rule in all the wards observed.

It has been shown so far that if the relative persists he can be successful in initiating interaction. But it has also been shown that firstly, some relatives who would like to interact with nurses for some

specific purpose are 'put-off' because of their reluctance to 'interrupt', and secondly, some relatives make some effort but end up abandoning the attempt to initiate interaction.

It was also found that relatives who were successful in locating a nurse and in initiating interaction, could be 'put-off' if they were directed to another nurse whom they perceived to be more busy (therefore less interruptable) than the one whom they had originally located. An example of this was when after successfully initiating an encounter a relative was told "You'll have to ask staff nurse". The staff nurse was within view of the relative but was 'busy' at the drug cupboard. The relative retreated saying "Oh, I'll ask her when she's not so busy". In fact the relative did not on that occasion re-attempt to initiate an encounter.

Although it has been shown that nurses are able to use avoidance tactics in order to avoid interruption of the work-flow, it should be noted at this point that many nurse-relative encounters take place on the telephone. If the telephone rings the nurse cannot in the end avoid answering this. In this way the encounter is successfully initiated. There are, however, a number of problems associated with 'telephone encounters' which we shall take up in Chapter 7.

We should now briefly consider the entry behaviour of nurses and relatives when the nurse is the initiator.

The nurse as 'initiator'

The nurse who wished to initiate an encounter with a relative almost inevitably used a 'direct approach' at a convenient time during the ward routine. In such instances the relative was asked if he/she (the nurse) could "have a few words", "speak to you for a moment" etc. This initial

approach could be made either as the relative was entering or leaving the ward or at the patient's bedside.

The nurse also had an advantage not possessed by the relative, in regard to the continuation of an encounter. The nurse situated in her ward territory was able to select an appropriate location within that setting for the encounter to continue. She had the authority to invite the relative 'backstage', while, as previously indicated, most relative-initiated encounters continued at the location in which the relative 'found' the nurse, for example in the corridor, or at the nurses' station, No problems were observed to be associated with initiation when this was carried out by the nurse. Problems only arose if the nurse had made a decision to "see" the relatives for some reason and the relative failed to visit the ward.

One further aspect of entry behaviour should be considered, that of the 'greeting'.

Greetings

It has been shown that some relatives wishing to initiate interaction used a direct approach, and that nurses were always observed using such an approach. In this way the opening phrase such as "Excuse me", or "Can I have a word with you?" serves as a 'greeting'. Greetings are important for they serve to clarify and fix the roles that the participants will adopt during the encounter and commit the participants to these roles (Goffman, 1971).

After the 'greeting' there was usually some closing of the 'space' between the participants. In this way it became obvious to the passing observer that this was more than a casual exchange.

In some instances, however, there was a physical barrier which

impeded the closing of the 'space' between the nurse and the relative. It has already been pointed out that much of the interaction between these two groups was initiated by the relative with a nurse who was sitting either in an office or at a nurses' station. The nurse in this instance was positioned in the "well bounded space to which she could lay temporary claim" described by Goffman (1971) as a "stall" (p. 56). In order to close the space between the participants both nurse and relative in this position were frequently observed to lean towards each other, although the lower half of their bodies were constrained by the physical barrier between them.

We have focussed in this chapter on two different aspects. We began by attempting to identify the different reasons for which encounters between nurses and relatives could be initiated, indicating that not all relatives and nurses had 'actual' relationships. We then considered the entry behaviour of both nurses and relatives pointing out that in many instances the relative could perceive a need but because of a number of different social constraints was not successful in initiating an encounter relating to that need.

Before considering the encounters themselves in subsequent chapters we should briefly consider the implications of the problems so far identified. In Chapter 2 attention was drawn to the notion of the professional-client encounter and to the disadvantaged position of the client, in particular his lack of resources within the organisation. This has been shown in our discussion of the setting in which encounters between these two groups takes place, indicating that "being busy" is of some significance. "Being busy" is significant for the nurse for it is commensurate with her expectations of nursing practice. It is also of some significance for the relative for it creates a barrier which needs to be breached if an encounter is to be initiated. The nurse who wishes

to avoid interaction with the relative can adopt different forms of behaviour normally associated with "being busy". The relative who would wish to take similar action has no such resource.

We should now proceed to consider the behaviour of nurses and relatives within the different forms of encounter identified in this chapter. These will be discussed in the next five chapters, beginning with the 'relative gathering information' encounters.

CHAPTER 7

THE RELATIVE GATHERING INFORMATION ENCOUNTER

Having considered the way in which nurse-relative encounters are established, some attention should now be paid to the most frequent form of encounter between nurses and relatives, that of the relative gathering information encounter.

We shall begin by looking at relative and nurse behaviour in such encounters in relation to the different aspects of information required by the relative, paying particular attention to the role of the nurse as both 'information giver' and as an 'information withholder'. This will be followed by a discussion of the notion of information withholding.

The relatives 'need' for information

The relative's need for information concerning the patient's illness may be satisfied by the information he receives from the patient himself, but there are occasions when the relative perceives the need to seek further information from the doctors, nurses and other staff involved in the care of the patient. Two separate factors, both relating to the patient, may lead to this quest.[1] Firstly, the relative may require information to supplement that given to him/her by the patient. By seeking for further information the relative will add to his/her own knowledge. He/she may also, by giving this information back to the patient, increase the patient's own knowledge of his illness. The quest for supplementary information, therefore, may be to meet the relatives'

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1. One other factor is related to the quest for information, this is concerned with 'not knowing'. Because this aspect is specific to the early stages of the patient's illness it will be considered separately from the other two factors.

need only, or it may be to meet the needs of both relative and patient. Secondly, there are also a number of instances when the patient's physical or psychological condition either inhibits or totally prevents normal discussion concerning his illness. The relative requiring information in such a situation has no option but to approach the staff.

The desire for information may be due to the relative's concern for the patient or because of the relative's prudence:[1]

> "I wanted to know what she'd had done, she was too sleepy to tell me herself."
>
> (Husband of patient following gynaecological surgery)

> "I wasn't sure if they'd found anything bad and not told her."
>
> (Husband of patient following gynaecological surgery)

In certain situations (announceable events) information will be given to the relative by the staff without the relative asking for this, but as McIntosh (1977) has pointed out "the onus was very much on the relatives to find out about the patient" (p. 181). Most of the relatives interviewed in this study were aware that if they wanted information they would have to look for it:

> "Oh yes they'll tell you, but you've got to do the asking."

After the relative has successfully initiated an encounter with a nurse, as described in Chapter 6, he/she needs to establish the purpose for which he/she has engineered this interchange. The purpose was usually specified in the form of a question.

> "How is (he) getting on?"

---

1. In addition Goffman (1963) has indicated one further aspect of information seeking, pointing out that "although the asker will have a variable concern to obtain the information he asks for, he will have distinct from that a constant concern to obtain acceptance of his asking." (p. 197)

"How is (she) today?"

"Could you tell me how (he) is?"

Non-specific questions such as these usually evoked a non-specific reply.

"(He's) much the same."

"(He's) coming on fine."

"(He's) not doing too badly."

More specific questions were also used, either in opening the encounter, or following on from a non-specific 'opener'. However, before discussing these more specific questions it should be noted that many nurse-relative encounters concerning the patient's illness did not proceed beyond the 'generalised question-generalised response' format.

In some instances the relative's purpose for the interaction was achieved by this form of encounter.

"I like them to see that I'm interested, and it lets sister know that I'm around if she wants to see me."

In this way the information gathering format appeared to have a social function for the relative. But it was also found that some relatives used generalised questions hoping for a specific response:

"I used to ask how she was but they'd just say that she was doing well or something like that, but they never said what she could do or not do. That's what you wnat to know isn't it?"

"What did you particularly want to know?" (researcher)

"About the walking."

"Did you ask about it?" (researcher)

"No, you expect them to tell you don't you?"

The formulation of specific questions is a significant one, for it will be shown that while nurses attempt to answer specific questions, in most instances they do not proffer further information. It would appear, therefore, that unless the relative specifies the information required he/she is unlikely to receive specific information.

It was shown in the previous chapter that relatives required information concerning the patient's condition/progress, discharge, treatment, prognosis and diagnosis. We shall begin therefore by looking at the encounters relating to these different aspects of the patient's illness.

Patients' condition and progress information

Questions relating to the patients' condition and progress were the most common component of all the encounters between nurses and relatives concerning the patient's illness. Included in this category are the questions relating to the normal bodily functions which might be disrupted as a result of the illness and the patients' hospitalisation:

"Did he sleep better last night?"

"Is she eating all right?"

It was found that if information concerning the patient's condition and progress was required the relative was usually able to formulate pertinent questions, for the terminology and concepts involved were familiar ones.

Nurses also appeared to have little difficulty in answering such questions. They "knew" whether the patient was sleeping, or eating well or not, for the management of problems with regard to such matters are the province of the nurse. It is not surprising, therefore, that most relatives were satisfied with the information received during such

encounters, and that nurses perceived no problems concerning their role in this form of interaction with relatives.

'Discharge' Information

It was also found that most relatives seeking specific information concerning the patient's discharge were given the specific information they had sought. (This is not to say that the patient's discharge itself is always unproblematic, for nurses and relatives, but this will be discussed in Chapter 11.)

"When do you think mother will be ready to come home?"

"She has to have more tests tomorrow morning but I think it will be all right after that."

"Tomorrow then?"

"Probably, but if you ring tomorrow after the tests, say about 12.00, I can let you know for sure."

Although the doctor decides when a patient is to be discharged, this information is immediately shared with the nurse, who can then implement the 'discharge procedure'. The nurse asked by a relative for such information is therefore likely to 'know' when the patient is likely to be ready for discharge if such a decision has been made. The nurse is also in most instances prepared and able to share this information with the relative.

'Patients Treatment' Information

The relative requiring specific information concerning the patient's treatment may already have some knowledge concerning this, either from the patient, or from previous encounters with doctors or nurses. This previous knowledge is indicated by questions such as "What did the tests

show?" The relative may also be basing such questions on his/her observations, e.g. "Why is she having blood?" The answers to such questions were not necessarily meaningful in the first instance to the relative, who required in some instances to ask further questions to clarify the situation. (This will be further discussed in Chapter 11 describing the nurse as teacher.)

1) "How's the waterworks?"

"Not working very well. We've had to put a catheter in."

"A catheter?"

"Yes, he couldn't pass water as you know."

"Some sort of bag is it?"

"Oh no, it's a tube going into his bladder."

2) "Do you know what they found when they operated?"

"Are you her husband?"

"Yes."

"She had a large fibroid removed which is what they were expecting to find, but they also found some endometriosis."

"Oh, what's that?"

"That's just something on the lining of the womb which they've burnt off because it could have stopped her getting pregnant."

"There was some question of removing the Fallopian tube. Did they do that?"

"I'm not sure. I'll have a look." (refers to notes) "No, they haven't done anything to that."

3) "What did the tests show?"

"There's something missing in her blood."

"What sort of thing?"

"Well there are some chemicals which we all have in our blood and one of her glands is not making enough of this chemical so she'll have to have some tablets to replace it."

Unlike the relative gathering information concerning the patient's progress or discharge, the relative seeking for information concerning the patient's treatment did not always receive this information. In this form of 'relative gathering information' encounter nurses were frequently observed to adopt strategies by which such information was 'withheld' (these strategies are fully described in the next section of this chapter) because they were 'unable' to give them the information required. Yet most relatives expected that nurses would be able to give them this sort of information:

"Well of course they must know what's going on, they couldn't look after the patients if they didn't. Yes, they should be able to tell me what I want to know."

We shall return to this point later.

'Diagnosis and Prognosis' Information

Relatives also initiated encounters with nurses in order to obtain information concerning the patient's diagnosis and prognosis, although such encounters were far less common than those in which the relative attempted to gather information concerning the patient's condition and treatment.

In some instances the nurse confronted with questions concerning the patient's diagnosis was 'able' to give the relative the information requested.

1) "Have they found out what's the matter?"

"Yes, he's got a touch of pericarditis and that's what has been giving him the pain, but we're still investigating to make sure that everything else is O.K."

"How did he get that?"

"Well it could be a virus that caused it, but we may know why after the rest of the tests are done."

"What does that 'peri-whatever' mean?"

"Oh just a bit of inflammation around the heart, but that's why he's been having the pain."

"It's not a heart attack then?"

"Oh no, you can be reassured about that."

2) "What exactly is the matter with her then?"

"Well she's still anaemic, but we're treating her now with tablets. I don't think she'll need another blood transfusion."

"It was that bad then?"

"Yes."

"She doesn't look too bad."

"No well if she's always been pale it wouldn't show in her looks."

"What about those things on her hands?"

"They're corns."

"Corns?"

"Yes. I've never seen anything like it, but apparently that's what they are."

"What was the cause of her swollen hand then?"

"Oh they thought at first that it was cellulitis and that if they treated it it would go down, so that's why she was given antibiotics."

However, most of the encounters concerning information which related to the patient's diagnosis were not answered in this way, and it was observed that the nurse in most encounters in which the relative asked specific questions concerning the patient's diagnosis adopted one of three strategies in order to avoid answering the relative's question by giving specific information. These three strategies were also used by nurses who were 'unable' to give the relative information concerning the patient's treatment referred to above.

The three strategies observed were a) using a non-response, b) making excuses, c) role-switching.

a) The non-response

The 'non-response' appeared to take two forms i) 'ignoring' the question, and ii) using a non-committal phrase.

i) 'ignoring' the question

"Have they found out what's wrong with him yet?"

"You can go and see him if you like."

"What is his blood pressure now?"

"It's all right."

"I only wanted to know if it had gone down."

"The doctor will see him later."

"Oh, all right."

ii) non-committal phrase

"How is she?" (daughter to SEN in charge of ward)

"Much the same."

"She's not very well is she?"

"Yes, I think you can say that."

"How long will she be?"

"I can't say how long."

"How much of that is sedation?"

"Not much - if she wasn't sedated she would be more distressed."

"Oh yes" (long pause) ... "My sister rang up this morning and suggested that perhaps she had cancer, but I said to her 'who knows'."

"Ummm."

"Yes, well, I'd better go and sit with her again."

The nurse involved in the above discussion pointed out the difficulty nurses have when no diagnosis has been made. Medical uncertainty produced a tendency to be over-cautious in any interaction with relatives. "It's not for me to say anything which might not be right, so I just waffle."

b) Making excuses

At times the nurse 'made an excuse' for not 'knowing' and therefore not giving the relative the required information.

"You'll have to excuse me, I've been on my holidays for two weeks, so I can't really give you much more information at the moment." (SRN)

In some instances the nurse using this strategy genuinely did not 'know' the answer to the question asked, but in many other instances making excuses was used to absolve the nurse from further questioning concerning this matter.[1]

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1. Scott and Lyman (1968) have pointed out that 'excuses' are "socially approved vocabularies for mitigating or relieving responsibility when conduct is in question".

After making an excuse some nurses then adopted the strategy of 'role-switching', described below.

c) Role-switching

The most common strategy adopted by nurses who were not 'able' to give the information required was that of role-switching.

Role-switching involves referring the questioner to a person at another level in the hierarchy. This tactic is used by all grades of nurse to refer the relative to the doctor or by junior nurses to refer to a higher grade of nurse. The nurse using this tactic pleads ignorance concerning the answer to the question, and then suggests that the relative see someone else. This strategy may involve a chain of referrals.

Relative to first-year pupil nurse:

> "Could you tell me if my wife's condition is in any way related to the fact that she's got a loop (IUD) in?"
>
> "No, I can't I'm afraid, I just don't know. If you'd like to ask that nurse over there (points to SEN) she may be able to help you."
>
> "O.K." (goes over to SEN)
>
> "I was just wondering if my wife having a loop in made any difference to her condition."
>
> "I'm not really able to answer that, perhaps it's best if you see a doctor."

Glaser and Strauss (1965) have described how in extreme cases the family member is referred from an "aide up through various members of nursing staff with perhaps a few side trips to an orderly, social worker, nun, chaplain, or ward clerk and ends up by asking the doctor".

Role-switching was the only one of the three withholding strategies which could be functional for the relative for it directed him/her to a more appropriate source of information. Some nurses were observed after 'making excuses', or 'making a non-response', to then adopt a role-switching strategy. However, unless the nurse, after suggesting an alternative source of information, made a positive attempt to arrange such an encounter the onus was once again placed on the relative to re-initiate another interchange with an alternative 'expert'.

The nurse who did not 'know' the answer to a question because such an answer was not yet available, could also make a positive attempt to re-initiate an encounter in which such information could be given.

> "We haven't got the report back from the lab. yet, but it will be here later." (pause)
>
> "Will you be here this evening? Come and see me then." (SRN)

> "I don't know about that until doctor's seen him, but if you like to ring back in about half an hour we'll be able to tell you."
>
> (SRN to relative making an enquiry by telephone)

It was also observed that some of the nurses prepared themselves for possible questions so that they 'would know' the answer:

1) "What exactly is this, is it pre-cancerous?" (SRN looking at pathological report to doctor).

The doctor explains the term and its consequences after which the nurse stated:

"The husband might ask so I thought I'd better know."

2) "Have the rels been told about the bin? They might come and ask me about him."

(SRN to doctor)[1]

Why were these strategies used in regard to information concerning the patient's diagnosis and prognosis, and to some extent his treatment?

It would appear that in some instances the nurse does not have the 'knowledge' with which to answer such questions. It is possible that the nurse does not have this knowledge because she is too junior in the nursing hierarchy:

> "It's easy for me not to answer because in most cases I really don't know. Still, I won't be a first-year nurse for ever and then I'll have to answer or get them to see a doctor."

It is possible for a nurse not 'to know' because she is just back on duty after a period of time away from the ward and has not yet had the opportunity to obtain this knowledge:

> "It can be awkward because so often you have to say you don't know especially if you're just back from days off." (E/N)

However, in such instances other nurses on the ward were in possession of this 'knowledge'. But there were also occasions when none of the nurses on the ward possessed this 'knowledge' because it had not yet been shared with them by the doctor.

All patients admitted to the hospital are the responsibility of a doctor who diagnoses the patient's condition, and orders and monitors his treatment. In this way he 'directs' the patient's care according

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1. The use of the words 'rels' and 'bin' (psychiatric unit) would not be used in interaction with the relatives but are an example of what Goffman (1959) has described as back-stage talk between members of a team, i.e. the doctor and nurse, about an audience, in this instance the relatives, which is inconsistent with their normal face-to-face behaviour. (p. 168)

to his own 'knowledge'. The hospital as an organisation is structured on the assumption that the doctor has such knowledge, and it has been indicated that "nurses' work is regarded as being in service to this knowledge" (Thompson, 1975).

It would seem, therefore, that the nurse who gives information concerning the patient's treatment, diagnosis and prognosis, carries out this task as the doctor's agent, for he retains the responsibility for these aspects throughout the patient's stay in hospital. This can create a number of problems for the nurse.

Firstly, she may not have the 'knowledge' required because the doctor has not yet shared this with her.

> "I have to plead ignorance because I don't always know the full story." (SRN)

Secondly, nurses in some instances 'know' the answer to the relative's question but they do not 'know' if it is their task to give this information.

> "If they ask about the diagnosis I'm not sure what to tell them. I don't want to put my foot in it." (SRN)

> "I'm all for the relatives having all the details they require, but it's up to the doctor to decide, not me."

The doctor is the decision-maker concerning the amount of information to be shared with the relative. In order not to make mistakes it was easier for the nurse to role-switch than to take on this task herself. A number of nursing texts advise the nurse specifically concerning this matter:

> "It must be remembered that certain information must only be given in conjunction with the doctor's wishes, as he

himself may wish to convey certain details of the patient's condition to the relative."

(Roberts, 1971, p. 2)

The nurse confronted by the relative's questions, therefore, needs to decide if she 'should' answer them, bearing in mind the warning given by Roberts that the "well-meaning nurse could inadvertently say the wrong thing or give the wrong impression". In order to avoid this error the nurse is advised to "refer the questioner to a higher authority. It is sometimes better to say too little than too much" (p. 3).

It is not surprising, therefore, that many nurses do not believe that they should take on the role of doctor's agent concerning these matters.

"If they ask questions about the patient's diagnosis or prognosis then they need to see a doctor - you can give them a general idea, but it's then best if you ask them to see the doctor."

Thirdly, the nurse may not 'know' what the relative has already been told, either by her colleagues or by the doctor:

"I always ask them to see someone else if they ask questions concerning the patient's prognosis or diagnosis: sometimes because we have been told atreport not to say anything, but mostly because you are not sure what other people have told them."

(3rd year nurse)

In this way the nurse avoids giving information which may conflict with the relatives' 'knowledge' of the patient's illness.

There is, however, some ambiguity concerning the sharing of the task of "seeing the relatives" between doctors and nurses. This lack of task definition is not confined to "seeing the relatives":

> "The procedures which are performed by nurses and doctors, and those which are regarded as the prerogative of the doctor are by no means clearly defined, and the accepted policy of one hospital does not necessarily correspond with that of another."
>
> (Nuffield Hospitals Trust 1953)

Although it would appear that the lack of task definition between nurses and doctors is not unique to "seeing the relatives" it does appear to compound the difficulty for the nurse.

Hospital policy also may have influenced the behaviour of the nurse in such encounters for hospital staff were instructed to limit the information given to the relatives to "that of a factual nature, and to avoid speculation and conjecture".

We have focussed so far on the behaviour of the nurse in the relative gathering information encounter, indicating that the nurse may not have the 'knowledge' necessary for her to be 'able' to give the relative the information required. It has been shown that the nurse needs three different sorts of knowledge:

(a) he/she needs to 'know' the answer to the relative's questions,

(b) he/she needs to 'know' that he/she is 'allowed' to give the relative the information required,

(c) he/she needs to 'know' how to give the information in a way which is understood by the relatives.

Other factors relating to the nurse's knowledge will be considered later in the chapter. We should now turn our attention to the behaviour of the relatives in such encounters for it appears that some relatives are more successful than others at obtaining information.

Such relatives fall into four groups:

a) relatives with 'client skills',

b) relatives with previous experience either as a 'carer' or concerning 'being' a relative,

c) relatives who are themselves health professionals,

d) relatives who 'shop around'.

(a) Relatives with client skills

Rees (1978) has noted that in their experiences with contacting professionals some people show evidence of 'client skills'. She pointed out that such clients possessed assumptions and an awareness not shared by all clients:

> "Assumptions that though they lacked precise knowledge about agencies' terms of reference they could obtain such information and use it to enhance their chances of obtaining a service.
>
> "Awareness that when meeting people in positions of authority they were involved in negotiations and had knowledge of how they might influence decisions in their favour."
>
> (p. 33)

In addition to the above skills, this group of clients were also more optimistic in their expectations of "officials and officialdom", and had a sense of security which was derived from income, or status. Weglinsky (1973) has indicated that this predominantly middle-class group uses such skills to ask more questions. It has already been pointed out that the amount of information received related to the 'pertinent' questions asked, so that in this way these relatives are more likely than others to obtain information.

But in addition this group of relatives often by-passed the nurse

as a source of information, and went straight to the doctor, although they used the nurse as an intermediary.

"I'd like to see Dr. -" (consultant)

"Well he won't be here until Friday. I could arrange for you to see Dr. --" (junior doctor)

"Oh no, give me his (the consultant's) secretary's extension number and I'll arrange it with her."

It was found, however, that some nurses appeared to perceive such relative behaviour as mildly threatening to their own status as 'information givers'. If the nurse herself suggested that the relative should see a doctor this was justified as 'correct' behaviour, but if the relative himself asked to see a doctor, this could be viewed somewhat differently:

"Every time they come in they ask to see the doctor. There's no need. I could help them just as much as he can."

(SRN)

While on another occasion an SRN, on being told that the relatives wished to see the doctor, replied:

"Oh not again. 'Suck-suck', 'creep-creep', that's all they do. Why do they think we're here?"

One further way of indicating that the relative "had knowledge of how they might influence decisions in their favour" with regard to information, was by the use of jargon in the questions posed by the relative.

"Do you think she's got 'osteo' in that hand?"

Jargon is the special language used by members of an occupational culture, as a way of identifying objects. In this instance the term 'osteo' used

by the relative instead of the term 'osteo-arthritis' or simply 'arthritis' served to indicate that the relative was familiar with medical jargon, and that in this way he/she shared a cultural bond with the information giver. A later discussion with the nurse involved in this encounter indicated that the nurse had perceived the relative as a 'well-informed layman' and had tried to respond appropriately.

> "Some relatives have read more about medical subjects, you can't fob them off so easily."
>
> (SRN)

(b) The Carer

A small number of relatives in the study had been involved in the care of the patient throughout a long period of illness before the present period of hospitalisation. They were therefore acquainted with many of the problems which caring for an incapacitated person involved. These relatives may have had very little experience of hospitals, unlike the third group of relatives, described below, but they tended to refer to their previous experience in their search for further information. It is possible that this group of relatives were also looking for credit as a 'proper carer', as well as seeking to gain something by demonstrating their superior competence.

Some of this group of relatives used the information given to proffer suggestions for patient care:

> "Is she drinking well?" (husband of patient nursed at home for two years following a stroke who was readmitted after a further stroke)
>
> "We're trying to encourage her, but she is a bit reluctant."
>
> "What are you giving her?"
>
> "Tea, coffee, that sort of thing."

"I've found that in the past it was best to give her complan,[1] I'll bring some in for her."

"That's all right we can give her some."

"No, I'll bring her in some ready made up, I know just how she likes it."

In this way the relative not only asked for information, but used that information in an attempt to maintain some aspect of care across the institutional boundary.

But this form of behaviour was also considered threatening, although not to the status of the nurse as an information giver, but to her status as 'administrator of care':

"They think they know what's best for the patient and ignore our experience with this sort of thing. I find it slightly irritating personally."

(SRN)

(c) <u>The relative with previous experience of 'being' a relative</u>

It was observed that a number of relatives appeared to be more skilled at asking questions than others. These questions were not only related to client skills but were also related to the relative's previous experience of 'being a relative'. If the relative's socialisation process had included numerous interactions with nurses and doctors, either during the period of the patient's present illness or in relation to other periods of illness, the relative had learnt by experience the sort of questions he needed to ask:

"Well what about this pacemaker then? Tell me exactly what I must do if it goes wrong. I don't want all the trouble we had last time when I didn't know what to do."

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1. A fluid 'food'.

(d) The relative who is a health professional

The relative who was a health professional and wished to use this fact in the information gathering encounter usually stated this early on in the encounter:

"My wife's a paediatrician."

"I'm an RN from Dallas."

This form of statement immediately established the status of the relative. But such relatives could be perceived as a threat to the status of the nurse. It was found that 34 out of the 56 nurses interviewed believed that talking to relatives "with some medical knowledge" was more difficult than talking to other relatives, although it was seen by the others that there might be advantages to both nurse and relative in any interaction, for example, some nurses used phrases such as "you both speak the same language", "they're familiar with the words we use". However, relatives, by identifying themselves in this way, were perceived to create problems for some groups of nurses, especially junior nurses or those with little experience:

"They make me feel nervous, because I think they know more than I do."
(First year student nurse)[1]

"I'm afraid of saying the wrong thing so that they'll think I'm stupid."
(First year pupil nurse)[1]

Having considered the four different groups of relatives who used certain skills related to their life-style or to their previous experience either as 'carer' (both professional and lay) or of 'being' a relative, we should now consider another common form of relative behaviour in 'relative gathering information' encounters.

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1. The 'student' nurse is a learner who is training for State Registration, the 'pupil' nurse is a learner who is training for State Enrolment.

Relatives who 'Shop Around'

Davis (1965) has pointed out how the parents of children with poliomyelitis who failed to extract the information they were seeking from the staff concerning their child's illness, would sometimes begin an 'information seeking expedition' both within and outside the hospital. The term 'shopping around' for information was applied to this form of behaviour in the client-practitioner relationship by Hughes (1958) and developed by Davis (1965). A small number of relatives were observed to 'shop around' for information in this study.

An example of this form of behaviour concerned a patient, in a small side ward next to the nurses' station, who had been admitted for investigations of abdominal pain. The conversation began as the student nurse entered the ward to collect the patient's cup, the relative was sitting by the patient's bed:

"Has she had the X-ray yet?"

"No, it's been ordered but they haven't done it yet."

"Why is she getting so much pain? She only had a cup of tea and it started again."

"The doctor saw her this morning and he couldn't find anything (turns to patient) could he Mrs. B?" (No reply from patient, nurse leaves the room)

About half an hour later the relative comes out of the room and stops a SEN in the corridor:

"Is staff nurse on duty?"

"She's busy, can I help?"

"Mrs. B's still waiting for the X-ray then?"

"Yes."

"No results yet then?"

"She's starting on new medicine today to see if that will help her."

"Why is she in so much pain?"

"Well, doctor saw her this morning and he wants her to get up and move around a bit."

Further interaction took place trying to encourage the patient to get up and then the relative rejoined the patient. The SEN saw the staff nurse and told her that "Mrs. B's relatives have been asking 'the same old questions'." The staff nurse replied "I only saw them yesterday and we went through all that." Twenty minutes later the relative saw the staff nurse pass the ward and initiated a further encounter using a direct approach:

"Has she improved at all?"

"The doctor saw her this morning and he wants her to get going on her feet."

"But what about the pain?"

"She'll be better if she can get moving."

'Shopping around' had a number of variations. In the above example one relative went from nurse to nurse asking the same questions. Another variation was that instead of one relative asking the same question of different nurses, at least two relatives were observed to ask the same specific question, relating to the patient, of one nurse.

This was not unlike the behaviour which takes place when a relative who has not received a 'satisfactory' answer attempts, after a period of 'thinking time', to re-initiate the interaction possibly with the same nurse, but formulating the questions in a different form:

"Did the doctor say what it was?"

"No, she just complained of feeling tired, so he watched her

walk a few steps and that was all."

"Did she sleep better last night?"

"Yes, they gave her a sleeping tablet."

"Did the doctor say anything?"

"She's a very anxious lady." (a non-response as described earlier in the chapter)

"So the doctor didn't say what it was then?"

"No."

The same relative approached the same nurse half an hour or so later:

"Did the doctor say the gall-bladder trouble had spread?"

"No, he didn't say anything specific was causing it."

'Shopping around' as an aspect of relative behaviour is one which most nurses recognise. In common with the other 'gathering information' skills, this form of behaviour is also perceived as status threatening.

"Some relatives go from one nurse to another asking the same question."

(SEN)

"The relatives will often try and pump you for more information after they've seen another doctor or another nurse."

(First year student nurse)

"What really gets me about some relatives is the way that they go from one nurse to another asking the same question, trying to play you off against the other."

(SRN)

Davis (1965) has described the form of behaviour known as 'shopping around' as the "constant bane to the practitioner's control of his client" (p. 59), for it would appear that at times such persistence is rewarded and the relative can obtain information which the professional may have wished to conceal. However, in the present study, the relatives

who adopted this strategy appeared to do so to no avail.

It was noted earlier on in the chapter that the information seeker needed to obtain acceptance of his asking in order to save face. If, after attempting to obtain information, the relative perceived his attempts as futile, in some instances any further attempt to obtain information was abandoned.

> "During the first 2-3 days I used to ask anybody and everybody, sister, staff nurse, doctor, anybody. But it soon became obvious that they weren't going to tell me anything so I decided not to bother any more."

We have so far considered nurse behaviour and relative behaviour in the relative gathering information encounter in the ward situation. We should now consider the final factor related to the need for information, that of the relative gathering information related to 'not knowing'.

The relative who does 'not know'

'Not knowing' is a condition which can be divided into two different aspects - 'not knowing what is happening', and 'not knowing what to do'. It was specially significant to the relative in the Accident/Emergency department for if the relative was in a state of 'not knowing' he/she was unable to structure his/her time within the immediate future. This state was usually related to the early stages of the patient's illness, when not knowing what was happening to the patient left the relative in a sort of limbo.

By talking to relatives it was possible to identify those for whom 'not knowing' caused most difficulty. It was found that most of these relatives for whom this was a problem needed to make some sort

of arrangement concerning other people, in particular other members of the family.

> "You see, the children are due to be picked up from school at 3.30 p.m., and I don't know what time he's going up to the ward."

These arrangements are naturally an important concern and in such circumstances 'not knowing', that is the absence of specific information, could become a real and pressing problem. The questions asked by the relative, therefore, are directed towards solving this problem.

This particular problem was, however, not necessarily identified as such by the relative when asking questions of the nurse. These questions were often in broad terms, such as, "Can you tell me what is happening to Mr. S?" and were answered equally in broad terms, "We're waiting for the doctor" etc. Such answers did not in fact help the relative with the problem which prompted the question because the relative did not specify 'why' this information was needed. Nurses did not always appear to appreciate the need for such questions:

> "They will keep pestering you, every time you open the door, but there's nothing we can tell them."
>
> (SEN)

> "They keep trying to catch your eye, wanting you to tell them something, but they don't realise there are other patients to be seen to as well as theirs."
>
> (SRN)

On the other hand there were legitimate reasons why such information could not always be given by the nurse when asked for by the relative.

> "I know he's worried and that he doesn't know why she's here, but she has asked for him not to be told."
>
> (SRN in regard to relative's husband)

Some nurses also perceived that it was their task to discover if the relative needed to make other arrangements:

> "they don't always like to say that there's a problem so I think it's up to us to ask." (SRN)

The problem of 'not knowing' arises because in many instances the relative has to 'wait' while the patient receives attention. 'Waiting' in out-patient and Accident and Emergency departments has been the subject of a number of studies, (Ministry of Health Report 1958, Nuffield Provincial Hospital Trust, 1965, Sussman 1967), designed to collect data for administrative or planning purposes. Gibson (1977) looked at 'waiting' with regard to the criteria used for deciding priority in treatment, and in particular the role of the receptionist concerning this aspect of the treatment process. She found that the waiting room was used to control the passage of patients through the department and that "waiting is irrelevant for staff except as far as patient flow is concerned or when waiting time is interrupted by the patient ... only when waiting time is interrupted and therefore interferes with other routines does it become significant." (p. 163).

One further point should be made in regard to the relative waiting in the Accident and Emergency department. In many instances the relative accompanied the patient, but efforts were made to control the number of relatives accompanying:

> Nurse: "Oh no, you can't all come in with him. Which is the boy's father? O.K., you come, the rest of you wait here."

By directing relatives and friends to the waiting area some form of control is maintained. It also means that such relatives need only be contacted when it is opportune for the nurse to <u>give</u> information

not when it is convenient for the relative to gather information. The walls, by acting as physical barriers, define the front and backstage.

> "Waiters of news do not have accurate knowledge of the goings on in backstage areas, not knowing for example, whether or not a particular person appearing from behind the doors was involved in their relative's case."
>
> (Sudnow 1967: 120)

The relatives who accompanied the patient were able to some extent to control the contact which they required to make with the nurse, for they had this particular knowledge.

It would appear therefore that although 'not knowing' (as used in this context) may not be the main factor concerning the relatives' quest for knowledge, at certain times in the relative career it may be of particular significance.

We should now turn our attention to two further matters concerning information gathering - that of 'understanding' the information given, and that of information giving through the medium of the telephone.

'Understanding' information

We have already noted that the desire for information is not uniform among the relatives and that some relatives are more successful than others in the activity of information gathering. We should now consider the notion that relatives also vary in their ability to accept and understand information. This difference has been identified in a number of studies concerning patients in the medical setting (Cartwright 1964, Skipper and Leonard 1965 amongst others). This difference was also to some extent found in the present study, although as indicated below

there are certain difficulties inherent in identifying this difference.

It was difficult to evaluate with any accuracy how well the information received was understood within the confines of the present study, for during the interviews with relatives, most of them stated that they had in fact 'understood' all that they had been told. But to admit anything else to some extent would involve loss of 'face' although a few did specify misunderstanding.

> "The nurse did say what was wrong, but I didn't quite catch her words. The wife's going to ask about it again."

There were indications, however, that some information was apparently accepted, without further questioning, but was not always fully understood, for in some instances it was observed that apparent lack of understanding could lead to a quest for an explanation of information received in a previous encounter.

The mother of a patient, after asking for this information, was told by the nurse in charge that the patient had been placed 'in isolation' because the drugs she was receiving had destroyed her white blood cells making her more prone to infection. The father of the patient arrived on the ward later that day and asked to see the nurse in charge:

> "What exactly is the trouble then? We don't quite understand."
>
> "As I told your wife this morning, her blood count's a bit low as a result of the drugs. It's only what we expected, but it does mean she might more easily catch other people's germs. So this will stop her from catching an infection."
>
> "So she hasn't got an infection then?"
>
> "No, this is to stop her from getting one."

Other evidence concerning a lack of understanding with regard to the information received can also be perceived from the relatives' use of the lay network of relatives and friends for clarification:

> "I didn't realise at first that she was 'acting funny' because of the stroke, so I asked my neighbour what she thought. She told me her mum was like that after her stroke, so I thought, well that makes sense now."

Interviewer:

> "Did you talk to the nurses about her 'acting funny'?"

> "Oh yes, several times."

This form of behaviour was also noted by Dyche (1979) and Finlayson and McEwan (1977), Dyche pointing out that the wives of coronary patients in her study resorted to "lay sources of advice" (p. 21).

It would appear, therefore, that not only are there difficulties in obtaining information, but that there are also varying difficulties concerning the understanding of information. This is not surprising for as Wood (1979) has indicated, quoting Kando, "human interaction is far from always being characterised by neat, mutual understanding." (p. 10)

Yet an understanding of the information given is essential if an encounter is to be considered 'successful' from the relative's point of view. The onus for ensuring that understanding is reached is placed on the professional. The problem is one which is well-documented.

> "What seems to the doctor or nurse to be simple, straightforward information may not be understood or absorbed even by the intelligent layman."
>
> (Central Health Services Council 1963)

The solution to this problem is related to professional practice:

> "The sister or doctor must spend time explaining to the relative about the patient's condition."
>
> (Bickerton, Sampson & Boyland, 1979 p. 110)

> "With practice the nurse can usually learn to tailor her explanation to the level of understanding of the individual patient (relative)."
>
> (Marsh, 1979 p. 17)

Although little evidence has been offered to indicate misunderstanding, the existence of this notion must be considered as an aspect of the relative gathering information encounter. The various possible behaviours described so far are reproduced diagramatically in Table 4 (p205).

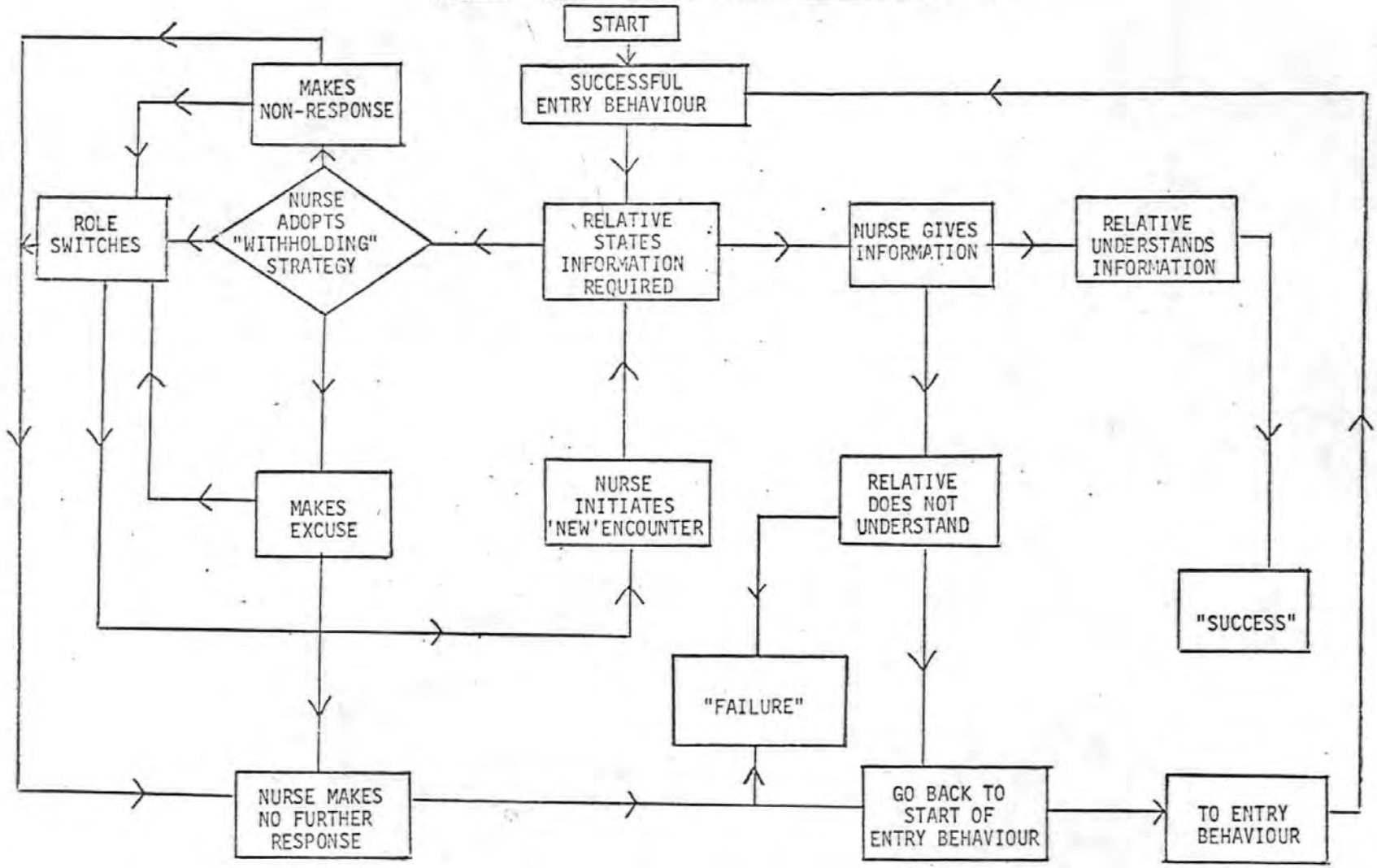
We should now consider one final aspect of the relative gathering information encounter before discussing the notion of information withholding.

Information exchange via the telephone

It was indicated in Chapter 5 that many nurse-relative encounters take place through the medium of the telephone and that this was perceived as a source of interruption by the nurse.

The nurse confronted with the relative seeking information through this medium was observed to use the same sort of withholding or non-withholding information tactics used in face-to-face encounters. However, it was also found, both by observation and from the interview data, that nurses were more likely to withhold information from the relative using the telephone to gather information than in a face-to-face encounter. Nurses were also observed to use more cliches in this form of encounter. The use of cliches and the withholding of information

TABLE 4 - RELATIVE GATHERING INFORMATION ENCOUNTER



was justified in terms of confidentiality.[1]

> "I say very little on the phone, you don't know who it is ringing - it could be the press, a nosey neighbour or anybody."
>
> (SRN)

Exceptions were made if the relative was unable to visit and lived at a distance, but this was recognised by the nurses themselves as 'abnormal' behaviour.

After giving detailed information concerning the patient's condition to his son in Australia an SRN pointed out "I don't usually say that much on the telephone."

Relatives themselves reported the inadequacy of the information they had received over the telephone:

> "I thought I'd better ring and ask how she was after her operation, but I might just as well not have bothered. They tell you nothing."
>
> (Patient's husband)

A ward sister recently reported her own experience as a relative, living 200 miles away from the hospital, who needed to rely on telephone enquiries for information:

> "The first week my telephone enquiries left me reassured that my grandmother was 'comfortable', 'progressing slowly', 'satisfactory' and 'settled'. Imagine my horror when I arrived to visit her to find her with an indwelling catheter, a wound infection, reeking of Hemineurin, disorientated, confused, constipated and in pain. The following week I was a wiser

---

1. This notion will be considered later in the chapter.

> woman. I didn't settle for 'comfortable' etc. but asked how her confusion, water-works and so on, were."
>
> (Cooper, 1981, p. 319)[1]

In response to this criticism of her fellow nurses in the nursing press, another nurse pointed out that there were different reasons for the nurse to behave in this way. Firstly the nurse does not know how much information to give the relative on the telephone so he/she "rightly or wrongly, falls back on such platitudes as 'comfortable', or 'satisfactory'". Secondly, the nurse may prefer to be non-committal in order to avoid alarming the relative by being "brutally honest" (Conway, 1981, p. 54).

In whatever way these behaviours are justified, the outcome is the same, information which is requested from the nurse by the relative is withheld. We should therefore now consider this notion of information withholding in some detail.

Withholding Information

In the first section of this chapter it has been shown that nurses and relatives can adopt a number of different behaviours within the 'relative gathering information' encounter. It was shown that in some instances the relative obtained the information he required but it was also shown that nurses adopted certain strategies which resulted in a withholding of information. We shall now turn our attention to the notion of 'withholding' or 'concealing' information as an aspect of nursing practice, relating the discussion to the issues raised in the first section of this chapter, and in addition considering other issues which may lead to the 'concealing' of information.

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1. The different expectations of the nurse as a relative from those of other relatives will be considered in Chapter 8, but in this context the point is not really significant, and the extract is used only to further illustrate the problem already identified by other relatives in this study.

Goffman (1969) has attempted to explore the individual's capacity to acquire, reveal and conceal information from another person drawing on the popular literature relating to intelligence and espionage for illustration. One of the issues he raised in that discussion is relevant to the present study. The issue raised by Goffman is the relationship of what is said to what is known by the sayer. He has pointed out that three different matters are involved in this issue:

a) No information replies may be of several varieties, 'don't know', 'know but won't tell' and 'not telling nor telling whether I could tell';

b) The respondent may reply with varying degrees of disclosure of what he thinks might be relevant, thus raising questions of 'frankness' or 'candour';

c) The answer may be one that he believes and would give to himself or it may be one that he does not believe and would not give himself, thus raising questions of 'honesty' and 'self belief'.

Some attention was paid to 'no information' replies in the first section of this chapter, and reasons related to the nurse's knowledge leading to this outcome were proffered. There are, however, other reasons which constrain the nurse's ability to 'inform' which are not related to her knowledge, but are related to the other factors raised by Goffman, those of 'frankness', 'candour', 'honesty' and 'self belief'.

All the nurses interviewed were asked to state their views concerning the matter of 'withholding information' as an aspect of professional practice.

In accordance with Everett Hughes' statement that "most occupations

rest upon some explicit or implicit bargain between the practitioner and the individuals with whom he works and with the occupation as a whole and society at large about receiving, keeping and the giving out of information gathered in the course of one's work" (p. 81) the majority of nurses stated that it was right for them to withhold certain information in specific situations, and that this was good professional practice. Withholding information can be legitimated by the practitioner as being in the best interests of the client. The British Medical Association, (1963) giving support to the Government Publication 'Communication between Doctors, Nurses and Patients: An aspect of human relations in the Hospital Services',[1] stated:

> "Doctors and nurses know, of course, that the patient and his relatives should be given a clear explanation of the nature of his illness, the diagnosis, the prognosis and the treatment. Such an explanation should be limited only by their capacity to grasp the complexities of human disease and by the therapeutic necessity to withhold information which, by alarming the patient, might impede his return to health."
>
> (cited p. 22 in Ley and Spelman, 1967)

It was found that while "the capacity to grasp the complexities of human disease" and "therapeutic necessity" might be justification for the medical profession to withhold information, these were not the only reasons which nurses themselves offered as justification. The analysis of the reasons offered by nurses showed that they fell into four main groups:

a) Some nurses perceived an inadequacy in their own knowledge to deal with the further questions which the giving might provoke,

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1. Report prepared by a Joint Sub-Committee of the Standing Medical and Nursing Advisory Committee of the Central Health Services Committee.

that is, a form of 'don't know', which has already been discussed.

b) Some nurses believed that the giving of such information would be a breach of the confidence which the patient had placed in the nurse, that is, 'know, but won't tell'.

c) Another group believed that to give such information was 'not my job'. (This has already received attention in the first section of this chapter.)

d) Some nurses believed that as professionals they should operate a 'doctrine of reserve'.

We should now turn our attention to the two notions which have not been previously discussed, that of 'confidentiality' and that of the 'doctrine of reserve'.

Confidentiality

It has already been stated that a number of the nurses interviewed expressed the belief that to give the relatives certain information would be a breach of the confidence placed in the nurse by the patient. On closer examination of the data it was noted that this attitude was especially prevalent among those nurses working in the gynaecological ward and that eight out of the sixteen nurses on this ward put forward the idea of breach of confidence as a reason for withholding information, although other nurses working in other wards and departments also put forward 'breach of confidence' as a reason for withholding information.

"Yes, the patient may not wish the relatives to know."

(SRN)

"It depends what the relative is asking. On this ward you need to be guided by the patient."

(SEN)

> "I don't think you should keep anything from them except when the patient doesn't want the relative to know. Patients must have that right."
>
> (SRN)

This attitude which was prevalent in, although not exclusive to, the gynaecological ward is related on that ward to the nature of the patient's diagnosis. New students who arrived on the gynaecological ward were given specific instructions, concerning confidentiality in relation to relative's questions, from the nurse in charge of the ward.

> "Take care especially when you are admitting a patient not to mention the reason for the patient's admission. Not all the relatives who are with the patient will know the real reason for this ... Be very careful on the phone. You don't know who you're speaking to. People claim to be relatives when they are not. Answer the question if you can without breaking any confidence, but if there are any questions you feel uneasy about refer the call to one of us."

(This 'briefing' was not observed in any other ward, although all nursing students are given general instructions concerning confidentiality in broad terms during their introductory course.) The gynaecological ward information book also contained the instruction that "no awkward questions should be asked (on admission) if a friend or relative is present".

If information is to be kept confidential some collusion may be necessary between the patient and the nurse so that they both tell enquiring relatives the same story. In one instance which was observed the agreed explanation for the patient's ectopic pregnancy was the use of the term 'cyst'.

Withholding information, even if this is at the request of the patient, may of course lead to some dissatisfaction on the part of the

relatives who could feel that they have not received the information for which they were seeking, but it would appear to be essential that in this instance the nurses' first loyalty must be to the patient.

While accepting the necessity for confidentiality most of the nurses were aware that withholding information could increase the relative's stress.

> "If the relatives don't know what is happening to the patient this worries them, but if the patient has asked for them not to be told what can you do?"
>
> (SRN)

> "I was having a drink the other night and one of the patient's husbands was leaning on the bar telling the barmaid how little information he had been given about his wife, and he was obviously upset about this. I knew why this had happened of course but I couldn't say anything."
>
> (SRN)

It was not possible, because of the very nature of the concept, to discuss 'confidentiality' with any of the relatives of the patients on any of the wards. The concept was, however, discussed at length with a number of nurses who worked on the gynaecological ward because of its apparent sub-cultural significance. From these discussions a number of further points arose.

a) The patient's reluctance to allow the nurse to discuss their condition with the relative was almost always related to pregnancy.

> "Obviously some of them are not going to tell anyone what they are coming in for. They can be in and out and back to work within three days so no-one has to be any the wiser."
>
> (SRN re. induced abortion)

b) Some difficulty could arise because of the problem of identifying relatives who contacted the ward by phone.

> "This morning a man on the phone said he was the patient's husband and wanted to know if she had had a miscarriage, but she's had at least two men visit her since she's been in here so I wouldn't say."
>
> (SRN)

c) Withholding the required information would occasionally precipitate an aggressive response from the relative.

> "He became very abusive when I wouldn't tell him, so I had to insist that we never gave any relative any information about patients, which isn't strictly true, in order to calm him down."
>
> (SRN)

A further aspect of confidentiality may affect two alternative members of the triad in that a situation may arise in which the nurse and relative both have information which they have some reason or other to withhold from the patient. No examples of such a situation were observed but this situation has been described by Glaser and Strauss (1965), Cartwright et. al. (1973) and McIntosh (1978), in relation to the dying patient.

It has been pointed out that all professionals hold information on trust, some of which is clearly confidential (Brearley, 1978), but it would appear that in some instances nurses tend to be particularly cautious concerning information which could be shared with the relative.

This caution can be legitimated in terms of 'professional judgement', for 'professional judgement' is supported by the Royal College of Nursing who have produced guidelines to assist the nurse in this matter. These guidelines are very specific concerning the nurses' role vis-a-vis the relatives:

> "The relatives may request access to confidential information, but the nurse must decide primarily what is in the best interest of her patient/client. If she is asked for information which she regards as confidential she should use her professional judgement and in general, if in doubt, she should not pass on information ...
>
> However, she must also be sensitive to the needs of the patient's relatives and on rare occasions the needs of the relatives may supercede those of the patient - e.g. in the case of the death or sudden collapse of the patient."
>
> (1978 p. 3)

'Professional judgement' may therefore be seen to exercise a constraint on information sharing between nurses and relatives.

The Doctrine of Reserve

During the 19th Century the members of the Oxford Movement produced a number of 'Tracts for the Times' under the editorship of John Newman. Two of these tracts, written by Isaac Williamson, outlined the "doctrine of reserve in communicating religious knowledge". This was a doctrine which the members of the Oxford Movement believed to have originated in the practice of the primitive church in which the teaching and communication of the church was accommodated to the moral and intellectual state of those to whom it was communicating. This doctrine implies a judgement by the 'communicators' concerning the suitability of the recipients to receive such information. While all relatives were not judged by all nurses according to their moral or intellectual suitability, it would appear from the interview data that sometimes a judgement is made by a small number of nurses, the communicators, concerning the suitability of relatives to receive certain information which they were seeking:

> "It depends on the relatives and their reaction what I tell them. Mostly when people ask you tell them as much as possible, but sometimes it is not in their interests. For example, if the relatives are really anxious you can increase

> their anxiety for no good reason. You need to judge this as a nurse, sometimes you have to assess the relatives in a very short time."
>
> (SRN)

> "You have to sum up the relatives before you can tell them anything."
>
> (SEN)

> "They aren't always able to cope with the news. I'm selective who to tell and when I tell it."
>
> (SRN)

It would appear, therefore, that the criteria by which relatives were judged by some nurses as suitable to receive the information which they were seeking was based on an assessment of (a) whether the relative could take it, and (b) the anxiety level of the relative, not on whether he had the 'right' to know.

Although it has been indicated that most nurses believed that withholding information was justified in some instances, a few nurses took the opposite view.

> "If it was our relative we would want the sort of care which involves explanation and comforting. They need to be kept fully in the picture."
>
> (SRN)

Some of the nurses had changed their attitudes because of previous experience:

> "I used to think that you should be a bit reserved in giving information, but then an aunt of mine died in hospital, and we had not been told to expect it, although we later found that the nurses and doctors had been expecting this for some days. This has made all the family very mistrustful of hospitals. Having seen that happen I now believe that you shouldn't withhold anything."
>
> (3rd year student)

It was, however, not possible within this study to discover whether the nurses who made similar statements to those quoted above, were in

fact always able to reveal all the information for which they were asked.

One other point should be made concerning the notion of 'candour' or truth raised by Goffman. Brauer (1965) has indicated that the notion of 'truth' with regard to illness is problematic.

> "This takes us to the controversial question: 'should the patient and family be told the truth?' We tend to think of truth as something circumscribed, immutably bound, mathematically accurate - an absolute as precise as a digit. Thus, 10 is obviously not 9 or 11, or even 9 and 9/10, but exactly and only 10 in any country, in any culture. But we are talking about disease which is as inconsistent as the weather and with people whose concepts of 'disease', 'prognosis', 'pain', 'disability' and 'metastasis' are as individually and personally defined as 'God', 'devil', 'good', 'bad', 'work', 'leisure'. Doctor Bernard Meyer of Mount Sinai Hospital in New York, suggested that when the question 'should the patient be told the truth?' is raised, we ask 'Pray, which patient, and what truth?'"
>
> (p. 173)

By raising this point Brauer has drawn attention to 'medical uncertainty' (discussed by Scheff, 1963, Davis, 1965, and others) which to some extent constrains all information exchanges between health professionals and clients.

However, there may be more to the notion of withholding information than the justifications[1] described above, justifications which it has been pointed out by Schrock (1980) rest largely on "paternalistic assumptions of professional superiority" (p. 147). For, as Simmel (1950) has indicated "In every society the right to question must be allowed to be limited by the right to secrecy." (p. 329) It has been suggested (Coser 1962) that occupations and professions are the ground in which the intersection of these two rights can be seen operating. She has also indicated that the determination of who can hide what from whom

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1. i.e. the justifications of therapeutic necessity, confidentiality and the doctrine of reserve.

may be as essential to the workings of a social system as the determination of who has power over whom. In addition, as Hughes (1958) has indicated "all occupations - most of all those considered professions ... include as part of their very being a licence to deviate in some measure from common modes of behaviour" (p. 79).

The notion of withholding information, therefore, needs to be considered as an integral part of the professional client encounter. In this way it is possible that the professional maintains some control of the encounter and also maintains professional mystique.

> "If doctors explained everything to every patient it would soon become apparent how often doctors simply do not know; thus withholding information has the double advantage of keeping the patient pliable through the anxiety of uncertainty, and keeping the myth of medical omniscience intact through never revealing ignorance."
>
> (Bennett, 1976 p. 141-142)

We have considered in some detail the most common form of nurse-relative interchange, that of the 'relative gathering information encounter'. A number of problems have been identified indicating that nurses and relatives have different perceptual frameworks concerning the matter of communication of information. It has been pointed out that both groups adopt different behaviour strategies in order either to obtain or to withhold information and that these strategies relate to the 'knowledge' and 'ability' of each group.

The problem of communication in the hospital setting is not a new one (indicated in Chapter 2) and, as Deliege (1974) has indicated, occurs partly because people have different styles of reasoning, different ways of talking and different abilities to understand. In addition people are neither rational or objective and this individual susceptibility can lead to a distortion of meaning. We shall refer to these notions in later chapters.

We should now turn our attention to another form of nurse-relative encounter in which the nurse takes the role of initiator. In such encounters the nurse takes on the roles of 'announcer' and 'forewarner'.

CHAPTER 8

"SEEING" THE PATIENTS' RELATIVES: THE NURSE AS AN 'ANNOUNCER' AND 'FOREWARNER'

Introduction

It has been shown in the previous chapter that in most information exchange encounters the relative takes the initiative as a 'gatherer of information'. There are, however, situations in which the nurse seeks out the relative in order to give unsolicited information. A jargon term commonly adopted by nurses to describe this task was that of "seeing the relatives". "Seeing the relatives" takes two different forms, that of 'announcer' and that of 'forewarner'. The conditions which lead to "seeing the relatives" and the encounters themselves are discussed in this chapter.

The 'announceable event'

There are a number of events which can occur during the course of a patient's stay in hospital which are of such status that it is considered mandatory that their occurrence be reported to the family whether or not an enquiry is made about them. These events have been described by Sudnow (1967) as 'Announceable Events' because of the announcement-like structure of the interaction, which is usually initiated by the use of a phrase such as "I have something to tell you." (p. 117)

Policy statements concerning such events, not only identify the event itself but also indicate the 'announcer' of such an event to the relatives, and any post-announcement activity which should be undertaken:

> "Where possible the relatives must be informed of an accident or incident concerning the patient by a doctor. If a doctor is not available to see the relatives the task should be

undertaken by a Nursing Officer or by a Ward Sister following consultation with a Nursing Officer.

The interview must be noted in the Kardex and the relatives given the option of seeing a doctor."

Three announceable events were identified from the policy data relating to the wards observed:

1. the death of a patient
2. a "sudden turn for the worse"
3. an accident or incident in which the patient had been involved.

The policy statements also indicated that the 'announcer' of all these events could be, if the doctor was unavailable, the nurse.

A small number of such announcements made by nurses were observed.

Announcements concerning the death of a patient will be considered in Chapter 12, so we shall begin by considering the role of the nurse as an announcer following a "sudden turn for the worse", setting this announcement in the context of nursing practice.

A sudden turn for the worse

Preparation for the possibility of 'a sudden turn for the worse' event begins when the patient is admitted to the ward. At that time certain details are collected by the nurse, from the patient, or his relatives, which would be necessary if such an event occurred and the relative needed to be contacted by the hospital. The details required include:

1. the name of the person to be contacted in case of any emergency,
2. the relationship of that person to the patient,

3. the telephone number(s) through which the relative can be contacted,
4. whether or not the relative to be contacted lives alone,
5. whether the relative wishes to be contacted immediately should such an event occur during the night.

Not all the relatives have a telephone number and in this situation a neighbour may be asked if they are willing to allow their telephone number to be given to the hospital so that it may be used in this way if necessary. The information collected in this way will of course not be needed in most instances as only a very small proportion of patients admitted will experience a sudden deterioration in condition, but, the availability of such information allows for any announcement concerning a sudden turn for the worse to be made with the minimum of delay.

Relatives and nurses appear to have mutual expectations concerning this form of announceable event, for most relatives mentioned expecting to be informed as soon as possible if this situation occurs.

The announcement followed an easily identified pattern. Firstly, the relative was identified as being the right person to receive the announcement. Secondly, an "I have something to tell you" type of phrase was used, followed by the specific piece of information. As Sudnow has pointed out the "obligation directly to report such matters, once face-to-face contact is initiated, is at least partially due to the fact that the announcement is considered to be of some import and that the recipient is taken to be highly keyed-up to hearing some news." It would be inappropriate for other forms of interaction to intervene between the initial announcement phrase and the announcement itself, although after such an announcement had been made it was observed that qualificatory remarks could be added either to reduce the apparent seriousness of the event or to offer some hope or comfort. The relative's response to the

announcement, in all the encounters which were observed, was to accept the information without comment and without asking questions. If there were any questions these came later after a short period of time during which the relative attempted to adjust to and redefine the new situation.

Much of the initial interaction concerning announceable events relating to 'the sudden turn for the worse' took place on the telephone. Where this was considered appropriate the relative was then invited to the hospital to visit the patient. In some instances the substance of the initial announcement was observed to be repeated to a number of relatives, although the pattern differed from the initial announcement in that the opening interchange which prepared the relative for the announcement was omitted. Otherwise the information was given in much the same way.

The points discussed so far can be identified in the following interchange, which took place between an SRN and the son of a patient who had unexpectedly collapsed. The information previously collected and recorded on the Kardex indicated that although the patient's wife was not on the phone the son could be contacted at work:

"Is that Mr. Black?" (identify the relative)

"This is Sister B speaking. I'm afraid that your father has had a bit of a set-back," (preparing the relative for the announcement) "we think that he has had a slight stroke and that it might be best if you could let your mother know this." (the actual announcement).

"Yes, if she would like to come in I'll have a word with her then."

"Yes, any time."

(Because this exchange took place on the telephone, only the Sister's comments were recorded.)

After a short while the mother and daughter came to the ward and approached the nursing officer. Although the nursing officer had just come from the patient's bedside, she did not perceive herself to be the appropriate announcer at that time, so she referred the two relatives to the ward sister, that is, 'the announcing authority'. The ward sister then repeated and added to the information which she had given the son:

> "As you know he had a slight stroke this morning which has left him with some left-sided weakness. His speech is also a little muddled but he seems to have made a good recovery and is certainly better than when we phoned you. Of course, we can't say that it won't happen again, but as I said, he's a little better." (Qualifying remarks)

The relatives then went to see the patient but decided to go back home after a few minutes. About half-an-hour later another son arrived (not the one who had received the first telephone call):

> "What happened to Mr. Black this morning then?"
>
> "Are you a relative?" (After confirmation) "He had some sort of blackout this morning and it seems that it was a stroke, and as I said to your mother, there's no guarantee that it won't happen again." (No preparation for the announcement given)
>
> "So that's what happened."
>
> "Yes, as I say, he's made a good recovery, but it was a small stroke."

The policy concerning the recording of an announceable event relating to a 'sudden turn for the worse' states that, "if relatives have been advised of a deterioration in the patient's condition (it should be recorded) who advised them and what they were told". The record concerning the above interaction states that "Wife informed of

patient's condition, has visited". The few relatives interviewed about announceable events concerning a sudden turn for the worse, although they were upset by the 'bad news' reported that the encounter itself had been well managed. The only problem identified concerned the choice of announcer; this is discussed later in the chapter.

Sudnow found that although there were mutually held expectations concerning announceable events, there was also a rule of entitlement specifying those to whom an announcement is due and those to whom it is not. He found that this did not only rely on the actual relationship of the relative to the patient, but on other factors relating to the announcer's perception of the person entitled to receive an announcement. The number of announceable events observed here was small, and it is not possible from the small amount of data to either support or refute this view.

We should now consider the announcements and conditions relating to accidents or incidents in which the patient has been involved.

An accident or incident in which the patient has been involved

(The terms 'accident' or 'incident' are administrative terms which refer to a form which has to be completed in the event of certain unforeseen happenings in the patient's career. The completed forms are inserted into the patient's notes and can therefore be used as evidence in case of litigation.)

If any occurrence, which can be defined as an accident, takes place in the ward, then that patient needs to be examined by the doctor. An examination is needed in case of any injury caused by the fall. No actual 'incidents' were observed, and only one accident, in which a patient fell while attempting to transfer from chair to bed, took

place during the course of the observation. There were other accidents during the period in which the observation took place, and some data was collected concerning the way these were announced. But it was not possible to discover whether each event which took place was in fact announced, as the designated announcer for this event was the doctor, and doctor-relative interaction was not monitored.

There was no urgency concerning the initial contact as in the majority of cases the patient's condition was unaltered by the accident, and it appears that it is only if the accident precipitates a 'sudden turn for the worse' that the relative would be contacted immediately.

The announcement concerning an accident was likely to provoke a different response from the relative to an announcement concerning a sudden turn for the worse. Two forms of response were observed. In the first instance the patient had fallen while walking to the toilet. The son was informed as he passed the nurses' station on his way to visit the patient:

"Oh Mr. Gray, can you just spare a minute?"

"Yes, sure."

"Your mother had a little fall this morning, but she's O.K. The doctor saw her and he couldn't find any damage."

"Oh yes, well she does that at home sometimes, as long as she didn't hurt herself."

"No, no. She'll tell you all about it I expect."

The event in this instance was no real surprise to the relative as such an event concerning his mother was part of his previous experience concerning his mother, and there was also no apparent injury.

In the second instance, although no serious injury had been sustained by the patient, there was extensive bruising evident. The announcement was again made as the relative entered the ward. The patient's wife was asked to come into the office and asked to sit down (non-verbal "I have something to tell you" behaviour). The patient's wife was a 'carer' in that she had already nursed the patient at home for some time before his admission.

"Now Mrs. Brown, just before you go and see Mr. Brown I thought I'd better tell you that he had a little fall just after supper last night, and he's got a few bruises on his legs."

"How did he fall?"

"He slipped as nurse was putting him back to bed."

"Well that's funny, he's never fallen with me. He'd be better off home if that's what's going to happen here."

"Now it's all right Mrs. Brown, it was nobody's fault and he's not hurt. The doctor has seen him, and it hasn't affected your husband at all."

"Well I'm not very happy about it." (walks away)

After visiting her husband the relative returned to the nurse in charge and once again stated that he would be better off at home. The nurse allowed her to talk but made little verbal response. The relative then returned to her husband and started to discuss the matter with a student nurse in the ward. At this stage her husband intervened and insisted that no-one was to blame. By the end of the visiting period the wife appeared to have accepted that no-one was to blame but was obviously still unhappy that it had happened.

Although no other relatives were seen to respond in this way, this form of response was perceived by nurses to be fairly common:

"You know before you tell them that some of them are going to make a fuss." (SRN)

"Most of them are O.K. about it but some try and make you think that you are personally responsible ... but they calm down after a while."
(SRN)

In such instances the nurse may need to 'cool the mark out'. 'Cooling the mark out' has been described by Goffman (1952) and applied to the nursing situation by Colledge (1973) who noted that "at ward level the nurse also has to 'cool out' the patient's relatives" (p. 1157). 'Cooling the mark out' is used in those social situations where people may need to be consoled following failure of some description. The relative, on hearing that the patient has had a 'sudden turn for the worse', will have to adjust his previous expectations concerning the patient's illness, and it has also been shown that the relative of a patient involved in an incident or accident may also have to reach a new definition of the situation. By both allowing suspicion that all is not well, and then allowing the relative to express feelings of anger, the nurse allows him to save face and self-respect and therefore it can be said that he is allowed to 'cool out'.

After the announcement is made concerning either a sudden turn for the worse, or regarding an accident or incident, the interaction can be terminated in a way that leaves the nurse 'available' for further interaction.

"Look, you can come and see us or ring us at any time." (SEN)

"If anything seems strange or comes to mind come and talk to us about it, we'll be able to help." (SRN)

The interaction may also end with the nurse 'reassuring'[1] the relative:

"These set-backs do sometimes happen. It will take a little longer, but she will get over it." (SRN)

The termination of the 'announcement' concerning the above events may be followed by other forms of nurse-relative encounter, most

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1. The problems associated with this term are discussed in Chapter 9.

commonly by a relative gathering information encounter, or by a nurse as counsellor encounter. In the latter form of encounter (which will be fully discussed in Chapter 9) the nurse will either reassure or give advice to the relative in order to assist his own needs which result from this changed situation.

One further 'announceable event' was identified by Sudnow (1967) from his observations in American hospitals. This was the 'findings of laboratory investigations of expected import'. Unlike the two events already described, this occurrence was not defined as an announceable event by policy data. However, some observations were made concerning laboratory findings which were given this status by staff.

Laboratory investigations of 'expected import'

All the observed 'announceable events' concerning the results of laboratory investigations took place in the medical ward, but it is possible that, given the conditions outlined below, such announcements could be made in any of the wards observed.

All investigations ordered by the medical staff are of 'expected import' to the staff who will base further treatment on these findings, but in some instances these findings are also of 'expected import' to the patient and to the relative.

There are a number of patients in whom the course of the illness can only be monitored by the continued interpretation of sequential investigations. In such instances the patient may well realise the significance of laboratory findings, for example the diabetic patient may well be familiar with the changes which can occur in his blood sugar, and also the importance of such changes when he is in a period of instability as far as the disease process is concerned. When such announcements were

observed to be made the nurse making the announcement appeared to believe that the findings would have some meaning for the relative. The father of a patient who had leukaemia and had been admitted for further blood transfusions was called by the sister as he walked past the nurses' station. "Oh Mr. Green, the results of his blood tests are back". After the relative had been given the information concerning these results, the course of the patient's immediate treatment which would be related to these findings was discussed with him/her. The qualifying remarks in such announcements related directly to the significance of the laboratory findings.

The preconditions which appear to be related to this event are that the results should be perceived by the announcer to have some meaning for the relative, and that the results were of 'some import' to the relative and patient as well as to the staff because of their effect on future treatment. There were also other events which related to the patient's illness that were not identified by Sudnow, nor formalised by policy statements, but which were given the status of 'announceable events' at ward level, in that nurses (and doctors) sought out the relative to give them certain information whether or not this was requested.

This situation could arise because of the 'unpredictability' of some forms of illness, and in such instances the nurse took on the role of 'forewarner'.

Unpredictability leading to forewarning

While nothing in medical practice is certain, there are periods during a patient's illness when the outcome is less predictable than at other times. When this unpredictability could lead to a sudden or rapid deterioration in the patient's condition, it was usually considered necessary to forewarn the relative of this possibility. Most of the

nurses questioned believed that this was a necessary part of medical and nursing practice, although the majority believed that it should be done by the doctor. The use of a 'forewarning' tactic alerts the relative to the possibility of a change in the patient's condition which could have serious consequences.

> "At times you must paint a blacker picture, in case anything happens."
>
> (SRN)

Because of the unpredictability of the outcome if the nurse is the 'announcer', it may be necessary for her to check with the doctor the precise nature of the 'forewarning' which should be given.

SRN to doctor: "What exactly should I tell Mr. White's relatives?" (The patient had been provisionally diagnosed as having suffered a pulmonary embolism)[1] The doctor advised the nurse to tell them that he had had some severe chest pain "then at least they'll have been warned if anything serious develops". When the relatives arrived in the ward they were given information concerning the chest pain. They then asked i s was anything to worry about. The nurse replied:

> "'ell I wouldn't like to say what might happen, but I ould ask the doctor to see you about it."

instance the nurse believed that she had fulfilled her role by the relatives, but felt that she needed to use the 'role switching tactic' so that the relatives' more specific questions could be answered.

The relative who is given a forewarning may find it difficult to relate the information given to his perception of the patient's condition which is based on his previous knowledge, and also to his present visual perception.

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1. A clot of blood which travels through the body and lodges in the lungs.

SEN to relative (son of patient admitted with cardiac failure):

"I think that I'd better tell you that she's really not too well at the moment."

"Oh, I thought that she was looking very much better."

"No. She's not out of the woods yet."

"I didn't realise that she was that bad."

"Well, it's difficult to say what will happen."

Forewarning can be seen as an attempt to 'soften the blow' should anything unforeseen occur. The use of this tactic also provides the staff with a defence against future criticism by the relative which could occur if they were not warned of the possibility of further deterioration in the patient's condition. In this way it is also a form of 'cooling the mark' (as described earlier in this chapter).

The use of a forewarning tactic was observed on all the wards, but it was of special significance in the coronary care unit, where it was seen by the nurses to be part of their role in relation to the nearest relatives of the patients admitted after suffering from a coronary thrombosis. There is a high risk of further complications occurring during the first few hours following the initial attack: "the subsequent clinical course of patients with acute myocardial infarction (coronary thrombosis) is by no means predictable. Many patients who appear perfectly stable on admission may suddenly die." (Webb, 1980, p. 74). The following table indicates the incidence of complications in 57 'good risk' patients admitted to hospital.

Congestive cardiac failure		7%
Major arrhythmias		55%
Ventricular fibrillation/asystole		5.5%
Ruptured Ventricle	0	0%
Deaths	6	8.8%

(Webb p. 74)

The patient admitted to the coronary care unit, therefore, remains for the first few hours in a period of the illness which is so unpredictable that all the relatives must be warned of this unpredictability:

> "This (coronary thrombosis) is an unpredictable illness so we warn the relatives that the first forty-eight hours is a critical period and that there are possible complications which can arise ... Some relatives ask outright 'Will he be all right?', but they don't always realise so after telling them I try to put out feelers to see if they've fully understood ... This is something that is done here and I think you would find it done in all CCUs ... I think it's really done to cover ourselves if anything does happen, nobody can say that they were not warned."
>
> (SRN)

The relative was 'forewarned' during the interaction which took place during the admission of the patient to the coronary care unit. In most instances the relative was seen by both the doctor and the nurse at this time. While the details required in case a 'sudden turn for the worse' occurred were being collected, the importance of maintaining contact with the unit was stressed. This helped to reinforce the forewarning:

> "I tell them that if things happen, they happen quickly, and so we need to know where the relatives are."
>
> (SRN)

The situation is sustained by the use of frequent interactional tactics by the nurse relating to the possibility of complications:

> "You must see the relatives frequently in the first few days and stress the severeness of the condition; as soon as the patient starts to look better, they think he will be all right, but they need to realise that he is still critical."
>
> (SRN)

Nurse to patient's wife "As you know we must keep a careful eye on the situation for several days."

"He's looking better today."

"Yes, but he's still not out of danger."

Some of the interaction relating to forewarning was also carried out on the telephone, and the opportunity was taken to reinforce the original forewarning if this was considered necessary:

> SRN to SRN at report "His wife rang up and I had to go over all that I told her this morning, she hadn't grasped the situation at all."

Other telephone conversations observed included tactics which helped to sustain the relatives' definition of the situation:

> "As you know, he is still a very poorly man. If everything is straightforward he won't need to stay in this unit, but at the moment we need to keep a careful eye on the situation."
>
> (SRN to wife of patient)

The particular problem affecting the relative at this time has been identified by Obier and Haywood (1972) who noted that although the patient is alert and communicative, the family is faced with the reality of the patient's death and its meaning for them. They have indicated that the relative may need help from a social worker to cope with this difficult situation.

Forewarning to some extent helps to define the situation for the relative. But in order for this definition to be maintained, other interaction tactics are necessary until the patient's condition no longer warrants keeping the relative alert to the possible consequences of the diagnosis or treatment. This may be done by the use of phrases such as 'much the same' in answer to any further enquiry regarding the patient's condition, or the relative may need to have the forewarning repeated "it doesn't change the situation at all, we still can't say it won't happen again, it doesn't really make any difference."

One other way in which the relatives' definition of the situation was maintained was by the use of the word 'stable', particularly in the coronary care unit:

> "His condition at the moment is 'stable', he's had a fairly good day and we are quite pleased with him at the moment."
>
> (part of telephone conversation between an SRN and patient's wife)

> "Well, he's stable, he hasn't really changed for two days, that's all I can say really."
>
> (SRN to son and daughter-in-law of patient)

As the word appeared to have a particular meaning for the nurses using it in this unit they were all asked what they themselves understood by this word and asked to state when they would use it.

> "'Stable' refers to stable rhythm and observations as well as the patient's overall physical condition stabilising. The word doesn't give false hope to the relative because it indicates that a certain stage has been reached and maintained, but it shows that the patient can go up or down, and even at that stage you must keep the relative aware of a potential collapse."
>
> (SRN)

> "It means 'no change for the better or worse', the patient can be extremely ill but stable. I only apply it to ill patients not well ones."
>
> (SRN)

Nurses perceived some difficulty with forewarning and maintaining the relatives' definition of the situation as aspects of nursing practice. These aspects of nursing practice were seen to be difficult for at least two reasons:

1. the difficulty surrounding the actual explanation,
2. the stress which the patient's admission had engendered made it difficult for the relative to fully understand the implications

of what they were being told:

> "This can add to the stress because explaining it simply, is difficult."

> "Obviously if they are distressed they don't take in what you say."

Although only five relatives were questioned concerning this aspect of nursing practice, they all appeared to have understood that the time during which the patient was receiving care in the unit was a potentially dangerous one.

There appears to be little reference to 'forewarning' as an aspect of the nursing practice of the coronary care nurse, or to the effectiveness of this form of communication, although it appears to be an element of the subculture of the Coronary Care Unit.

This aspect was to some extent followed up by letters sent to nine other coronary care units in England asking for information from which it was thought that it might be possible to identify the shared norms and language of coronary care nurses using these interactional tactics.

Six units replied describing the practice in that particular unit. All of the units included a forewarning in the first encounter with the relatives, relating this to the unpredictability of the illness, and also, in one instance, to one other aspect of nursing care, that of 'trust' in the relationship between relatives and staff:

> "This reminder does relate mostly to the unpredictability of the illness, but also the relatives are then prepared for the worst and improvement is a bonus. Also it is better to tell the relatives the truth rather than say for example 'your husband will be fine', and then for some serious complication to develop. In this event mistrust develops between relatives and staff."
>
> (CCU reply No. 5)

Four of the six units also reminded the relatives during the

intervening period that the situation remained critical but two stated that this was not found to be necessary:

> "We do not find it necessary to keep reminding the patient or relative about the critical nature of their illness, and our observations show that reinforcement is not needed, but continual support is required."
>
> (CCU reply No. 6)

One further point should be made about 'forewarning' in the coronary care unit. Dyche (1979) reported that many of the wives in her study, which described the effects of a coronary thrombosis on the spouse, would have liked more information with regard to the early symptoms. Given the findings of Ley and Spelman (1967 p. 76) that patients (and in this case relatives) remember best the statements they consider most important, it is possible that the 'forewarning' statement with its implications of the possibility of death could obscure the receptivity of the relative to any other information given. The result of this could be that the relative would perceive that such information had not been given.

It would therefore seem that the possible significance of this form of interaction could be profitably examined in the future.

The 'choice' of 'announcer' or 'forewarner'

In some instances the 'announcer' was specified by the policy document. In others some negotiation concerning this role took place among the 'potential' announcers. This was observed to take place between both nurses and doctors, and also nurses and other nurses of equal status. There appeared to be no formal arrangements concerning who should call the relative to the hospital, but in practice it was almost always the nurse who carried out this task. However, when the relative arrived at the hospital he could be seen by either the doctor or by the nurse in

charge of the ward. This arrangement was not necessarily related to the patient's diagnosis or condition, but appeared to be related to the availability of the announcer at the time of the relative's expected appearance in the ward.

Some nurses stated that they believed that it was better for the relative if the doctor was called to see the relative:

> "I'll ring them up (the relatives) and ask them to come in, but I think they should then be able to see the doctor. After all, these things are a bit of a shock." (SRN)

Other nurses appeared to believe that this was an important part of the nurse's role:

> "If it was our relatives we would want the sort of care which involves explanation and comforting, and we have more time to do that than the doctor." (SRN)

It appears, from the observational data, that both nurses and doctors take on the role of 'forewarner' and that this is also a 'negotiable role' between doctor and nurse.

However, as previously indicated, it was found that some relatives were not happy with the 'choice' of announcer or 'forewarner', particularly if the announcement was made by a nurse. It would seem that in some instances it is believed that the status of the event was such that it merited the attention of the doctor:

> "I think we should have seen the doctor, when they knew that there was no chance, but we only saw the nurse."
> (relative after a 'sudden turn for the worse' announcement)

Because this form of interaction, that is, nurse initiated interaction, occurs much less frequently than relative initiated interaction, it was thought that there might be other situations which could occur, but

which were not observed, that would also lead to this form of interaction. All the nurses interviewed were therefore asked if there were any circumstances relating to the patient's illness which would cause them to seek out the relative and give them any sort of information whether or not this had been asked for. In addition to the conditions already described, some nurses identified two other events in the patient's illness career which could cause them to "see" the relatives by seeking them out as they visited, or by contacting them in some other way. The two other illness events suggested were:

1. the sudden mental confusion of a patient
2. the onset of an unexpected period of depression

It is, however, likely that the initiating of interaction with relatives concerning such events in the patient's illness is idiosyncratic, for two relatives (of different patients) reported their own feeling of distress on finding the patient 'confused' without being given such information.

It has been shown that 'announceable events', which are events of such status that it is considered mandatory that their occurrence is reported to the relative, leads to interaction between the nurse and the relative that has a clearly perceived structure. It is 'nurse initiated' and contains either verbal or non-verbal "I have something to tell you" cues. In almost every instance the announcement is followed by qualificatory remarks which can offer hope or comfort. Such remarks could also be an attempt to reduce the apparent seriousness of the situation. It was shown that relatives and nurses had similar expectations concerning the 'events' which would result in this form of interaction. It was also indicated that while most relatives were upset at the 'bad news' they perceived that the encounter itself was well

managed, although there was some disquiet identified with regard to the announcer.

Unlike the 'relative gathering information' encounter described in the last chapter, the 'nurse as an announcer or forewarner encounter' was not perceived by nurses as an interruption of the routines, for after an announceable event had occurred "seeing the relatives" as an activity was built into the routine for that day.

The role of the nurse as an announcer, particularly concerning the 'sudden turn for the worse' was part of the traditional role of the nurse and appears to be less problematic for him/her than the 'relative gathering information encounter'. It is a role for which the nurse can be 'prepared' as he/she has to take the initiative, and the 'structure' of the announcement is possibly more easily acquired by the nurse in training.

We should now turn our attention to encounters in which the nurse attempts to meet the relatives' needs, other than the need for information.

CHAPTER 9

MEETING THE RELATIVES 'NEEDS'

Introduction

A number of studies, discussed in Chapter 2, drew attention to the psycho-social needs of the relatives which could arise as a result of the patient's illness. The nurse's role vis-a-vis the relative with such 'needs' has been identified by Nurse (1975):

> "Relatives need a great deal of help and understanding at this time, for they also are anxious, perhaps feeling guilty or resentful, and the necessity of visiting and making alterations to the routine of their lives can be traumatic for them too."
>
> (p. 19)

The behaviour patterns adopted by the nurses in an attempt to 'help' and 'understand' the relatives' needs can be described as 'counselling' and will be discussed in this chapter as such, although the inadequacy of this label will also be considered. As well as looking at the encounters in which nurses adopted 'counselling behaviour' in response to the needs of the relative, some attention will also be paid to situations in which the relative perceives such needs but these remain unrecognised by the nurse. We shall begin by considering this aspect.

The relatives' perception of their own 'needs'

Most of the relatives interviewed stated that at some stage of their relative career they had perceived a need for some form of intervention or care from the nurse relating to their own problem, the majority (25 out of 36) indicating that such needs were not met by the nurse. It should be noted that such needs were not generally articulated in specific terms, but were implicit in the interview data collected from

the relatives concerning all aspects of 'being' a relative. From these interviews it would appear that the main need identified by the relatives themselves centres around the notion of 'having someone to talk to':

> "The nurse said 'Dad is too ill to speak. You realise how ill he is don't you?' and then she walked away and left me; I wasn't allowed to see him. I needed to talk to someone but there was nobody there - I was feeling pretty frightened by it all at this stage. I then found someone and asked for a cup of coffee; after some deliberation they gave me this."
>
> (Daughter of patient)

> "When they told us she would have to have an amputation, we were that shocked we couldn't say anything. The nurse said the doctor would see us in the morning and then left us. That's my only complaint really. We went home without talking to someone about it. I think somebody should have let us talk about it."
>
> (Daughter-in-law of patient)

> "When it first happened (the patient's illness) they called us from his work. He was in the ward by the time we got there (the hospital) and they asked us to wait for a minute. Then sister came and saw us, she was nice, but as soon as she had told us the trouble she went off. We looked at each other and started listing all the things we wanted to discuss but hadn't had time ... little things really like what we should do."
>
> (Mother and daughter)

> "I wanted somebody just to sit down with me and let me talk. We run a club at home and our working day starts at 6.30 p.m. and it's well into the early hours before we clear up. I used to leave him at 8.00 and spend hours on my own just longing for someone to talk to. They're always so busy, they answer your questions and that's it - off you go."
>
> (Wife of patient taken ill while travelling through the area)

The examples quoted so far both identify a need and report a lack of nursing intervention with regard to that need.

One group of 'relatives' who were also critical of the lack of nursing intervention concerning the needs of the relative were the nurses interviewed who had themselves also been relatives. All the nurses who

were interviewed were invited to discuss any 'relative experiences' which had affected them personally. Some of the nurses interviewed praised the care which they personally had received but others (six out of the eight who discussed the matter of 'being a relative') were unhappy at the way their needs had remained unrecognised.

> "When my mother was admitted with a severe asthmatic attack they told me to wait in a small room, while she was treated. Nobody came near me for nearly an hour. Nobody brought me a cup of tea or anything, yet they must have known I was worried."
>
> (SRN)

> "It was awful. I think that they thought because I was a nurse I would know what was going on, and could look after myself."
>
> (3rd Year Nurse)

> "I saw the sister come away from his cubicle and I knew by her face something was wrong. She sent a nurse to tell me to wait outside. You can imagine how I felt, but all they wanted to do was to get me out of the way."
>
> (3rd Year Nurse)

The relatives who were not nurses, although they were critical because nursing care directed towards the reduction of their anxiety or other needs was not given, tended to try and offer excuses for the nurses. As in the case of relatives who had failed to obtain information many relatives appeared ready to forgive such shortcomings, because of the nurses' 'busyness':

> "I know that it's difficult for them to see to us - they're so busy with the patients. Of course they must come first."

We have so far considered the relatives' own perception of a need for some sort of nursing intervention. One further point can be made which would tend to reinforce the notion that such a 'need' exists. It had been feared by the researcher that many relatives would be reluctant

to discuss the emotional feelings associated with the relative career. However, it was found that in fact most relatives welcomed the opportunity at interview not only to answer the questions posed, but also to "talk through" the experience. It was not possible within the confines of this study to evaluate the therapeutic value of this form of 'relative talk', but it is an aspect which appears to merit some further study.

Although we have so far focussed on the negative side of nursing practice, some examples of positive intervention by the nurse were observed and reported by the relatives. Such occasions were highly valued by relatives:

> "We reached the hospital after midnight, I'd followed the ambulance in the car. I was shaking like a leaf, but she (the nurse) brought me a cup of tea and just sat there and listened while I chattered away. I also cried a bit but she just let me do this. She was really very good."
>
> (Wife of patient)

> "She (the ward sister) was fantastic. I can't speak too highly of her. Not only did she do all she could for dad, but she's tried to do all she could for us. Not everybody's like her. When my mother died in (another hospital) they couldn't have cared less about us."
>
> (Although the father of the relative quoted here also died, the relative sent a letter of appreciation to the ward and enclosed a substantial donation for the hospital 'comforts fund'.)

We should now turn our attention to the role of the nurse as an 'expert' in the encounters in which relatives' needs are identified, and the efforts made to meet them.

The role of the nurse

The nursing literature specifies the task of the nurse in relation to the needs of the relative. Nurse (1975) suggests that the nurse can perform:

> "a very important and therapeutic function by making time to listen, by helping to clarify the thoughts and feelings of both the patient and his visitors, helping them to come to terms with the situation, and when necessary by giving clear information and guidance."
>
> (p. 19)

This function of the nurse is usually described as 'counselling' although as Nurse (1980) has also pointed out "little clarification is given as to what this particular function entails". (p. 737)

Before discussing the notion of 'counselling' with the nurses interviewed, some attempt was made by the researcher to discover their understanding of this term.

The nurses interviewed were therefore asked what they primarily understood by this term in relation to the patients' relatives. Of the 49 nurses questioned, 3 stated that they did not have any understanding of this term. 46 replied in positive terms as follows:

to give guidance or advice/tell the relative what to do	18
to help with their problems	10
to listen to their problems	10
to explain the patient's condition	6
to talk to the relatives	2

Although it can be seen that there is no consensus with regard to one meaning for this term, it is a term which has some meaning for most nurses, although it would appear that the emphasis is placed on the nurse as "teller" indicating an active role, rather than nurse as "listener" thereby allowing the relative to work through his problem himself. Yet all of the ways identified are recognised as legitimate 'expert' roles, for Hambling (1975) has indicated that there are three ways by which a client with needs can be helped:

1) by the directive method in which the 'professional' gives her considered advice

2) by the non-directive method in which, by reflective discussion, it is hoped the client will confront the problem himself

3) by the middle stream approach, in which the counsellor listens without interruption.

Before considering these three ways by which nurses attempt to meet the relatives' needs, we should briefly consider the way in which such encounters are initiated.

In the first instance it was observed that all of the difficulties encountered by relatives attempting to initiate interaction for the purpose of gathering information were also encountered by relatives wishing to initiate this form of encounter, with one exception. The relative who was obviously distressed could be self-identifying and cause the nurse to initiate interaction. An example from the field notes illustrates this form of entry behaviour:

Nurse passes by distressed relative sitting in the corridor, then turns back to look at her:

"Are you all right?"

Relative lifts her head, is obviously crying.

"No you're not are you. Come in here a minute (indicates office) now just wait there and I'll be back in just a moment."

Goes and fetches a cup of tea and then returns to the relative and asks her:

"What's the trouble then?"

However, not all needs were self-identified in this way and the

difficulties with initiating encounters already described in Chapter 6 mean that some relatives with perceived needs for other than information never successfully initiate an encounter in which such needs could be identified by the nurse.

Secondly, many of the encounters in which the relatives' needs were identified were initially initiated as 'relative gathering information encounters'. After giving information the nurse was then observed to allow the relative to express any other needs:

> "You look very tired - before you go back to him (the patient) would you like a cup of tea?"
>
> "Oh yes I would. I can't sleep very well at the moment - it's all this worry."

The nurse continued the interaction by looking at the relative in an encouraging way indicating (non-verbally) her receptiveness, and the relative responded by discussing her feelings. In a later conversation with the relative concerning this 'intervention' she stated:

> "they (the nurses) are wonderful, they really are."

On another occasion in another ward after a short piece of interaction concerning the patient's condition the nurse said:

> "And what about you? How are you feeling?"

The relative responded by "talking through" her reaction to the situation in which she found herself, eventually stating her fears about coping with the patient when it was time for him to come home. The nurse responded:

> "Why didn't you come and tell us about this before? We're here to help you know, you don't have to worry like that, we'll see what we can do."
>
> "I didn't like to bother anybody with it."

"I'll see the doctor and then I'll see you again tomorrow and we'll see what we can sort out."

Having considered the way in which such encounters are initiated we shall now consider specific aspects of the expert role of the nurse, vis-a-vis the relative as a giver of advice, as a listener, and as a reassurer.

The nurse as 'giver of advice'

It has already been indicated that most nurses associated meeting the relatives' needs with this form of behaviour. Giving advice concerning the patient's after-care as an aspect of nursing practice will be considered in the chapter describing the nurse 'as a teacher'. In this section we shall focus on giving advice concerning the relatives' own needs.

Advice could be given in response to a "what should I do" question, or, it could be given if the nurse perceived a need even if such advice was unsolicited by the relative. If the nurse was asked for advice, it was observed that he/she would at times legitimate his/her response in terms of the patient's, as well as the relative's needs:

1) "Do you think my sister should come and stay with me tonight?"

"Yes that might be a good idea. It might be best if you had some company, and then he (the patient) wouldn't worry about you."

2) "Should I go and see a doctor about these bad nights?"

"Yes I should. He'll give you something to help you sleep. You'll feel better for it and I'm sure she (the patient) doesn't like to see you looking so tired."

In those instances in which the nurses perceived a specific need specific advice was given:

"You're looking done in Mrs. Red. Why don't you go home, have a hot bath and an early night. It'll do you good."

(SRN)

In those instances in which advice was asked for by the relative, and in which the nurse believed that this was not part of her task, it was observed that efforts were made to direct the relative to a more appropriate source of 'advice':

"Do you think I should give up my job? He's going to need help when he comes home isn't he?"

"Yes he'll need help, but before you take that sort of step I think you should talk about it with the social worker, she could advise you better than I could."

This form of 'role-switching' is of some significance for it was found that while nurses accepted that relatives, as well as patients, had needs, not all nurses agreed that the nurse was the best person to attempt to meet those needs. Other 'counsellors' or 'givers of advice' were suggested - medical staff, the medical social worker, the chaplain and the deaconess. In those instances in which nurses perceived the nurse as the 'right person' to do this, it was seen as an aspect of the role of the senior nurse, and almost all of the untrained nurses questioned stated that they would refer a relative seeking help for their own needs to a senior nurse, or to one of the named counsellors listed above.

It was found that in most of the encounters observed in which the relative identified needs, and the nurse adopted a role-switching tactic, that the nurse also offered to make the appropriate arrangements for the relative to meet the named person to whom the relative was 'switched'. In this way, nurse behaviour in such encounters was different from nurse behaviour in the 'relative gathering information' encounter in which,

although role-switching was a strategy commonly used, only rarely were arrangements made by the nurse for the relative to meet a more appropriate 'giver of information'.

We should now turn our attention to the role of the nurse as a 'listener'.

The nurse as 'listener'

Listening as an art is well-described in the prescriptive literature for nurses (O'Brien 1974), Parsons and Stanford 1976). It is also recognised by nurses as an important aspect of nursing practice with regard to the needs of the relative:

"I try to listen and help in that way." (SEN)

"I do this mainly by listening. There is often nothing else you can do, and I'm sure it helps." (SRN)

The encounters in which the nurse 'listened' were longer than most other nurse-relative encounters. Other nurse-relative encounters were observed to be of very short duration, but one 'listening' encounter which took place between a nurse and an elderly relative was observed to last for twenty minutes. This was the longest nurse-relative encounter observed during the observation period. In this encounter the nurse nodded, agreed and used non-committal phrases such as "umm" to allow the relative to continue to talk about her feelings. The encounter terminated abruptly however when the nurse was called to the telephone.

The abrupt termination of 'listening' encounters was frequently observed - the nurse having to attend to other intrusive matters. This may be of some significance if the role of the nurse is to be extended in this aspect of nursing practice, for the work setting in which such

encounters take place is one which is very public and subject to interruption. In this way it may be difficult to allow either relatives or patients the time needed for this form of 'care'.

In a very small number of encounters the relative was encouraged to reach his own solution to the problem. In this way the 'listening' resembled the Rogerian method of 'counselling'[1]. An example of such an occasion concerned the wife of a patient admitted to the ward 'seriously ill'. Prior to the patient's illness his wife had been travelling to her father's home, 200 miles away, three times a week, to help her mother for the father was also ill. After the patient's admission the wife received a message from her mother that her father was now dying. She asked the nurse what she should do, should she stay with her husband, or go to her father:

> "I can't tell you what you should do, but let's just think about it for a moment. We've told you that at the moment your husband is still critically ill but we hope he'll pull through. On the other hand, we don't know about your father, or how long the doctor thinks it will be."
>
> "I'd like to be with them both, I don't want to leave my husband, but I'd like to see my father."

She then went on to consider ways in which she could visit her father without leaving the hospital for too long. The nurse just listened at that point. Eventually the relative decided to contact her home again before making any decision. This encounter was later discussed with the nurse.

> "I couldn't tell her what to do, she's got to live with her decision, not me. I just hope it turns out to be right for her."

Having considered the role of the nurse as a 'giver of advice' and as a 'listener' we should now turn our attention to the role of the nurse as a 'reassurer'.

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1. See Rogers, C.R. "Client Centred Therapy", 1965.

The nurse as a 'reassurer'

The phrase "reassure the patient" is a familiar one in nursing terminology, although as French (1979) has pointed out, this phrase has remained a cliche, among many other hackneyed phrases which "engender the well meaning of the user ... but rarely convey what the nurse is required to do in any particular situation" (p. 627). After considering a number of definitions of the verb 'to reassure' in relation to patient care, French suggested that the definition 'to restore confidence in himself and in his treatment situation'[1] most closely describes the task of the 'nurse as a reassurer' in the nurse-patient relationship. This definition has been adapted for the present study by substituting the word 'relative' for 'patient', for as Marshall (1975) has indicated, relatives, as well as patients, have a need for reassurance.

Nurses frequently tried to reassure the relative by the use of phrases such as "don't worry", "it will be all right", but such opinion statements are not generally thought to be reassuring. Burton (1958) for example, has indicated that statements such as these may make the speaker feel better but are less useful to the patient or relative. Such statements may also appear to dismiss the problem:

> "Of course they said we didn't have to worry, but you can't help it can you? I think it was worse because we both knew the possible consequences, and all the 'don't worries' in the world couldn't stop us from worrying."
>
> (Daughter)

At other times the phrase "don't worry" was accompanied by a fragment of information designed to alleviate that particular worry:

> "Don't worry, we won't separate you for very long."

---

1. Roberts (1971) suggested the first part of this definition, the phrase "and in his treatment situation" was added by Longhorn (1977).

"If you're at all worried, ring the bell."

"Oh don't worry about that, nurse will give her (the patient) an injection to stop the vomiting."

Adding any information, however fragmentary, appeared to be more helpful for the relative than a simple "don't worry".

Relatives were given 'reassurance' concerning a number of different aspects of patient care. In the first instance relatives were given reassurance concerning the patient's treatment:

"As you know there is nothing more we can do for him, but we will do our best to make sure that he is not in any pain." (SRN)

"All patients look like that after a big operation, it's the effect of the anaesthetic, she'll look better when she's had a chance to sleep it off." (SRN)

"No the bleeding won't delay her recovery, it's very common and nothing to worry about." (SRN)

Secondly, relatives were 'reassured' that they were making the 'right' decision:

1) "We've decided not to stay any longer, he's a bit tired." (Patient's two sisters)

"That's very sensible of you. But don't worry about it. It's just to be expected during the first two days." (SEN)

2) "Yes he will be better there (long-term care). You couldn't manage him at home like he is now. You've done your best for him and have nothing to feel ashamed of." (SRN)

Thirdly, relatives were 'reassured' that they would be able to cope with the patient after he/she was discharged from the hospital.

"Don't worry about it. The district nurse will come every morning and she'll help you. You'll wonder after 2-3 days why-ever you were worried."

Finally relatives were also given reassurance concerning their own 'problems' especially their feelings of 'guilt':

> "Now look, it's not your fault. It would have happened anyway, whether you had been there or not, and there was nothing that you could have done to stop it." (SRN)

Most nurses stated that 'reassurance' was an important aspect of nursing practice:

> "Relatives are not used to seeing the patient looking like that (post-operatively). They need reassuring that everything is normal." (SEN)

> "Relatives sometimes worry that you are not doing all you can for the patient - they need reassuring that you are." (Second year nurse)

> "The patient is your first concern but the relatives are often just as shocked and whoever deals with them must have some understanding of their needs." (SRN)

Some of the nurses stated that simple explanations were necessary if the relative was to feel confident in the hospital situation.

> "When the patient comes in it is as much an emergency to the relatives as it is to the patient. They need to be kept in the picture otherwise they feel left out and can get the wrong impression of hospital. This (Accident and Emergency) is the first door they come through and we are the first nurses they see - all their other judgements are based on us." (SRN)

We have focussed in some detail on the behaviour of the nurse as 'giver of information', a 'listener' and a 'reassurer'. However, in spite of the examples observed, we need to remember that most of the relatives interviewed indicated that this was a largely unmet need. We should therefore further consider the views of the nurse concerning these tasks, and also try and reach some understanding of the 'knowledge' which the nurse as an 'expert' has of the psycho-social needs of the relative. Each nurse during the interview was asked to give an opinion

concerning the effects of hospitalisation on the relative. The results are given in Table Five, most nurses suggesting more than one effect.

TABLE FIVE

THE EFFECTS OF HOSPITALISATION SUGGESTED BY NURSES

'Social' Effects	Number of Nurses Suggesting this	*
a) family difficulties associated with finance leading to a lower standard of living	42	
b) difficulties for the relatives who wished to visit the patient 1) because they need to rely on others to 'baby-sit'	26	
2) because there are geographical difficulties related to transport	16	
3) because it disrupts the daily routine	15	
4) because the relative may have to take time off work	4	
	103	56
'Emotional' Effects		
a) relatives 'worry'	18	
b) relatives may feel left out	4	
c) work suffers	4	
d) the relatives feel guilty	3	
e) relatives have difficulty in coming to terms with being apart from the patient	3	
	32	56

* Number of Nurses Questioned.

Although these figures are only a very crude indication of the nurses' understanding of the effects of hospitalisation on the relatives, they are interesting in that the social effects were more readily identified than the emotional effects, yet the social effects rarely became a problem for the nurse.

During the interviews concerning this matter a number of nurses indicated that they had little understanding of the effects of the patients' hospitalisation on the relatives. This is discussed more fully in Chapter 13.

Two further points should be made concerning the data collected in this way.

Firstly, certain categories of relatives were identified as more likely to present with problems than others. This identification related to the patient's illness rather than to any identified personality characteristics of the relative:

> "... especially the relatives of stroke patients. Some of them (the patients) remain on a plateau for so long that you need to counsel them to help them through that period when nothing seems to be happening." (SRN)

> "They (the relatives of patients in coronary care) need to be supported through the critical period and often just need to talk about this. We must let them do this." (SRN)

Many nurses also referred to the particular problems experienced by the relatives of dying patients. These are discussed elsewhere.

Secondly, some nurses pointed out how the relatives' expectations of the nurse could be unrealistic:

> "They think that if they tell you, you can solve the problem. Some of them think that nurses are superhuman." (SRN)

"They expect us to have all the answers to their problems. It's just not like that."
(SEN)

Although these observations are far from conclusive it would appear that many nurses do not have a full understanding of the needs of the relative during the patient's hospitalisation. It is not surprising, therefore, that although some effort is made by some nurses to help the relatives with such problems, many relatives reported unmet needs.

This is obviously an area in which the relatives' expectations and nurse-behaviour are not commensurate. The nurse cast into an expert role by the relative is not always able to fulfil this role. It has been suggested that this may be because the nurse does not have the knowledge of the relatives' needs which arise as a result of the patients' hospitalisation which would enable him/her to fulfil the role of expert, for it is possible that the expansion of knowledge concerning the needs of the relatives discussed in Chapter 2 has not yet been fully absorbed into the curriculum for student and post-registration training for nurses.

One other interesting point has emerged from an examination of this aspect of the nurse-relative relationship, that of the expectations of nurses who themselves become relatives. They are the relatives who are most critical concerning the lack of nursing intervention with regard to their own needs as relatives (although it should be stated that their behaviour vis-a-vis relatives was not observed to be any different from that of other nurses).

The picture of the nurse and relative in the different forms of encounter described in this chapter is by no means complete, and it would appear that further questions need to be raised in this area before a full understanding of this aspect of the role relationship can be fully understood.

CHAPTER 10

THE NURSE AS TEACHER

Introduction

Teaching the patient certain aspects of his/her treatment is an accepted part of nursing practice. In some of the encounters observed the nurse also adopted the role of teacher vis-a-vis the relatives. Although the number of such encounters observed was small several difficulties were identified in this form of the nurse-relative relationship.

The definition of teaching/learning

Most educationalists appear to agree that there is some difficulty with the definition of the word 'teaching', and that learning is much more easily defined. One definition of learning has been suggested by Curzon (1976):

> "the apparent modification of a person's behaviour through his experiences, so that his knowledge, skills and attitudes towards his environment are changed more or less permanently."
>
> (p. 34)

It is widely accepted that teaching is secondary to learning; "teaching serves learning; it has no other purpose" (Ruddock 1972); and it is the function of the teacher to (a) provide the 'experience' which will lead to a change in behaviour and (b) to evaluate that such a change has taken place. It was possible during the observation period to define some of the encounters taking place between nurses and relatives as 'teaching the relatives', in that the nurse made some attempt to provide 'experiences' through which learning could take place.

This account will focus primarily on those 'experiences', by describing the situations in which they occurred and the methods used. Although it was not usually possible in this study to evaluate the effectiveness of the 'experience' in modifying the relative's behaviour, some reference will be made to those instances in which it was obvious that learning had or had not taken place. It is also evident that there is a need for further research into this aspect of nursing practice, for the nurses' perception of the need for teaching relatives and the relatives' own need for this form of interaction were not always congruent. Reference will, therefore, also be made to the difference in perceived needs, in those instances in which this was identified.

In this chapter we shall consider four different aspects of the role of the nurse as teacher:

1) the nurse as a teacher of manual skills,
2) the nurse as a teacher of observational skills,
3) the nurse as a 'giver of explanations',
4) the nurse as a health educator.

1) The nurse as teacher of manual skills

Most of the 'teaching' observed consisted of the nurse teaching the relative the manual skills required for the continuing care of the patient following discharge from hospital, particularly in those instances in which rehabilitative measures were required following the patient's illness. Such teaching was usually necessary if the patient had had a cerebro-vascular-accident, and a small number of 'teaching' encounters relating to the rehabilitation of 'stroke' patients were observed.

The family's need to be taught the care of a patient after a cerebral catastrophe is well documented:

> "A stroke is actually a family illness ... We as professionals are obligated to provide careful family instructions to assist in lessening the fears that may exist in the minds of those within the household."
>
> (Buck in Overs & Belknap, 1967, p. 46)

> "An important task of the rehabilitation team is the encouragement and education of the relatives."
>
> (Langridge, 1974, p. 65)

The nurse as a teacher of the relatives of the patient who has suffered a 'stroke' is only one member of the team involved in the teaching of these relatives. In the hospital in which the research took place some of this team teaching took place at meetings convened for the relatives of stroke patients. Relatives were informed of such meetings by a notice on the ward door:

Stroke Relatives Meeting

Relatives of patients who have had strokes are requested to attend the stroke relatives meeting, which is held at 3.30 p.m. in the physiotherapy department on the last Wednesday in each month.

Over a cup of tea there will be an opportunity for you to discuss and enquire about various problems both you and your family are facing.

The meeting lasts an hour and is attended by members of the rehabilitation team including the doctor.

It is hoped that you will continue to attend these meetings when your patient first returns home in order that his or her recovery may be as successful as possible.

One such meeting was attended during the course of the fieldwork. The meeting was attended by 14 female and 2 male relatives, the physiotherapist, the occupational therapist, a staff nurse, a medical social worker and a speech therapist. The relatives were first given a demonstration by the physiotherapist of the correct way to help a hemiplegic patient in and out of bed and how to transfer from bed to chair and back again. This demonstration was followed by a discussion and a repeat of some parts of the demonstration. The speech therapist then discussed the different ways in which relatives could help the patient with speech difficulties. This was followed by a more generalised discussion. The nurse played no active role in this particular meeting, although her role varied according to the problems covered at each meeting.

Meetings for the relatives of stroke patients have been established in a number of hospitals in the country. The obvious need for this form of instruction has been shown by Manuel (1979):

> "After the first meeting ... it was immediately apparent that the relatives had little, if any, idea about the cause of a stroke and what to expect or how to deal with the situation. While it was already appreciated that relatives were ill-informed and frightened, the extent of their lack of knowledge and the degree of their fears and distress so dismayed the staff that immediate action was taken."

She concluded by stating:

> "There is much room for further study in finding better ways of helping the relatives." (p. 28-29)

Relatives meetings, which are held monthly, can be helpful to the relatives of stroke patients at any stage of the rehabilitation process, but most of the relatives of 'stroke' patients also needed some individual teaching concerning the daily activities with which the

patient would require some assistance.

It was observed that most of the teaching of rehabilitative skills by nurses took place on an 'ad hoc' basis in that at some stage it was indicated that a need for teaching the relative a specific skill existed. This could be during the 'report' or it could be indicated in an informal exchange:

Nurse to other nurses at report:

"If Mr. Yellow comes in someone will need to show him how to feed her. He wants to know how to do it, and I think it would be helpful if he could do this (tube feed a patient)."

Nurse to colleague (of equal status):

"I suppose somebody should see him about the catheter. She'll be ready to go home soon."

The relative was then contacted during the next visit and the teaching encounter arranged, in some instances immediately, and in others, a time was arranged for this encounter which was mutually convenient.

In those teaching encounters which were observed it would appear that many nurses confused 'showing' with 'teaching', and that the 'demonstration', that is 'showing' was not followed by any evaluation of its effectiveness.

This failure to evaluate can be seen in the situation described below.

One of the stroke patients had a colostomy which he had managed unaided for a number of years. He was still able to manage most of the bag-change, but required assistance with one aspect of this process. It was therefore arranged for a nurse to show his wife exactly what she

needed to do. It was decided by the nurse that only one demonstration would be necessary as (a) the wife was familiar with the appearance of the colostomy and the appliance, and (b) the husband would be able to advise the wife what should be done even if he couldn't do this himself. The demonstration took place as planned, although the relative was given no opportunity to practice. Later that day when the nurses were given 'report' it was said that the relative was "now able to help him change the bag". However, on the following day, the daughter of the relative who had been shown the procedure, asked the nurse in charge if it would be possible for "mum to see it again. She's worried that she won't do it right for him". Another demonstration was arranged following which the relative was satisfied that she would be able to manage, although once again she was only 'shown'.

Nurses were also observed to ignore cues which indicated the relatives' other learning needs. This is well illustrated in the following encounter, which is set in context.

During the time when the nurses coming on duty for the afternoon were given a report of each patient's condition it was stated that 'somebody' would have to show Mrs. Green, the wife of one of the patients, how to empty Mr. Green's catheter bag before his discharge, due to take place on the following day.

Later that afternoon a trained nurse enters the ward and sees, and greets, Mrs. Green:

Nurse: "Has anybody shown you how to empty this bag yet?"

Mrs. G: "No."

Nurse: "All right then I'll do it."

Nurse leaves the ward, re-enters carrying small jug. She pulls the

curtains around Mr. and Mrs. Green and herself. She speaks first to Mr. Green:

Nurse: "Now you'll be able to show your wife if anything goes wrong won't you?"

Mr. G: "Yes I think so."

Nurse now turns her attention to Mrs. Green who is standing next to her. The nurse is crouched down at the level of the catheter bag.

Nurse: "You take off the clip and tip it up like this."

Nurse takes off the clip and directs the end of the bag into the jug as she says this.

Mrs. G: "Don't you need two so that you can wash it out?"

Nurse: "No, you only wash around the tube."

Mrs. G: "Don't you have to wash it out most days?"

Nurse: "No. Now you close this tube then clip it back again."

Mrs. G: "How far down does the clip go?"

Nurse: "To there (shows her). There that's all there is to it."

Mrs. G: "And you don't have to wash the bag?"

Nurse: "No."

Mrs. G: "That's strange."

Nurse: "Will you be able to manage that all right?"

Mrs. G: "Oh yes."

Nurse removes screens from around the patient and leaves the ward.

Mrs. G to Mr. G: "Isn't it funny that they don't wash the bag?"

A number of points arise out of this encounter:

a) The nurse was apparently unable to interpret the cues offered by the relative as an indication of the relative's need to make sense of the demonstration by relating the skill she was being shown to her lay expectation that receptacles which have contained urine are washed after use.

b) As in the first example described above, it was assumed that once the relative had been 'shown' she would feel competent. No apparent evaluation of the teaching took place.

c) Finally, this is a good example of the way in which the bridge between 'lay knowledge' and 'expert knowledge' needs to be breached before effective teaching can take place.

In some wards or units within the hospital, for example, the Renal Unit, the relative may have to acquire 'expert skills' in the patient's treatment of renal dialysis before the treatment is able to continue at home. Within the wards observed, however, teaching the relatives new skills related more to the continuing rehabilitation and nursing care of the patient rather than to his treatment. This is not to say that such teaching never takes place within these wards. It was obvious that, for example, some relatives of an elderly patient suffering from mild diabetes had been taught to test the patient's urine, in order to monitor the effect of diet and drugs, prior to the observation on that ward, but no teaching of this sort was observed during the fieldwork.

Some relatives also needed to be taught specific manual skills before they were allowed to visit the patient. One of the patients in one of the wards in which the observation took place was placed in 'protective isolation'. 'Protective isolation' is the attempt to

prevent the patient from being infected by other people's organisms as distinct from 'isolation' where other people need to be protected from the patient's organisms. The relatives visiting this patient needed to be taught preventive measures so that the patient could come to no harm as a result of their visit. These measures included putting on a gown and a mask before entering the ward in which the patient was located.

Most relatives in the first instance needed to be 'shown how' to put on the gown and mask as the array of tapes can be bewildering. It was observed that each time the relatives visited they were always asked if they knew how to do this and if necessary were then given a demonstration. Unlike the 'demonstrations' already described, this form of demonstration, of necessity, had to be followed by practice.

2) The nurse as 'teacher' of observational skills

As well as teaching the relative skills which were predominantly manual skills, in some instances the relatives were instructed how to play a positive role in the early detection of complications including observational skills. This form of teaching frequently took place in the Accident and Emergency department.

If a patient was to be discharged home following the application of a plaster of Paris splint to a limb, he, or in a number of instances the relative, was given certain verbal and written instructions relating (a) to possible complications, (b) to the care of the plaster.

The patient or his relative were instructed to Report AT ONCE:

1. If it (the plaster) cracks, becomes loose or otherwise uncomfortable.
2. If there is any discharge.
3. If there is any pain.

4. If the fingers or toes become numb or difficult to move.

5. If the fingers or toes become swollen or blue.

The patient is also instructed not to "wet, cut, heat or otherwise interfere with this plaster".

The nurse instructing the patient or relative would first of all read the instructions. Then she would ask the relative/patient if they understood these instructions. Finally the relative/patient would be asked to sign a form stating that such instruction had been given. The nurse usually finished off with a reassuring phrase:

> "Don't forget. If any of that happens come back and I'll see to it." (SEN)

The other occasion on which clear verbal and written instructions were inevitably given was before a patient with an apparently minor head injury was discharged. All patients losing consciousness as a result of a head injury are admitted for observation as head injury complications are not always apparent immediately following the injury. If there is no loss of consciousness and no apparent complications, the patient may be discharged after being advised to seek medical advice immediately if any of the following symptoms develop: vomiting, double vision, severe headache, drowsiness or loss of consciousness. These instructions were given verbally and the patient was then given a head injury sheet of written instructions and the relative was reassured that 'immediately' meant just that:

> "We're always here, day or night, so don't forget to let us know <u>at once</u> if anything like this happens." (SRN)

The giving of instructions with regard to the role of the relative as a detector of possible complications concerning either plaster of

Paris applications, or minor head injuries, is an important function of the nurse with regard to patient care. Because of the importance of these matters, and in order to minimise the possibility of the instructions not being understood the verbal instructions are also accompanied by written instructions.

This aspect of nursing practice is an interesting one in relation to the present study for, as with the case of announceable events, the need for instruction is stipulated by hospital policy and as such is incorporated into the structure of the department. Instructing the relative concerning these matters very quickly becomes routinised, and subsequently the 'routine' is easily 'learnt' by other nurses who also need to carry out this task. It would therefore appear to be less problematic than some other aspects of the teaching role of the nurse.

3) The nurse as a giver of information

It was shown in Chapter 7 in which 'relative gathering information encounters' were described, that some relatives asked for further explanation of the patient's illness or the terms used by the nurse to describe this. Such information was, however, usually only given in response to pertinent questions posed by the relatives. This is illustrated in the following encounters:

(1) During a conversation relating to the patient's discharge the SRN told the patient's two sisters that a brain scan had been arranged for the week following his discharge. The conversation continued around the subject of the discharge and apparently ended. The relatives were walking down the corridor when one of them turned back and asked:

"By the way what is this scan?"

"Oh it's a sort of X-ray, it shows up the brain, not just the bones."

"How do they do it?"

"They'll give him an injection then they take these pictures when he's lying down quietly."

"Is it painful?"

"Oh no, you don't feel anything at all, only the injection."

(2) If a patient needed nursing care while the relative was visiting, the visitor was usually asked to wait outside, thus removing the necessity for a 'pertinent explanation' concerning the procedure. However, in those instances where the relative asked questions, answers were readily given:

"Can I see Mrs. Orange?"

"You're her daughter aren't you?"

"Yes."

"Yes, she'll be along in a moment but nurse is just giving her an enema."

"Problems?"

"Yes, she's had some trouble ever since she's been in, she says she's O.K. at home, but a change of diet can play havoc with the bowels."

"I've never heard her complain of trouble."

"Well we've tried everything, gave her tablets and suppositories, but no use, so we've got to try this. I expect this will do it."

(3) One of the procedures frequently carried out in Accident and Emergency by the nurse for the patient is an Electrocardiogram (E.C.G.). In most instances the relatives stayed with the patient while this procedure took place. The apparent complexity of the procedure usually elicited questions from the relative:

"What are you going to do now?"

"I'm just going to do an E.C.G."

"What's that?"

"That's a reading of his heart."

"With all those things?"

"Yes, I'll put these things on different parts of his body and then we get a reading on this machine."

"Can I stay with him?"

"Yes, certainly."

Although 'explanations' usually only occurred following relatives' questions, occasionally nurses were observed to offer an explanation, without being asked a specific question.

An example of this was in the Accident and Emergency department; when the X-rays were returned from the X-ray department with the patient it was observed that if the relative/patient indicated any interest in the X-ray a simple explanation of the findings was sometimes offered by the nurse:

"It looks like there's a small crack. Do you see?"
(SEN to patient's father)

"Oh, I wouldn't have noticed that."

One other specific form of 'explanation' was frequently offered without waiting for the relatives to ask questions. This form of explanation related to the monitoring equipment which is used to detect the possible onset of complications following a coronary thrombosis. Nursing text-books instruct the nurse to undertake this form of teaching:

"The nurse must explain to the visitor about the form of apparatus which the patient has attached to him ... and whenever possible give assurance that it is not painful and is helping the patient."

(Bickerton, Sampson and Boylan, 1978 p. 16)

The nurses working in this unit also readily identified the need for the nurse to 'explain' the purpose of this equipment:

"We try and explain the monitoring equipment and answer questions about that." (SRN)

"The relatives are encouraged to ask for an explanation - they need to be informed about the chest leads." (SRN)

There is no doubt that the equipment can be alarming to some relatives. Dyche (1978) found that some of the wives she questioned had mentioned that the technical equipment of the ward was alarming, but the few relatives with whom this was discussed had received an explanation which they had found reassuring.

4) The nurse as a Health Educator

It has already been pointed out that most of the teaching observed related to the patient's illness rather than to the relatives' health state, but some examples of the nurse counselling the relative concerning health threats were observed. An example of this concerned an elderly relative (aged 85) who was visiting her brother. She had asked to see the nurse in charge about his impending discharge and was invited to talk to the nurse in sister's office. The relative needed assistance with walking. The nurse assisting her noticed that she was wearing loose-fitting slippers:

"Do you find it easier walking in slippers?"

"Yes, I haven't been able to get my shoes on for sometime, they hurt my poor feet."

"You can get some nice soft shoes at Marks and Spencers and they would give you more support. They're not very expensive, Mrs. Fawn has got some, I'll ask her if I can show them to you. I'm sure they would help your walking."

"Yes dear."

"Not only that, but you would be less likely to slip with a more closely fitting shoe."

In other instances observed the relative was advised to encourage the patient to regain or maintain a better health state:

"They took a long time to do the operation because of her weight. You must try and encourage her to loose some of it - it won't help her to recover properly unless she loses a couple of stone."

(SRN to husband of post-operative patient)

"If you can encourage him to cut down (smoking) it will help his chest."

(SRN)

As well as the nurse advising the relative to encourage the patient, it was observed that the nurse was asked by the relative to counsel the patient concerning his health state:

"I'm worried about his weight."

"He should try and keep it down if possible."

"Will you talk to him about it - he won't listen to me, but when the doctor told him to stop smoking he did, so if you were to tell him to lose weight he would probably try."

"Yes, I'll have a word with him."

Before discussing the implications of the teaching encounters observed, some reference should be made to one aspect of nurse teaching which has been discussed at great length in the nursing press during the last two to three years and which is relevant to the present discussion, although no examples of this form of teaching were observed.

During the last few years a number of studies have shown that the patient can benefit in a positive way from pre-operative teaching in that it reduces post-operative anxiety. Dziurbejko and Larkin (1978) designed an experiment to:

> "both replicate the findings that pre-operative teaching of adult surgical patients would reduce anxiety, promote more positive attitudes and hasten recovery, and to extend previous research by testing the hypothesis that pre-operative teaching that included the patient's family would produce even greater beneficial effects than the pre-operative instruction given to the patient alone."
>
> (p. 1892)

Their study was carried out in a gynaecological ward and although the resulting differences between the two instructed groups, 'patient-family' and 'patient-alone', were not statistically significant, they claimed that "the direction of the means points to more co-operativeness, less patient and family anxiety, fewer questions and less post-operativeness demandingness" (p. 1894). Silva (1976) found that the spouses of patients who were given pre-operative teaching showed a significantly more positive attitude towards the patient's hospitalisation than those who did not receive this information. These spouses also experienced significantly less anxiety. A recent letter in the Nursing press in this country has described the way in which an American hospital has appointed a Nursing Officer for the sole purpose of preparing the patient and his family for surgery by teaching:

> "The major benefit of this was that the patient knew what was going on and what to expect ... Likewise his family were prepared and could give tremendous support to the patient ... (in this country) nursing staff seem reluctant to discuss in detail with the patient or his family the cause and after-effects of surgery."
>
> (McGeorge 1980, p. 1526)

The methods of teaching used in the above research and practice included video tapes followed by discussions, and may be some

indication of the way in which teaching relatives may develop in this country.

From the interview data it would appear that many nurses find the role of teacher a difficult one, although only one nurse expressed disinterest in this aspect of nursing practice, and it would appear that even the one who expressed this attitude appeared at times to carry out this task:

> "It usually depends on the sort of mood I'm in whether I do this. Sometimes I can't be bothered." (SRN)

Although all except one of the nurses accepted that 'teaching' was an integral part of the nurses' role, this was an aspect of nursing which was associated with 'seniority' and all the 'junior' nurses questioned (1st and 2nd years) stated that they never did this, either with patients or with relatives.

Those nurses who perceived that they did teach relatives mostly identified the form of their teaching as the teaching of new skills, 'urine testing', 'care of a catheter', 'care of a colostomy', 'how to lift a patient', 'how to manoeuvre a patient in and out of a car', 'the giving of insulin injections', 'care of a wound', 'managing patients ambulation following a stroke' etc. On further questioning most nurses stated that they would try and explain procedures or treatments if asked. In this way it can be said they were teaching, although this activity was perceived to be associated with problems:

> "I feel really embarrassed if a relative asks me to explain, even when I know what I'm doing." (SRN)

> "They generally accept what you tell them but it can lead to further questions that you would rather not answer." (SRN)

This evidence of role conflict may occur because 'the nurse as a teacher' is a comparatively new aspect of nursing practice. In her study of the changing role of the general nurse during the twentieth century Pearman (1971) found that teaching patients/relatives was not considered any part of nursing practice until the 1930's and 1940's, and not developed in any way until the 1950's. By the early 1960's, however, teaching was being discussed in the literature as an accepted part of the nurse's role, for example, Ray (1962) argued that the contemporary nurse needed ability in planning nursing care, making objective observations, providing psychological support and in teaching the patient and his family. More recently Tramposh (1979) has specified an educational programme for the relatives suggesting that verbal teaching should be supplemented:

> "Reinforce your teaching by writing down important information ... Also ask family members to demonstrate special skills you've taught them ... Be sure they know why they should do things in a certain way."
> (p. 11)

Although the role of the nurse as teacher may be changing, it was observed that teaching the relatives, except in the very specific situations described in the Accident and Emergency department, is a relatively unstructured aspect of nursing care, which is planned, and 'evaluated' informally; (the evaluation in this instance not relating to the effectiveness of the teaching but instead referring to the completion of the task).

It was indicated earlier in the chapter that 'planning' tended to be carried out verbally during 'report' or other discussions. It was also during this time that relatives' 'misunderstandings' were also discussed, and the previous 'teaching' evaluated:

> "He really had no idea what I was talking about. He asked if he would need to get a spare one from the appliance shop,

(everybody laughs) I think I need to go over it with him again."
(SRN)

The way in which nurse teaching is 'planned' would appear to be an area which could be usefully examined for this appears to have some influence on the relatively informal encounters which comprise nurse-relative teaching.

Related to the 'planning' of teaching encounters is the nurse's ability to adopt a variety of teaching methods in order to meet the relatives' needs. No such ability was observed, although some nurses appeared to appreciate that relatives might have different learning needs and also different ways of showing this need:

"Some do - they like to know exactly what is going to happen so we usually attempt to tell them. Others are just happy to let you get on with the job."
(SEN)

"I think sometimes they would like to ask but don't." (SEN)

"I find most people don't ask a lot, in spite of TV they don't really understand."
(3rd year nurse)

"Quite a few of the relatives ask about the E.C.G. and other things. I try and explain as simply as possible, but some ask more questions especially the more agitated and nervous."
(SEN)

"I usually try and make it as simple as possible, then I ask if they have understood. Some people ask more. I don't want to bring class into it, but the more educated the relative the more he wants to know."
(SRN)

It would appear from the interview data that nurses are given little instruction concerning effective teaching,[1] although the G.N.C. syllabus

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1. The instruction given to nurses about meeting relatives' needs is discussed in Chapter 13.

lays down that nurses in training should be taught the elementary skills of teaching, and that they should have an understanding of the principles of health education. However, from the discussions which took place with nurses, it appeared that very few felt competent to carry out this aspect of their role:

> "I wish we were shown how to do it. It's something we're going to need more and more in the future." (SEN)

This does not appear to be a local problem for as Miller (1978) has pointed out, teaching patients as an aspect of nursing practice is still not routinely carried out. "Every nurse must become a good teacher, working in partnership with colleagues, patients and relatives in this vital and sometimes neglected aspect of nursing care" (p. 1930). Miller goes on to suggest that three points relating to the patient's educational needs, what he needs to learn, how the nurse can help this process, and how it can be evaluated, should be written into every stage of the Nursing Process (see Chapter 11).

It has also been suggested that many relatives are 'ready' for such a development in nursing. "The family of the acutely ill patient will probably be highly motivated towards learning once the life threatening stage of the illness is safely passed." (Pohl 1978, p. 36).

Although little is known concerning the teaching role of the nurse, it was possible to draw a few tentative conclusions from the small number of nurse-as-teacher encounters observed.

1. Most of the nurse-initiated teaching observed consisted of the nurse teaching the relative the skills required for the continuing care of the patient following discharge from the hospital.

2. In certain wards and units specific non-skill teaching was incorporated into the patient/relative care-plan. An example of this was in the Accident and Emergency department where instructions were given to the patient or his relative concerning the care of a plaster of Paris splint and the early detection of complications.

3. The teaching which was not specific to the care-plan or related to skills was mainly relative-initiated and relied on the relative asking pertinent questions. Other cues indicating the relative's 'learning need' were often ignored.

4. A number of nurses found teaching relatives difficult and embarrassing.

5. Few nurses evaluate the effectiveness of their teaching.

6. Nurses ask relatives, and relatives ask nurses, to assist each other with the health education of the patient.

7. Finally, it should be noted that the small number of 'nurse-as-teacher' encounters observed may itself be significant in that nurses do not utilise all the opportunities for teaching which present themselves.

This and all the other tentative conclusions suggested need to be confirmed or repudiated by further research into this aspect of the nurse role, not only vis-a-vis the relatives, which was the concern of the present study, but also vis-a-vis the patient.

CHAPTER 11

THE RELATIVE AS A 'SURROGATE PATIENT' AND THE RELATIVE AS A 'PATIENT'S AGENT'

Introduction

In this Chapter some attention will be paid to two other forms of encounter that take place between the nurse and the patients' relatives. The first form of encounter to be described is that in which the relative is cast into the role of 'surrogate patient' by the nurse, the second form of encounter to be described is that in which the relative adopts the role of 'patient's agent'. It is worth noting the symmetry of these relationships although the subsequent analysis does not appear to have any significant implications.

The relative as a 'surrogate patient'

During the hospitalisation of any patient there may be a period of time during which verbal communication with others may be limited or non-existent. Such a period may occur when the patient is not fully conscious, disorientated, in pain or otherwise too weak to respond verbally. When this situation arises some of the interaction which would normally take place between nurse and patient may instead take place between nurse and relative. In such encounters the relative may be perceived by the nurse and by him/herself as a 'surrogate' acting in place of the patient.

The role of the relative as a surrogate patient was found to relate to three aspects of nursing care:

(a) Obtaining the patient's history,

(b) Checking the patient's nursing care,

(c) Making discharge arrangements.

(a) Obtaining the Patient's History

Certain information relating to the patient's medical and social background must be obtained as soon as possible in order to meet the patient's immediate needs. This information, which is obtained during the period of admission, can be sub-divided into (1) administrative details; (2) medical details; (3) supplementary details to (1) and (2) around which the patient's nursing care can be planned.

(1) Administrative details

These are usually obtained first, although as will be shown, there are exceptions to this. Although the 'collector' of these details and the setting in which they are collected vary from ward to ward, hospital to hospital, the time of day and the nature of the admission, the details required are standardised throughout, and are related to the information required for the patient's medical and nursing notes which document the patient's age, sex, civil state, occupation and address. If such details cannot be obtained from the patient they need to be obtained from a relative or friend. Most of these patients were first seen in the Accident and Emergency department. In those instances where such patients were sent directly to the ward, the required information was usually available from the accompanying doctor's letter.

When a seriously injured or seriously ill patient was brought into the Accident and Emergency department he/she would be taken to the cubicles or resuscitation area, while accompanying relatives would be

directed to a clerk who would obtain the administrative details outlined above. The history of the injury, or the description of the illness, would normally be obtained by the nurse or doctor, concurrently with the administrative details, from the patient, or from the doctor's letter which was brought in by the patient. However, if the relative was the only person who could give relevant medical information, then this was obtained before the administrative details, as illustrated by the following example:

A woman assists a man, on the verge of collapse, into the Accident and Emergency department. He is immediately taken to the cubicles supported by a nurse. The SRN asks the woman:

"Can you tell me what happened?"

"I don't really know. I found him like this in the field near the farm, he doesn't remember anything but he went out early this morning to start breaking in one of the horses. She's a bit frisky and whether she's thrown or kicked him I don't know - he can't remember anything."

"Did he vomit?"

"No, he was just very cold and confused, so I gave him a cup of tea and decided to bring him in."

"How long ago did you find him?"

"About half-an-hour ago. It's taken me fifteen to twenty minutes to get here."

"Well now, you've done the right thing to bring him in. Are you a relative?"

"Yes, I'm his wife."

"Right, doctor will have a look at him and then he'll have a chat with you. Now can you go to the desk and give them a few details and then you can go and stay with him."

Gibson (1978) has drawn attention to the routinisation which can be found in such encounters in an Accident and Emergency department.

She has also pointed out that such interactions are constructed by the nursing staff, who use the information to carry out the appropriate routine. In this way the relative, by acting as an historian, helps the nurse to maintain the smooth flow of patients through the department.

(2) Medical Details

Although the medical history is officially taken by the doctor, in many instances the nurse collected 'medical' information either intentionally or otherwise which was then given to the doctor in order to aid the diagnosis or establish the treatment regime. The intentional collection of medical information is an example of the blurred line of demarcation in the division of labour between nurse and doctor similar to that found in 'relative gathering information encounters'. Such information gathering appeared to be at the instigation of the doctor who was not always available to carry out this task when the relatives were in the ward:

SRN to daughter of semi-conscious patient admitted 24 hours previously:

> "The tests have shown that he probably had an internal bleed several days ago and the weakness this caused may have triggered off his heart attack. Did he complain of anything unusual?"
>
> "Well, he did complain of a lot of pain at the beginning of the week, and he had trouble with his bowels, so we put it down to that."
>
> "Do you know if his stools were black?"
>
> "No, but one day I saw him come out of the toilet and he looked as if he was going to pass out, so I had to help him on to his bed for a rest, but we just thought it was something that would pass off in a day or two."

Some medical information was gathered unintentionally, as illustrated

in the following example:

"The doctor is with your husband now, so can you let me have a few particulars. His full name first please."
(SRN to wife of unconscious patient just admitted to Accident and Emergency)

"He's not had a day's illness since the First World War you know, and then it was only his appendix." (Wife)

"Oh that is good, I'll tell the doctor. Now could you tell me his full name?"

The relative of the patient unable to respond in the normal way was often able to give the nurse or doctor information concerning the patient's previous medication.

Information was also collected from relatives during the course of the patient's stay in hospital relating to his medical history, in those situations where he was unable to provide this himself:

"Had you noticed anything different about his behaviour during the few weeks before he was admitted?"
(SRN to sister of patient admitted for investigations who had unexpectedly become confused following admission)

"Well only that he had been much more excitable at home and couldn't sit still, but other than that nothing."

In the geriatric ward a weekly case conference was held during which actual and potential problems relating to patient care were discussed. As a result of these discussions the ward nurse could be asked to see the relatives to obtain further relevant information. In some instances the relatives were to be seen so that a realistic future could be planned for the patient, but in others the relative was perceived as a surrogate patient who might be able to provide useful personal information.

SRN to niece of confused patient (after a case conference discussion):

> "Have you any idea of what it is worrying her? We can't get through to her. She's still confused."
>
> "No I can't really help, she keeps talking about Bert, that's my husband, but he's been dead for sometime. She also seems to think that she's going to be turned out of her house, but there's no likelihood of that."
>
> "So you've no idea what the problem really is?"
>
> "No, no idea at all."

(3) Supplementary Details

During the period of observation a model of care known as "the Nursing Process" was being implemented in a number of wards within the hospital. The implementation of this model of care is relevant to the present discussion in that the process involves four stages, the first of which may involve the relative as a 'surrogate patient'. The four generally accepted stages in the nursing process are, firstly to assess the situation in order to define the nursing problems; secondly, to plan the appropriate care; thirdly, to implement the care, and finally to evaluate the care given.

The first stage of the Nursing Process has been defined by Ashworth (1980) as "the collection from any available source, particularly the patient or client, of information which is relevant to his health state and care".[1]

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1. The information required is systematically collected by the use of a questionnaire relating to the patient's life-style including his home conditions, his religious beliefs and recreational activities, as well as information concerning his mobility, his nutritional likes and dislikes, his sleeping habits and his need for artificial aids, e.g. spectacles. Most of the questionnaires which have been designed to collect this information also have a section including questions which relate to the patient's understanding of his illness and its effects.

A number of instances were observed in which the relative, as surrogate patient, was asked to supply such information on which a nursing care plan could be based.

Nurse to relative of confused elderly patient admitted earlier that day:

"Are you a relative of Mrs. S?"

"Yes, I'm her niece, she hasn't got any children, only me and my family."

"Right, well I wonder if you could tell me just one or two things about her?"

"Yes, of course."

"Do you see much of your aunt?"

"Oh yes, every day. She lives in one of our cottages on the farm."

"Well we've got the letter from her doctor and some notes so we know all about her medically, but she's not been able to help us much with what she can do for herself."

"Oh yes."

"Does she eat well?"

"Yes, we take her a cooked meal every day."

"Can she wash and dress herself without any help?"

"Yes."

"Do you know if she has any bowel problems?"

"I don't think so. She's never said that she had anyway."

"Does she sleep well?"

"I think she wanders about a good deal in the night. We've seen her light on at all hours."

"Does she need a hearing aid or glasses?"

"She's got her glasses with her."

"Just one more thing ..." related to bringing in clothes for the patient.

The encounters which take place between relatives and nurses in which the relative is cast into the role of the surrogate patient are similar to the encounters in which the nurse would collect this information from the patient. This form of encounter is, naturally, nurse-initiated and as such can be fitted into the routine of the ward. Nurses appear to have the knowledge to manage this form of interaction for the structure of the encounter relates to information which is required in order to conform with nursing practice procedures. As the Nursing Process becomes more generally accepted into nursing practice it is likely that this form of encounter will become more common.

The role of the 'relative as surrogate patient' is not only confined to the patient's history. Some encounters were also observed which related to a 'checking of the patient's nursing care'.

(b) Checking of the Patient's Nursing Care

It has already been indicated in previous chapters that nursing practice comprises, to a great extent, specific tasks to be carried out on the patient. In this way the patient becomes the 'work object'. On the completion of any patient-centred task the nurse who has carried out this task is required to record this completion on the patient's 'Nursing Orders'. In this way each nurse on the ward can formally check what has been done and what is still to be completed. As well as this formal check it appears that some nurses check 'the state of play' with the patients, by asking for confirmation concerning the completion of some of these tasks, for example, by asking the patient "Have you had your bed made yet?" In those instances in which the patient was

unable to reply, the relative was used by the nurse in a similar fashion. In this way the relative was perceived as a surrogate patient.

1) Third-year student to husband of unconscious patient:

"Have they been in to turn her yet?"

"No, not since I've been here anyway."

"All right then, I'll just get someone to give me a hand."

2) Second-year pupil nurse to the wife of a confused patient:

"Has he had a drink lately?"

"No."

"Well we need to 'push fluids' so I'd better give him one."

Giving information whether it was related to the patient's history or to his on-going nursing care was perceived by some nurses as a useful aspect of the relative-role and was mentioned by several nurses as one way in which relatives could actively help with patient care.

> "Yes, relatives can often help by telling you things nobody else knows."
>
> (SRN)

> "I find the relatives a great help, particularly with the elderly patient who may not want to tell you about their background."
>
> (SRN)

(c) Making Discharge Arrangements

Relatives were also used as 'surrogate patients' concerning the patient's transfer to another ward/hospital, or his/her discharge home. If the patient was able to make the discharge arrangements him/herself the relatives were not involved in this process, for Hospital policy

was specific concerning only certain groups of patient:

> "On receipt of the decision (concerning discharge) the nearest relative of children, patients over 65 years of age and those who will not be able to communicate the information to their relatives must be informed of the date and time of discharge and the fact noted in the Kardex."

Before a final decision was made there was at times some discussion concerning the possibilities of after-care with the relatives:

SRN to wife of elderly confused patient:

"We've been thinking that perhaps it was time that we had a little chat about what we are going to do with Mr. Grey."

"Oh yes."

"It really depends on whether or not you think you can manage him at home."

"Oh I don't think I can. It was very difficult those last few weeks he was at home - that's why the doctor brought him in, and he's no better is he?"

"No, if anything he's a bit worse."

"I think he's quite a bit worse. I've been very worried about what will happen to him."

"Well you mustn't worry, that's our problem, but we can't keep him here much longer, and we have to give you the choice of having him at home."

"I suppose it's not possible for him to stay here then?"

"No, as I said, we've got to think about moving him. Now we could move him to ..... that's near you isn't it?"

"I don't know whether he's like it there."

"Well look, there's no immediate hurry, but start thinking about it and I'll see you again in 2-3 days time."

"Yes all right."

The relative was also used as a 'surrogate patient' if it was considered possible that the patient did not understand the importance of continuing with treatment, especially medication, after his/her discharge:

"Now you understand when these (the tablets) have to be given and what will happen if she forgets to take them?" (SRN)

"Yes."

"Well, you'll have to take the responsibility for reminding her to take them. They are very important to her."

"I will."

"There are enough pills here for two months, then your doctor will give her some more."

Relatives were also given instructions concerning other forms of treatment, again relating to the 'ability' of the patient, on the patient's discharge from the Accident and Emergency department. This was discussed in more detail in Chapter 10 in which the role of the nurse as a teacher was described, but it is necessary to briefly re-consider this aspect of nursing practice at this stage for it is relevant to the 'surrogate' role of the relative.

"Is Mrs. Rainbow ready to go?"

"Yes, but tell her husband about the plaster. I'm not sure that she really understood me."

"All right I will."

All the patients discharged following head injuries were given a

list of instructions which were explained to the relatives accompanying the patient, for while in such instances the patient being discharged was capable of understanding these instructions, if any complications were to develop, the nature of the complications were such that they could prevent the recognition of the signs denoting such complications.

The role of surrogate patient is a passive one in that it is initiated by the nurse who 'casts' the relative in this role. We shall now turn our attention to an active role adopted by the relative, that of 'patient's agent'.

The relative as 'patient's agent'

It was observed that there were a number of occasions when the relative visiting the patient interacted with the nurse on the patient's behalf, even though if the relative had not been in the ward at the time the patient would have been able to attract the attention of the nurse himself. Although he was using the term to discuss a change in emphasis from staff to patient control, Roth (1972) used the term 'patient's agent' to describe a person acting on behalf of the patient. This term appears to be an apt one to use to describe this aspect of the relative's role.

In most instances the role of the patient's agent was unproblematic but there were a few occasions observed in which it was possible to identify some of the elements, which Fagehaugh and Strauss (1977) have called 'political' taking place as the relative and nurse tried to "wheedle, argue, persuade, negotiate, bargain, manipulate and make attempts at deception" in order to achieve their respective objectives.

The 'patient's agent' was observed to both report and to make

requests on behalf of the patient. Reporting events related to happenings in the immediate past and could, for example, indicate to the nurse that the patient had just been incontinent. Such reports were accepted without demur and the appropriate nursing action taken. Many of the requests made on the patient's behalf also appeared unproblematical and related to simple requests, for example, for a drink or for a change of position in the bed. Again such requests usually produced the necessary nursing attention.

It was in those instances which did not rapidly produce the required or requested action that some of the elements listed above were seen to take place. In the following examples there is some shift of opinion after the interaction:

1) "Do you think my sister could have some tablets for the pain?"

"I'll bring her some later on."

"You are going to give her some aren't you?"

"Ummm."

Relative goes back to the patient, nurse tells colleague:

"Mrs. Brown is after some tablets again. Her sister asked this time, but she shouldn't need them now."

After an interval of ten minutes the patient's sister re-approaches the nurse:

"She's still asking for those tablets."

"Well she doesn't really need them now you know - the doctor examined her this morning and told her she should stop taking them."

"Yes, but they can't do her any harm can they, and she does seem better afterwards."

"Well she could become dependent. I'll come and talk to her and see if we can persuade her to manage without."

The nurse and relative then returned to the patient and between them persuaded the patient to try and manage without the tablets. In this way the patient's agent 'changed sides' after being persuaded by the nurse that this was for 'the good of the patient'.

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2) Attempts to negotiate and control the situation by the relative in this form of encounter were blocked by the nurse, particularly if the patient's 'nursing care' was questioned:

> "Could I have a sheepskin for my brother. He's complaining of feeling sore."
>
> "It's all right, we are seeing to that - don't worry, he won't get sore."
>
> "Well he has a sheepskin at home and the district nurse also uses 'supercreme'" - (brand name of a barrier cream).
>
> "Oh yes, but we're using 'extra-supercreme' which is just as good."
>
> "Can I bring in his 'supercreme'?"
>
> "No that's all right we've got some here."
>
> "Oh good, but what about the sheepskin?"
>
> "Well it might be a good idea, but we'll see how he gets on first and then we'll decide if he needs it."

The same nurse in a later conversation with a colleague commented:

> "Mrs. B (patient's sister) is a sweetie really but I wish she'd stop trying to interfere."

In another instance a patient about to be discharged from the Accident and Emergency department asked the nurse (SRN) if he could have an injection of insulin which was then due. The nurse, after consultation with the doctor advised the patient to go back to his hotel first, then give himself his injection and then have a meal.

After a few minutes discussion with her husband the patient's wife approached another nurse (student nurse), adopting the role of 'patient's agent':

"Can my husband have his insulin injection before we go?"

"Just a minute, I shall have to ask."

The student nurse approached the SRN who had discussed this situation previously with the patient and said:

"The wife of the patient in cubicle 4 is asking about his insulin, do you know anything about it?"

"I've already told him what to do - I'll go and see her."

The SRN then approached the patient and his wife:

"I've already explained to you that doctor does not want you to have your insulin before you get back to the hotel. Do you understand what I'm saying?"

"But he always has it now, at 12 o'clock." (Wife)

"Yes, but it won't hurt him to have it later."

"I want to see the doctor." (Wife)

"All right. He'll be along in a moment."

It is not perhaps surprising that such 'professional judgements' are not negotiable, for as Freidson and others have indicated this is the way in which professional control is maintained.

Roth (1972) has suggested that a greater involvement by the patient and his family in the care and treatment process would help to control the monopoly power of the professions. But as Stacey (1974) has indicated "Given the already existing power of health professionals, such a proposal is unlikely to be embraced with enthusiasm" (p. 434).

From the small number of encounters observed in which the relative attempted to become involved in the decision-making process it would appear that most professionals are not yet ready to utilise the relative in this way.

We began by looking at a passive role of the relative, that of 'surrogate patient', and then considered an active role of the relative, that of 'patient's agent'. The former role is one with which nurses are familiar for as Wilson (1975) has indicated "the patient's family has traditionally been regarded as a source of information for the staff" (p. 25). However, there are indications that relatives are more likely now and in the future to want to become more actively involved in patient care.

CHAPTER 12

THE NURSE AND THE RELATIVES OF THE DYING PATIENT

Introduction

'Dying' as a process has been the subject of some considerable sociological interest during the last twenty years. A substantial body of knowledge therefore exists concerning this process and the effects of dying on family members. Some attention was drawn to this body of information in Chapter 2 where it was indicated that the nurse experienced some difficulty in coping with both patients and relatives at this time.

During the fieldwork for the present study a number of encounters were observed between the nurses and the relatives of dying patients. Although insufficient encounters were observed to draw any new conclusions concerning this aspect of the nurse-relative relationship, the data collected helps to confirm previous work in this area as well as providing some insight into the totality of the nurse-relative relationship.

Before looking at the encounters themselves attention should be drawn to the status of the relatives of dying patients within the hospital organisation both historically and at the present time.

Historically the relatives of the dying patient were afforded a different status within the hospital to that of other relatives. Some indication of this was given in Chapter 5 (p.123). This 'special' status is still accorded both by national and by local policy documents.

The recent DHSS publication "The Organisation of the In-Patient's Day" (1976) identified the specific needs and status of this group of

relatives, after pointing out that death is very much a family matter:

> "Further, we are sure that counselling and supporting the family visitors is part of the daily work of the staff in these circumstances."
>
> (p. 46)

In order to assist the relatives to overcome the sense of guilt, which can arise because the patient has to be admitted to hospital to die, the Committee of the Central Health Services Council recommended that:

> "Relatives should be encouraged to help in the nursing of terminally ill patients".
>
> (Recommendation 171.7 p. 48)

Hospital policy at St. Davids to some extent also defined the 'special' status of the relative of the dying patient by stipulating the 'care' which they should be offered both during and after the death. In this way they were differentiated from other relatives. Further reference will be made to this 'stipulated care' and 'status' in the text.

The dying trajectory

Our understanding of the dying process or trajectory, owes much to the work of Glaser and Strauss (1965, 1968). They have described a number of 'critical junctures' in the dying trajectory as it takes place in an institution (1968). This model is used to structure the data collected in this study.

The critical junctures defined by Glaser and Strauss are:

1. The patient is defined as dying
2. The staff and family make preparations for the patient's death
3. At some point a stage of 'nothing more to do' is reached

4. The final descent
5. The 'last hours'
6. The death watch
7. The death itself

One further 'juncture' has been identified in the present study, although this is an extension of the last juncture defined by Glaser and Strauss, that of 'the dismissal of the relatives'.

We shall now consider the first stage of the dying process - 'the patient is defined as dying'.

1. The Patient is Defined as Dying

> "'Dying' and 'death' are definitions which can be ascribed to certain states as a result of procedures of assessment by those professional people who rightfully and routinely engage in assessing these states and premising courses of action."
>
> (Sudnow 1967, p. 63)

Definition within the hospital is the function of the 'institutionally designated legitimator', the doctor. In Western society doctors are seen as those persons who have the expertise, knowledge and experience to enable them to judge most accurately:

> "when the patient (status occupant) is in passage, through what transitional statuses he is passing and will pass, how long a period he will be in each transitional status, and what his rate of movement will be between the transitional statuses."
>
> (Glaser and Strauss, 1965, p. 48)

Sudnow points out that the medical base for noticing 'dying' is not entirely clear, although it is clearly distinguishable from noticing disease categories and from noticing bio-chemical-physical states. He also makes the point that in Western culture 'dying' is not an appropriate answer to the question of "What's wrong with me doctor?"

This appears to be "an essentially predictive term". Noticing 'dying' is "seeing the likelihood of death with some temporal perspective" (p 63).

Glaser and Strauss observed that the doctor making the sort of assessment which would lead to a definition of dying relied on his interpretation of two types of cue, physical cues and temporal cues. Death is the expected outcome of a number of conditions, and although these are based on the statistical probabilities for the various forms of the disease, and not the individual disease process within a particular patient, it was possible to measure the patient's progression against the typical progression of the diagnosed condition with some degree of certainty.

There is some uncertainty associated with the temporal cues as the time units within the status passage can be from minutes to months varying not only with the nature of the disease and with the age of the patient, but also with other less easily defined variables. The uncertainty is reduced as the physical and temporal cues accumulate and "in combination, certainty and time yield four types of death expectation; certain death at a known time; certain death at an unknown time; uncertain death but at a known time when the question will be resolved; and uncertain death and unknown time when the question will be resolved" (Glaser and Strauss 1965(b) p 49).

During the pre-definition phase, as the cues are accumulating, the nurse will also be interpreting them in the light of her own knowledge and experience, and, although the definition of dying is the public function of the doctor, this private interpretation is implicit in nursing practice.

It was found at St. Davids that the patient and his family in

many instances did not have the knowledge or experience to be able to interpret the physical cues in this way and only realised that the patient was in passage after some sort of disclosure regarding this status had been made to them. There was an exception to this; the 'wise' relative who either had wide experience and knowledge similar to the staff surrounding the patient, or who had some knowledge of the usual outcome of the particular condition affecting the patient:

> "As soon as I saw his face I knew there was no hope. I've seen that look too often not to know. I went right up to sister then and asked her to be frank with us."
>
> (Step-daughter who was an SRN)

Relatives were seen to be more likely to interpret temporal cues, such as a rapid deterioration in the patient's condition or unduly long hospitalisation, in a way which caused them to suspect that death was likely to occur within the foreseeable future:

> "She's been here so long now that I don't think she'll get over it; three months they told us, and she'd be back home, but we don't think she'll make it."
>
> (Daughter-in-law of patient who had been in hospital for 5 months)

> "I can't tell from the way she looks, the other night she looked so awful and I thought 'this is it', but the next day she looked her usual self; nobody has said to us she won't make it."
>
> (Son of the same patient as above)

2. The Staff and Family Make Preparations for the Patient's Death

(The patient may also be involved in this social process if he is aware that he is dying.)

When 'cure' is no longer perceived to be possible some preparation has to be made to care for the patient during the living-dying interval. The length of this period of time may be uncertain and in some instances the patient may be able to go home for a while before his final

admission, or the patient and/or his family may wish for the death to take place in the patient's home. It may, therefore, be necessary for the nurse to make arrangements for some support for the patient and his family during this period. The arrangements which have to be made for supporting the patient at home are not considered in this study and the focus in this section is on the preparations which take place during the patient's final or only admission to hospital before his death which lead to nurse-relative interaction.

In order to initiate the preparations for the patient's death, the doctor will need officially to relay the information that he has made a definition of 'dying' to the rest of the staff caring for the patient, although as previously indicated, some of the more experienced nurses will have already reached the same conclusion. As well as informing the staff further decisions will have to be made concerning who else should be informed, that is whether the patient and the relatives or only the relatives should be informed, by whom this information should be given, when this information should be given, and how much information should be given. Some arrangements will also have to be made at ward level so that everyone likely to come into contact with the patient or his relatives will know the policy being pursued and what has been communicated and why and to whom.

Glaser and Strauss (1968) have indicated that these preparations enable the staff to maintain organisational order as it has already been noted that death expectations are a key determinant as to how people behave during the dying process. They have also indicated that miscalculations in forecasting can disrupt the organisation of the ward, and that although most wards can cope with the "occasional expectable emergency" the organisational machinery will probably not be sufficient to manage crises which stem from gross miscalculations

of the dying trajectory (p. 13). Organisational order, as well as being maintained by preparations for the patient's death, is also maintained by the 'sentimental order' of the ward. The 'sentimental order' of the ward has been defined as "the intangible but real patterning of mood and sentiment that characteristically exists of each ward" (p. 14). For example, in a coronary care unit, as indicated in Chapter 8, sudden death is expected in a number of patients each year, but long lingering deaths are not. The sentimental order of the ward can therefore be shattered by the latter rather than the former occurrence.

To whom the information is given

When a definition of dying has been made it is believed by nurses and doctors that "someone must be told" (McIntosh 1978). This finding was supported by discussions with nurses in the present study:

> "If the patient is very ill and not going to recover the relatives have a right to know."
>
> (SRN)

> "I think you must see all the relatives of long-term and terminally ill patients and put them clearly in the picture."
>
> (3rd Year Student)

> "The relatives, the close ones anyway, should know when the patient has a terminal disease."
>
> (SEN)

McIntosh also observed that this was one of the few occasions when doctors would seek out the relatives rather than wait for the relatives to come to them. Doctors did this when the patient's condition was serious and they were reasonably certain that the outlook was hopeless (although he also pointed out that such information was not inevitably given).[1] It would seem therefore that the preparation of the staff

---

1. It has also already been indicated in Chapter 8 that 'a sudden change for the worse', which could lead to death, was defined as an 'announceable event' by hospital policy.

for the patient's death includes seeking out and preparing the relatives for the patient's death. This aspect of preparation is of some significance for the present study, as much of the data collected between the nurse and the relatives of the dying patient concerned this issue.

Usually the communication concerning the patient's prognosis took place with one member of the family who then had the responsibility of disclosure to the other relatives. There is not usually just one 'closest relative', for example a spouse or child, and it was observed that where there were a number of relatives who could all claim to be 'close', one relative seemed eventually to emerge as the main intermediary between staff and family. The role of 'intermediary' relative could be either one which was adopted by the relative or one into which he/she was cast by the doctor/nurse:

> "I've got to find out all I can because none of the rest of the family want to ask, although they all want to know."
>
> (daughter of 'dying' patient)

> "I suppose you should see my father really, he's the next of kin, but he's very deaf so if there is any change you'd best let me know, then I can tell him."
>
> (daughter of 'dying' patient)

> "Try and see his sister rather than the brother, I've spoken to both of them before and she seems to be a bit more with it than he does."
>
> (SRN to another SRN)

It was observed that some relatives themselves were also at times 'selective' in deciding which other family members should also be given the information they had received from the doctor or nurse. In one family group the eldest son of a patient told two out of the three other children of the dying, but conscious patient, but kept the

information from the third until the mother was unconscious:

"We kept it from her till the last because we knew she'd go to pieces and we didn't want that in front of mother."

By whom the information is given

It was observed that information concerning 'dying' was given by both doctor and nurse and that the informal arrangements regarding this appeared to be made at ward level, although it was also found that some nurses stated definitely that this was not their job but that of the doctor:

"Telling bad news is the doctor's job not mine." (SEN)

It was not possible from the small amount of observation of the behaviour of nurses and doctors before the disclosure of the patient's prognosis to the relatives, to determine with any accuracy how the 'announcer' was selected, although there was some negotiation observed between these two groups concerning this matter:

"Will you see Mrs. Gentian's daughter and make sure that she realises how ill her mother is."

(Doctor to SRN)

"Do you think that you'd better see her?"

(SRN to Doctor)

"No, you do it, unless she wants to see me."

"Oh."

The role of announcer, however, was perceived to be stressful by a number of nurses:

"Yes, I still find it difficult to break bad news." (SRN)

> "(This is) an anxiety-making situation, when you know the patient is dying and you can't give the relatives hope but you have to let them know that death is imminent."
>
> (SRN)

A further difficulty inherent in the role of announcer, in particular the less experienced announcer relating to the recipient was identified by Fradd (1979):

> "The houseman was, in fact, a medical student, who had the difficult job of telling my mother and me the prognosis. It cannot have been easy for him knowing that I was a senior nurse and had probably done the same job many times before."
>
> (p. 38)

When the information is given

There may be an interval of time between the doctor making the rest of the staff aware of his conclusions concerning the patient's prognosis and his informing the family. Such information can change the behaviour of those to whom it is given and Glaser and Strauss (1965b) have identified a number of considerations which may encourage the staff not to go on record with this information too early in the patient's disease process:

a) Reversals can occur and although these are seldom complete, the doctor's prognosis seems to be contra indicated and can cause an ever hopeful family to distrust the doctor;

b) The family members may experience stress for a longer time than they need to adequately prepare for the patient's death;

c) Putting family members under stress may make them more difficult to control.

While such considerations may be justified in some instances, this post-definition-pre-announcement period can be difficult for the nurse

who has to interact during this time with the patient's relatives. It is possible that the relative may interpret some of the physical and temporal cues which have led to the doctor's definition of 'dying' during this time and may confront the nurse with a direct question concerning the patient's terminality. This places the nurse in a dilemma: ethically she is bound by the doctor's decision concerning what, to whom and when to give this information, but she may also feel morally bound when confronted with such a question to give a truthful answer:

> "When we think the patient is dying, I believe in telling the truth, I don't like flannelling, but sometimes you have to. You've got to wait for the doctor to decide when to tell them (the relatives)."
>
> (SRN)

The standard tactic adopted to cope with this dilemma is the strategy of role-switching (already described in Chapter 7) to the doctor:

> "Well of course the relatives of a patient admitted at night are naturally very concerned and a number have asked me if the patient is going to die, but I always tell them it is best if they see the doctor."
>
> (SRN)

During this post-definition-pre-announcement phase the relative may also inadvertantly create a situation during interaction with a nurse, who is aware of the defined status of the patient, in which the nurse cannot role-switch but either has to 'bluff out' the situation as known by the relative, or has to give some forewarning that the patient's condition may be different from that perceived by the relative. Examples of both of these strategies are given below.

1) "Forewarning":

An elderly patient had been admitted for investigations. Her daughter and son-in-law lived several hundred miles away from the hospital.

Son-in-law to nurse "How long do you think she'll be in?"

"I can't say really."

"Only we were thinking that it might be better if she transferred to a hospital near us, then the wife's father could stay with us as well so we could keep an eye on him."

"Hmmmm, well, (long pause) It really depends if she gets over this, then perhaps we could do something like that, but she's looking very poorly at the moment."

"Oh, she's been looking like that for the last six months, I didn't know she was deteriorating."

"We'll give her a few more days and see what happens then, then we can have another think about what's best."

The relative (in a later interview) pinpointed this piece of interaction as his first intimation that the patient would not recover.

2) "Bluffing Out":

Another elderly patient who had been admitted on several previous occasions for treatment of a chronic condition was again readmitted. After examining her the doctor had indicated to the nurse that he thought that it was unlikely that the patient would survive this episode of the disease. That evening the relative (son), after asking what was happening to his mother in the way of treatment, was told that she would be seen by the consultant on the following day. The son was then asked for his telephone number as this had not been obtained when the patient was admitted. After giving this he said:

"Oh, next week I'm supposed to be going off for a few days, but I suppose she'll be running around again by then."

The nurse in this instance 'bluffs out', but introduces a note of caution:

"We'll see what happens. You can only take one step at a time."

"That's true, O.K. then."

The relative walks off apparently 'unaware'. The patient died three weeks later. (Both of the relatives in the above interactions were given information concerning the patient's prognosis within a few days of the interaction described.)

What information was given

The information concerning the patient's terminality could be given in one interaction similar to an 'announceable event', or it could be 'staged'. If the information was staged this would consist of a number of cues given over a varying period of time to stimulate a gradually growing awareness by forewarning.

An example of 'staging'

The brother and sister-in-law of a patient were talking to the nurse about a friend of the patient who had died recently of a similar complaint:

"But I can't see that happening to her, she's a tough old bugger and always good for a laugh, I can't see that happening to her."
(Brother-in-law)

"No not to her." (Sister-in-law)

"Well, I think I'd better warn you that she's not out of the woods yet."
(Nurse)

"No, I suppose she's not really." (Brother-in-law)

Forewarning cues could be repeated at short intervals or they could be followed by a more direct announcement within a very short period of time. Glaser and Strauss (1965) noted that the ineffective pacing of

forewarnings could result in the family shopping around for a 'better' doctor, one with a 'cure' even though cure was not really the issue. (The phenomenon of seeking alternative cures for the dying is well-known and can take place at any time during the dying trajectory, but is most likely to happen in those instances where 'certain death at an unknown time' condition prevails.) They also noted that too gentle a disclosure could be too weak to stimulate adequate family preparations, and that this consideration needed to be weighed against the possible positive effects of a harsher disclosure (p. 150). It was observed that one way of modifying the 'harshness' of a disclosure made by a nurse was by the use of euphemisms which hinted at dying without actually mentioning the word.

1) "We're not absolutely sure what's wrong with him but 'it could be serious', do you understand what that means?" (SRN)

2) "Well I have to tell you that he is 'quite poorly', not 'desperately ill' but it could lead that way." (SRN)

The information regarding the patient's impending death was observed to be followed by rationalisations (called 'loss rationales', Glaser and Strauss, 1965). Loss rationales by justifying death appear to make it more tolerable. In addition to the loss rationales 'supportive statements' were also observed to supplement the initial information. Examples of both a loss rationale and a supportive statement can be seen in the following:

"As you know there is nothing more we can do, but we will make sure that he's not in any pain." (Nurse)

"Well he looks very peaceful." (Relative)

"He is nearly 88 and he's had a good life I believe."

"Yes, mother's looked after him well and he's kept in good health right up till now."

"Well this is nature's way with the old (loss rationale). Now you know we'll keep him comfortable and look after him as best we can (supportive statement)."

"Yes I know you will."

These rationalisations and supportive statements resemble the qualifying remarks which follow an announcement in 'announceable events', and although they are unable to offer the relative hope, they offer him/her some reassurance concerning the patient's future, and help the relative to 'make sense' of the situation.

The setting in which the announcement took place varied but an attempt at privacy was usually made. It was observed that the relative was usually invited into the sister's office for such an announcement, although such announcements were also made at the nurses station and in the corridors.

A short case-history follows to illustrate the points about conveying information about dying which have already been discussed:

Mrs. Indigo was admitted to hospital, accompanied by her very deaf husband, for investigation. On admission she was seen by the doctor who then saw her husband and told him that the patient would be seen by the consultant the next day. Two days later, while the husband and daughter were visiting the patient, she collapsed. The doctor was called, and after examining the patient was asked by the nurse to see the relatives to reassure them that the patient's condition was still satisfactory. During the next few days the patient's physical condition deteriorated; she ate little and she also had periods of confusion. During this period the daughter emerged as the intermediary between the family and staff, although the husband continued to visit each day. During one of her visits the daughter was informed that her mother was worse, but that

it was still hoped that she would respond to treatment. The daughter returned to her mother's bedside, but after a while became very tearful and left the bedside. She was spotted by the nurse who had seen her previously, and taken to the visitor's room where she was given a cup of tea. The nurse sat with her while she talked out her belief that her mother would not come through'. The nurse neither confirmed nor denied this statement. In a later discussion with the nurse she stated that this was also her opinion, but that they would have to wait and see what the consultant thought when he saw her the next day.

After the consultant had examined the patient he asked the nurse to see the relatives to inform them that the patient was dying (definition of dying, selection of announcer). Later that day the husband and the daughter visited the patient. As they walked up the ward the daughter stopped a nurse and asked her: "What did the doctor say?" She was asked to come to the office (setting affording some privacy). Two nurses (both trained) accompanied her to the office but one did all the talking (announcer).

"The doctor saw her this morning." (nurse)

(the relative interrupted)

"What did he say dear?"

"He doesn't think she's going to come through this" (announcement).

"No, well I thought as much. How long?"

"I can't really say, she might go on like this for some time (pause) we'll give her some medicine to keep her comfortable" (supportive statement).

"Oh she can't suffer."

"No. The doctor did say that it wasn't really a sudden thing. She's had this going on for some time now" (rationalisation).

"Yes, I see."

The daughter then leant forward and touched the nurse on the arm:

"Thank you for telling me dear."

"Look, you can come and see us or ring us anytime you like."

"Thank you, I will."

It was observed that all similar interactions ended with the nurse leaving herself open to further interaction should the relative wish to pursue this.

After the relative had received an 'announcement' this was recorded in the Kardex.[1]

It can be seen from the above discussion that the preparation of the family can lead to fairly extensive interaction between the nurse and the patient's relatives which can take place over a period of time. Glaser and Strauss (1968) drew attention to the problem this preparation of the relatives can create:

> "So much can go wrong: so much is unexpected. This would be true even if dying were 'timeless' or took place only over a short period. But last days take time; hospital staff must juggle tasks, people and relationships that can and do change daily."
>
> (p. 150)

---

1. The Kardex was used as the basis for the verbal reports which were given to new staff coming on duty and this was the way in which the rest of the staff knew who had been informed, when and what information they had been given. It has already been noted, however, (in Announceable Events) that nurses were often ignorant of what information the relatives had been given as the detail in the Kardex was minimal.

Before discussing the data relating to the next stage in the dying trajectory we should consider the effect of 'knowing' that the patient is 'dying' on the relative. As soon as the relative perceives that the patient is dying, either by interpretation of the temporal or physical cues, or by a disclosure from a staff member, he takes on the role of the 'relative of a dying patient'. Giaquinta (1977) has devised a model for the systematic description of the functioning of family members facing the crisis of cancer. This model was based on observation and discussion with 100 families facing this crisis, and although in many instances it is possible to offer the family facing the crisis of cancer 'hope', which is not appropriate to the families facing the crisis of 'dying', this does not detract from the model's usefulness in attempting to organise the data which was collected from talking with and observing a small number of the 'relatives of a dying patient'.

The Giaquinta Model of Family Functioning Facing the Crisis of Cancer

The model highlights the phases of family functioning which may be altered as a result of the relatives awareness that the patient is dying. These phases occur within four stages, although only the first three will be used in this discussion.

1. Living with cancer - adapted in this study to living with dying.
2. Restructuring the living-dying interval.
3. Bereavement.
(4. Re-establishment).

In this section the phases which relate to 'living with dying' will be discussed, subsequent phases being dealt with later in the chapter.

Within the first stage of 'living with dying' Giaquinta identifies

five phases which overlap: impact, functional disruption, search for meaning, informing others and engaging emotions. Instances of some of these phases were found in the present study.

Impact describes the relatives' reaction to the disclosure. If the relationship between the family member and the patient was a close one, there will be some inner stress which may be observable in the form of distress, anxiety or agitation:

> "They called me to say that she was worse and so I went in. The thing I remember most is how angry I was that they'd put her in a hospital nightie, it made her look worse. I'm sure they didn't understand why I kept on and on about it. I didn't realise myself at the time that I was reacting to the news."

Functional disruption refers to the disruption in lifestyle which may occur as the relative adjusts to the situation and attempts to plan for the living-dying interval. Functional disruption is not, however, unique to the relatives of the dying patient but is itself a feature of 'being a relative'. It was not possible, therefore, from the few relatives of dying patients interviewed, to distinguish between the disruption caused by the illness and that caused by the relatives' attempt to cope with the 'dying situation'.

The search for meaning which may take place can be philosophical, 'Why did it have to happen to him?', or it may be practical, 'What is the cause?'. Glaquinta indicated that this search for meaning was more likely to occur if the death was perceived as 'tragic' either as the result of an accident, or if the patient was young, although from the interview data it was obvious that all the relatives of dying patients in the study to some extent were engaged in this 'search':

> "It's difficult to understand why it's her, she's always been such a good woman, never did anybody any harm, but I suppose it has to be."
>
> (husband of 'dying' patient)

Informing others may have to take place while the 'intermediary relative' is still suffering from the impact of news. Disseminating this information may be difficult for the relative who has been entrusted with this task by the staff:

> "I had to ring up the wife's sister after they'd told her, they hadn't spoken for over twenty years, she'd still kept in touch with the old girl but we never heard from her, somebody had to do it."
>
> (son-in-law)

Although the task of informing others may be a difficult one, the patient's dying process can also be a means of creating family unity. Some evidence of this is shown later in this chapter.

Engaging emotions is the final phase in the first stage of the model, when Giaquinta suggests that former family values, goals, satisfactions and positions of security may all be changed and cause volatile emotions to come to the surface. The family may feel particularly helpless and grieving begins at this stage. The family may also desire a final date to be set, believing that they will cope better, but as has already been indicated, this may not be possible when the disclosure is made:

> "We lived with my mother until she died three years ago, then we decided to buy a bungalow in C.... (5-6 miles away from the hospital) to be near my sister and her husband. We'd always got on so well and promised ourselves that if we were still fit and well after anything happened to mother we would move to be all together in our old age. We'd only been here a few weeks when my brother-in-law was taken ill. He died after six months. My sister was found to have cancer and died last November, and now this. I just can't believe that in a short time it will only be me, what will be the point of that..." (relative breaks down).

Some attention has been paid to the way in which relatives face the crisis of dying for it is from within this frame of reference that the relative engaging in any encounter with a nurse will operate.

Having briefly considered the reaction of the relatives as they

prepare for the patient's death we should now return to the next phase in the dying process as described by Glaser and Strauss - the 'nothing more to do' phase.

3. Nothing More To Do

When the arrangements have been made in respect of where the patient is going to die, there remains a period in which there is 'nothing more to do', but for the staff to attempt to meet the patient's physical and psychological needs as best they can. Glaser and Strauss (1965) have pointed out that this phase of the dying process is crucial because at its inception "the fundamental goal for the patient changes from recovery to comfort" (p. 177).

The nursing practice literature is replete with instructions concerning the way in which nurses should minister to the dying during this part of the dying process. Some of the literature also prescribes the way in which relatives can be assisted:

> "The relatives also need the chance to talk about the situation and their reactions to it: they will appreciate advice on how they can redirect their emotions more constructively."
>
> (Bickerton, Sampson and Boylan, 1978, p. 117)

> "Defer to the wishes of the relatives with regard to visiting the patient, demonstrating professional competence and warm understanding of the family's emotional and social needs."
>
> (Hoy and Robbins, p. 79)

> "Recognise the grief experience, indicate to the family that grief is appropriate. Help the family to know that it is a reality."
>
> (Marks, 1976 p. 1488)

The 'care of the dying' is, however, an aspect of medical and nursing practice which can be difficult for practitioners. Garfield (1977) has pointed out that in a society in which doctors are culturally

defined as 'healers', "death is tantamount to failure and the emotional consequences for the physician are often severe" (p.147). It has also been indicated that the recent attempts to improve the care of the terminally ill have "negated and neglected" the difficulties experienced by both doctors and nurses caring for the dying by failing to provide effective staff support systems to cope with the stress generated by this occupation (Vachon 1978, p. 147).

The care of dying patients during the 'nothing more to do' phase of dying is one which appears to cause stress among nurses, particularly among student and pupil nurses. Birch (1979) found that many student and pupil nurses perceived that they had received insufficient instruction concerning the care of dying patients and their relatives. Fazakerly (1978) pointed out that the way in which the General Nursing Council syllabus was interpreted by nurse tutors "avoided the reality of death and dying" and failed to equip the nurse for dealing with the psychological trauma which accompanied these events (p. 27).

Evidence of stress in relation to this aspect of nursing care was found in the present study:

> "We recently had a patient, a young woman it was, in the ward, and I found it very difficult to talk to her and her mother right up to the time she died."
>
> (3rd Year Student)

> "I suppose you get used to it but I find it a real problem."
>
> (3rd Year Student)

The nurse in such instances appears to be unable to maintain the 'detached concern' which she believes to be appropriate in such situations because she identifies strongly with either the patient or the relatives, perhaps intensifying the stress.

Some reference has already been made to the sentimental order of the ward and the way in which this is created by the combined requirements of dying patients, their families and the staff. It has also been indicated that each nurse's composure is vital if that order is to be maintained. Glaser and Strauss (1965) have indicated that this composure is maintained by the use of strategies which serve to reduce involvement with the relatives and with the patient who is approaching death. The nurses in this study were observed to use, and themselves identified, two different strategies, 'avoidance' and 'role-switching', which served to reduce their involvement with relatives during the 'nothing more to do' phase:

> "I used to try and avoid her (the wife of a 'nothing more to do' patient) but now I try and let her talk if she wants to."
>
> (1st Year Student)

> "Yes I must admit I do tend to avoid Mrs. Red's relatives if I can."
>
> (SEN)

Role-switching as a strategy has already been described in discussing the relative as a 'gatherer of information'. This strategy was also used in the present context, and relatives were 'switched' to other members of staff perceived by the nurse as 'grief workers':

> "We don't have many deaths on this ward but I believe in using the Medical Social Worker and the Chaplain in order to help the family."
>
> (SRN)

Glaser and Strauss also described one further strategy which nurses used to maintain their composure during this phase of the dying trajectory, that of using the relative as a helper. However, in the present study no relatives of dying patients were observed to be used in this way.

Some nurses may have used the strategies described above because

of their perceived 'helplessness':

> "With grieving relatives you don't know what to say. You feel helpless."
>
> (SRN)

This 'helplessness' was to some extent exacerbated by the traditional prescriptive literature for nurses, for although, replete with phrases which suggested that the nurse should demonstrate professional competence by helping the family, this literature gave little help to the nurse concerning the appropriate behaviour which would achieve these effects.

This deficiency in the literature is now being remedied to some extent. A small number of recent studies have made some attempt to identify the specific needs of the grieving relative in hospital in order to plan "meaningful nursing approaches to comfort, support and ease the suffering of the dying and the grieving" (Freihofer and Felton, 1976, p. 336). Hampe (1975) after identifying the needs of grieving spouses suggested that if nurses were to be able to effectively carry out this aspect of their role, they must be freed from the "traditionally organized work routines" to care for the emotional as well as the physical needs of the patient and his family, and that they must be prepared for their role as part of nurse education. It has been indicated in Chapter 2 that the 'routine' and 'lack of preparation' are constraints on some aspects of nursing activity vis-a-vis the patients, so it is not perhaps surprising to find a similar situation vis-a-vis the relatives. This inability to carry out his/her role adds to the stress experienced by the nurse.

While some nurses did undoubtedly find the care of the patient's relatives to be a stressful experience, they and others believed that they did try to meet some of the relatives' needs:

"If the patient is terminal you are probably more gentle with the relatives."

(SRN)

"If the patient is very ill I tend to fuss over the relatives a bit more."

(SEN)

Staff nurse to rest of the nurses at report:

"If (he) wants to talk we must let him, we must try and make time to speak to him. It must be awful for him going back to an empty home knowing she'll never be back. It doesn't seem as if they've got many friends, so he's in for a bad time when she goes."

In this way the nurse attempted to confer special status on the relatives of dying patients.

There was at least one patient with relatives who was at the 'nothing more to do' stage in all of the wards in which the observation took place. Although this was only a very small sample, certain similarities were observed in the interaction which took place between the relatives of such patients and all grades of nurse which was different from that which took place between nurses and some other groups of relatives. (These similarities also helped to confer special status on the relatives). The three similarities observed on each ward were as follows:

1. The relatives of the dying patients were known by name to a number of the nurses working on the ward, and they were observed to be greeted by the nurse using their name on arrival in the ward. (This also applied to the relatives of patients who had been in the ward for a long time.)

2. Opportunities were made for the relatives of dying patients to approach the nurse without any specific reason for interaction,

as there appeared to be an expectation that these relatives would need to 'talk':

"Sometimes she just wants to talk about herself, yesterday she was telling me about the effect of her husband's illness on her social life. She knows he won't come home and she's very worried about her future."

(3rd Year Nurse)

(It has already been noted that interaction with the relatives of dying patients usually ended with an invitation to "come and see us at any time.")

3. It was noticed that the opener "How is he/she?" used by the relative was not necessarily a quest for information, but could also be used as a social nicety from which the relative would proceed to other forms of interaction. (This also applied to long-term patients.)

"How is he today?"

"Much the same."

"I've brought him some flowers today, I know he won't notice them but I've been in the garden all morning...". (The conversation continued with the relative recounting her activities since her last visit on the previous day.)

Although the features described above were also observed in some other forms of interaction, the combination of the three features was consistent in the small number of interactions which took place between the relatives of the dying patient and the nurses.

One more point should be made concerning the 'nothing more to do' phase - that of the use of the strategy of 'shopping around' by relatives; only one of the relatives of a dying patient in this study appeared to 'shop around':

"Almost every day she'll tackle one of us plugging for more information, yet she knows all there is to know."

(SRN)

"I usually ask how he is, you never know they might find that they can do something."

(the relative referred to above)

It would appear therefore that most relatives accept that 'shopping around' is not very relevant when the patient is dying.

We should now further consider the behaviour of the relatives during the 'nothing more to do' phase. During the period of 'nothing more to do' the relative of the dying patient attempts to re-structure the living-dying interval. Giaquinta (1977) has suggested that there are two phases to this stage, 'reorganisation' and 'framing memories'.

Reorganisation

There may be reorganisation of the role obligations among the family to lessen the strain on some of its members. In this study, for example, the wife of a patient, who had very rapidly become critically ill, was invited to stay with her brother and sister-in-law, "It means I don't have to cook or do anything else but be with him as long as I need". Relatives who lived away from the area would in many instances attempt to both visit the patient and assist the relatives who might have been the 'brunt-bearer'[1] until the patient's admission. There was some evidence of families growing closer together at this time, and one of the relatives interviewed described the way that her father's terminal illness had been the means of a reconciliation between her and the rest of the family.

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1. A number of the relatives of dying patients will have had a period of 'bearing the brunt' of the patient's care prior to his/her admission. The term 'brunt-bearer' was coined by Cartwright et. al. (1973).

Framing memories

By framing memories in interaction with others, the relative can recall the dying person 'in all of his or her individuality'. Giaquinta has pointed out that not all relatives are able to do this, but a small number of examples of 'framing memories' were observed in nurse-relative encounters in this study:

> "She was such a lovely little lady, everything they've got, house and garden, she's put together."
> (Daughter of patient to SRN)

> "He was a proper laugh, you know, when he was himself."
> (Patient's wife to student nurse)

Having briefly examined the behaviour of relatives during the 'nothing more to do' phase, one further point should be made about nurses' behaviour at this time. Some nurses in this study appeared to have difficulty in understanding the behaviour of the relatives who were attempting to come to terms with the patient's death during the 'nothing more to do' phase. A small number of nurses reported that during this period some relatives 'behaved' inappropriately. In one instance it was reported that the teenage son of a dying patient 'wandered' all over the hospital for long periods of the day:

> "It would have been better for him to stay away if he couldn't sit with her."
> (SRN)

All the relatives of dying patients interviewed in this study (9) were apparently satisfied with the care they and the patient were receiving during the 'nothing more to do' phase, although some perceived differences in the individual care-givers, be they nurses or otherwise:

> "They all try and do their best for you but some are better than others."
> (Wife)

Although the small number of relatives in this study were satisfied, other studies have indicated that this can be a problem area. Cartwright, Hockey and Anderson (1973) found that only seven out of ten relatives of patients who had died in hospital were pleased with the way in which the patient had been looked after until his death. There are also a number of other reports which indicate that the care of the family at this time can be a matter for concern (D'Addio 1979, and Griffin 1978).

Before discussing the next stage of the dying process one further matter should be considered, that of 'prolonged visiting', that is 'visiting' which was spread over a long period of time. It appeared from the discussions with relatives that prolonged visiting could eventually lead to feelings of guilt in some relatives. These feelings occurred because although these relatives felt that they should visit the patient they also began to feel that they were neglecting other aspects of social life which were of some importance to them.

> "I've called to see her every evening since she's been in, but it's now getting a bit of a strain. If I was home I'd be spending that time with the kids, but the only time I see them is over a quick tea, they're in bed when I get home."
>
> (Son of patient who had been in the 'nothing more to do' stage for three months)

Prolonged expectation of the patient's death also led to an attempt to interpret the patient's appearance as a signal that she was reaching the end of the 'nothing more to do' stage and beginning the 'last descent'. This was reflected in relative-nurse encounters:

> "Ooooh, she looked bad last night, I expected you to have to call for me."
>
> (Patient's son to SRN)

> "Well, she will get days like that but there's no real change yet."

"She must be as strong as a horse."

"Yes, sometimes these old people are stronger than we think."

Related to the problem of 'prolonged visiting' are two other problems, that of 'awareness' which will be discussed below, and that of the relative who has finished grieving before the patient dies. It has been found that if the latter occurs the relative then visits less frequently (Glaser and Strauss, 1968). Although this was not observed in the present study it is a well-known phenomenon on chronic geriatric and psycho-geriatric wards.

There was no problem of 'awareness'[1] (Glaser and Strauss, 1965) in the small sample of relatives and dying patients in the present study. Only one of the patients in this study for whom there was 'nothing more to do' was fully conscious and mentally alert. She was 'aware' of her condition as this was in keeping with the personal philosophy of the consultant who was caring for her. In this ward each patient was given a full and frank discussion of their condition by the consultants serving that ward in the company of a trained member of staff. Glaser and Strauss (1965), McIntosh (1977) and Cartwright and others (1973) have pointed out the problems which can occur when the relatives are aware and the conscious, rational, dying patient is not, but as already stated this situation did not arise in this study.

We have so far considered the first three critical junctures in the dying process, as identified by Glaser and Strauss, and related the data collected in this study to these junctures. We shall now turn our attention to the later stages of the dying process, beginning with the 'final descent'.

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1. This concept is extensively discussed in 'Awareness of Dying' (1965).

4. The Final Descent

A stage is reached in the status passage between dying and death when temporal certainty can be estimated to within a few days. The patient may remain conscious at this stage but in many instances will appear to be no longer fully aware of the events which are going on around him.

The relative will have to be informed of this intermediate passage even though this is expected to happen. This may necessitate a phone call, if the relative is not visiting each day:

> "I was wondering if you were planning to come and visit her within the next few days as she is now starting to get worse." (Relatives live some miles away)
>
> (SEN)

> "Yes, tomorrow should be O.K., but I wouldn't leave it any later."

The same nurse tells the night nurse that the relatives have been informed, adding:

> "I hope they make it in time, they didn't want to travel down overnight so I said that tomorrow will probably be soon enough. I think I'm right."
>
> (SEN)

Because of the impossibility of determining exactly when death will occur there will inevitably be false alarms. If this happens the relative may become confused when confronted with fresh information or the short reprieve may spark hope:

> "I'm afraid he's worse. His heart is no longer strong enough to keep his blood pressure up."
>
> (SRN)

> "Well we were told when he came in that it was only a matter of 4-6 hours, and now 36 hours he's still here. I know no-one wants to give us false hopes, but perhaps he'll get over this as well."
>
> (Daughter)

"I think it's very unlikely."

"But you wouldn't classify him as absolutely hopeless at the moment."

"Well ..... "

"You really mean there's not much chance that he'll go much longer?"

"Yes, that's about it."

The patient may at the stage of 'the final descent' be moved to a side-ward, but this depends to some extent on the availability of such a ward. Any visiting restrictions are lifted and arrangements can be made for the relatives to spend the night in the hospital if they wish. Although the study was carried out in one hospital, the wards in which the field-work was carried out were in two separate buildings, with different facilities for relatives who needed to stay the night. In one of the buildings there were a number of rooms away from the ward area where the relatives could stay. In the other building some of the geriatric wards had a visitors room, in which was placed a chair which converted into a bed. In other wards the relative who wished to stay the night had to do this in the day-room. In both of these instances the relative remained within the precincts of the ward. All of the relatives who stayed in the hospital during the final descent were given tickets which enabled them to obtain meals. They were also given frequent drinks of tea or coffee by the ward staff. Not all the relatives wanted to stay at the hospital, and in some instances only one member of the family wished to stay:

"My father would like to be with her when she goes."

(Patient's daughter)

"Well, if you would like him to stay we can give him a bed, he can stay as long as he likes, as long as it doesn't wear him out."

(SRN)

"At home he just sits and cries all the time."

"Is he better here?"

"Oh yes; he says that's where he wants to be. You wouldn't mind if he stays?"

"No, not at all."

"He says he doesn't want her to be alone and without friends when she goes, they've been married 63 years. I couldn't face staying myself, but if he wants to."

"Yes, that'll be fine."

Not wishing to stay with the dying patient for long periods of time can be due to a number of reasons including the presence of unpleasant symptoms which can occur in the patient at this stage. In the Cartwright study (1973) a large number of relatives were aware of the distressing symptoms which occurred in the patients they had watched die in hospital. Because of this, Clark and Hockey (1980) suggest that the relatives of the dying patient might benefit from a discussion of these symptoms with health professionals. This was not observed to be a major problem in the present study.

Melia (1977) has pointed out how many relatives, especially those of the patients in critical care units, cannot accept the status quo and feel the need to express their frustration. If this happens their target is frequently the nursing staff. The combination of an unpleasant symptom and frustration leading to an aggressive interchange was noted on one occasion during a patient's 'last descent' in the present study:

"Why aren't you giving her drinks?" (Husband of patient)

"We are trying, but she is keeping her teeth clenched and it is difficult."

(SRN in charge of ward)

"She's got a dirty mouth."

"Yes, Nurse has tried to clean it, but the problem is the same. We do have difficulty in getting her mouth open."

"What are you going to do about it?"

"We will keep trying."

"I hope you will. I don't like to see it like that."

"I understand, but really at this stage we can't do more than we are doing."

(Long pause)

"No, I suppose not."

"Now, would you like a cup of tea?"

The reaction of the relatives during the final descent can be divided into two phases, separation and mourning (Giaquinta, 1977). (Mourning will be discussed later.)

Separation begins when the patient's consciousness diminishes and his awareness of the environment vanishes. (This was noted to occur in the 'nothing more to do' stage when these same conditions prevailed.) When this occurs it can produce an avoidance or emotional withdrawal of the relatives from those who are about to die. Hackett and Weisman (1961) have called this phenomenon 'the bereavement of the dying' (p235). This was observed in the present study on one occasion following an emergency admission. After being told that the patient was likely to die, the relatives, wife and son, decided to go home and wait there until he died.

Unlike American hospitals, most British hospitals do not have a 'critical list' which serves "to distribute an internally relevant message notifying that a death may be forthcoming, and that appropriate arrangements for that event are tentatively warranted" (Sudnow 1967). However, the term 'danger list' does have meaning for people in our

society, and the term was observed to be used. An example of this term was observed to be used by one relative in conversation with a friend as they were leaving the hospital:

"He's still on the danger list you know."

We should now consider the next stage in the dying process.

5. The Last Hours

During this time those members of the family who wish to do so will visit the patient to say their last goodbyes. This can be a very emotional experience. One relative, the grandson of a dying patient, was unable to do this for after just a glimpse of his dying grandmother, he was overcome with grief and had to leave the ward. Even those relatives who have elected to stay until the patient's death may feel the need of a break in order to compose themselves for a further stay:

"I'm just going home to get some dinner." (Husband of dying patient).

"Oh, you needn't do that, we can get you some here, or we can give you a cup of tea."

"No, the walk home will do me good. I'll be back in about an hour."

"Can you manage that all right?"

"Oh yes, I can't stay any longer. You'll have to ring me if anything happens."

The prescriptive literature advises that the relatives should be assured that "simply sitting by the bedside of the patient holding the hand is a positive act of caring" (Hoy and Robbins, 1979, p. 77-78), but it was observed that this form of relative behaviour was apparently very difficult to carry out. Most relatives needed to move around and were unable to sit still holding the patient's hand, but would move around the bed, or, if there were other relatives around, talk in quiet

tones.

6. The Death Watch

This is the stage when the patient is 'in extremis' and only lasts a short while. If the relatives are staying in the hospital they are called to the patient's bedside. If the relative has gone home for a rest and has requested to receive such information, he/she will also be called to be with the patient at the end of his life.

Although a number of patients died during the period of observation, no patients with relatives present died during the time in which the observer was on the ward, so that the data in this section is from the interview material only.

All the nurses who were in charge of the wards on which the observation took place were asked to describe how they managed the situation when the relatives wished to stay with the patient. They all stated that they allowed relatives to make the decision concerning whether or not to stay:

> "I think it's up to the relatives if they want to sit at the bedside till the patient dies. You can see that some of them don't want to, yet they feel guilty because of this feeling. If I think that's the situation I feel they need reassuring that they haven't got to do this."
>
> (SRN)

> "I have suggested to relatives that it might be better if they took a break from the bedside, because it doesn't always do them any good, and I think sometimes they need someone to make decisions for them, but in the end it's up to them what they do."
>
> (SRN)

During this time, if the patient is a Roman Catholic, the patient will be given the last rites, or the family of non-Catholics may ask their own Minister of Religion to visit and pray with the family and

patient.

We now need to turn our attention to the last of Glaser and Strauss's 'critical junctures', the 'death' itself.

7. Death

Hospital policy is specific concerning the behaviour of both nurses and relatives at this point:

> "If the relatives are with the patient at the time of death - they should be escorted to a quiet place (e.g. Sister's Office) and offered comfort and a hot drink.
>
> Arrangements should be made for the relatives to see a doctor should they wish it."
>
> (Procedure No. 4)

> "If the relatives are not present at the patient's death - they must be notified when the death has been confirmed by the doctor. If relatives are known to be elderly, or living alone (check kardex) care should be taken to find another relative, neighbour or general practitioner to break the news and comfort them. The hospital where the patient dies is responsible for notifying relatives even if the patient came to our hospital from another hospital, nursing home or home for the elderly."

Nurses were divided about the way they preferred to give this form of information. Some preferred to bring the relatives into the hospital if this was practical, saying that the patient had had a sudden turn for the worse, and inform them personally of the death when they arrived at the hospital:

> "If I ask them to come in I try to suggest that they bring someone in with them."
>
> (SRN)

This was only possible if the relative lived locally and had ready access to transport. All the nurses questioned stated that they followed the procedure with regard to relatives living on their own, utilising in addition to the policy suggestions, the police or a

local vicar.

Sudnow (1967) has pointed out that when an announcer has to make the death announcement this is made as soon as possible whether or not the family expects its likelihood:

> "The enforceable character of a prompt, straight-forward announcement derives less from the structure of the occasion than from the strongly held sentiment that persons have a right to be told immediately of their own status as a bereaved person."

Bereavement as a status takes place as the announcement is given.

The set of resources which are generally available to the announcer who has to make other forms of announcement (discussed elsewhere) are not useable at this time. The relatives cannot be told not to worry, nor can the announcer engage in social niceties such as exchanging smiles as the whole range of comforting remarks which may be appropriate in other circumstances are considered radically inappropriate as the death announcement is made.

"Breaking the news gently" as an act of anticipatory comforting seems proper only for those who have some degree of intimacy with the recipient. The most experienced 'announcer' interviewed in this study was the Coroner's Officer, who had an office at the hospital, who felt that "breaking the news gently" was not really possible:

> "I think it's best to tell the relatives in as straight-forward a manner and as quickly as possible. You then have to be prepared to cope with a whole range of emotions. It affects everybody differently and it's only after you've told them that you can start to comfort them."

"Breaking bad news" as a social act does not appear to have received very much attention from sociologists. Apart from the study by Sudnow already mentioned, the only other study located concerning

this was carried out by Lofland (1976), who with Lachlan and McClenachan attempted to analyse one such occupational bearer of bad news - the Deputy U.S. Marshal. From this analysis they found that the problematic aspects of the situation are managed in three stages: 'preparing', 'delivering' and 'shoring up after delivery'. These three stages appear to be inherent in announcements of death made in hospital. One such announcement was made on the phone to a relative:

> "Oh Mr. Crimson this is staff nurse on 'A' ward. I'm afraid I have some bad news for you ('preparation').
>
> "I'm sorry to have to tell you that Mr. Violet died about five minutes ago ('announcement').
>
> "He died very peacefully. } verbal 'shoring up'
> "Yes it's all for the best." } after delivery.

It has been noted by Sudnow (1967) that death seems to be a paradigmatic example of what might be termed a 'clear social fact' as persons have complete and unquestioned faith in the social organisation of medical enquiry which produces the proclamation of death so that for a doctor to pronounce death makes it so. This unquestioned faith is in contrast to the doubts which many people hold with respect to the doctor's ability to diagnose disease. While this matter does no doubt apply to the majority of announcements, the issue can be less clear-cut than would at first seem, if it is considered in the light of the contemporary controversies which occasionally arise relating to the notion of 'brain death'. However, having noted this exception, it is unlikely that most relatives would question the validity of such an announcement.

The response to the death announcement can vary, but this is one occasion on which the relative is allowed to 'flood out' (Goffman 1961

p. 55) as mourning begins, without fear of sanction. During this period the announcer usually waits silently until the relative reopens the interaction which may then proceed to the matter of cause, the matter of pain and the matter of preventability. Some attention is then paid to the matter of 'shoring up after delivery'.

The nurse is frequently present with the relatives in the early stage of their grief either because she is the announcer or because she has been delegated to make them a cup of tea. The 'cup of tea' is universally prescribed by all the nursing textbooks as a practical way of coping with the initial grief of the relative, (this) "is usually appreciated more than a lot of empty words even if it is not drunk" (Bickerton and Sampson p. 117). (There appears to be no evidence to suggest that the textbooks are correct in this assumption.)

This period of time is seen as particularly stressful by a number of nurses:

> "After the patient died his wife kept hugging me. I didn't know what to say, it all sounds so false."
>
> (3rd Year Nurse)

> "If you've been close to the patient or his family, sitting with them after the patient's death can be distressing as you share their grief. In a short time you can get very close to people."
>
> (SRN)

The nurse's own personal experience of bereavement may increase the difficulties of this situation:

> "One thing I can't face very well is staying with the relatives of children who have died from drowning. That always upsets me because I have experience of it in the family."
>
> (SEN)

Some nurses felt that it was wrong to show emotion at this time:

> "It could be upsetting dealing with bereaved relatives but if we took it too deeply then we wouldn't be nurses. If you get upset it affects your work, and that still has to go on when the relatives have left the ward."
>
> (SEN)

Other nurses felt that they were unable to separate themselves in this way:

> "You cannot disassociate yourself, especially in the sudden death situation. I know that's what I was taught, but I can't do it."
>
> (SEN)

Just occasionally the relative will arrive on a ward after the patient has died but before the relatives have been contacted. If the patient has 'arrested'[1] then the staff may have only just completed their unsuccessful attempts at revival, and the patient may be surrounded with equipment:

> "Although she'd died I had to keep him out of the room and I didn't know what to tell him, he wanted to see her but they were clearing up and I didn't know what to say, it was just awful."
>
> (SRN)

On the other hand, if no arrest procedure has been instigated the relative can see the patient right away if he wishes:

> "I've never seen anybody die so peacefully. One minute he was speaking to me, the next minute he lay back, and I realised that he'd died. It startled me for a moment, but I straightened him up and as I walked out of the door there was his daughter and son-in-law walking down the corridor. I had no time to do anything but tell them there and then. She burst into floods of tears and asked exactly what had happened. She wanted to see the body, nothing would have stopped them from going in, but he looked really peaceful and it was lovely for him to go that way."
>
> (SRN)

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1. A 'cardiac arrest' is said to have occurred if the heart stops beating. When this happens resuscitation measures are immediately instituted.

We shall now turn our attention to the final part of the dying process, that of the dismissal of the relatives.

8. The 'Dismissal' of the relatives

Before the relatives leave the ward certain administrative duties need to be performed:

> "These functionalities allow the nurse to adopt a business-like conversational tone and allow the relative to concentrate his attention, thereby temporarily distracting him from his emotional reactions."
>
> (Fazakerly 1978, p. 21)

This aspect of interaction between nurses and relatives can be mutually supportive in that it allows the nurse to remain detached and calm. At this stage the nurse may have to ask the relative for permission for a post-mortem:

> "I always think it's easier if they have had a short period of time to prepare for the death. It's awful if you have to break the news when it's unexpected and then ask them if it's O.K. for a P.M."
>
> (SRN)

("P.M." is an abbreviation used for post-mortem)

The nurse usually gives the relatives information concerning the actions which must be taken regarding the death certificate and the patient's property. The hospital in which the fieldwork took place also provides the relative with a leaflet which repeats the information. This leaflet opens with the words:

> "We hope the following information will help you at this sad time when it is often difficult to remember what Sister or Staff Nurse has suggested you should do."

and ends with the sentence:

> "If we can be of any further help to you please do not hesitate to contact the hospital administration department."

"Dead on Arrival"

One other aspect of the process of dying should be discussed because of its relevance to the present study. A number of patients brought to the hospital are "dead on arrival", abbreviated as DOA, either due to accidental or natural causes. The relatives in most instances will have been informed by the police that an incident or accident has occurred, but may well arrive at the hospital unaware that the seriousness of the patient's accident may already have led to his death. In these instances the doctor or nurse has no prior acquaintance with the relatives. When the relative arrives at the hospital his expectations are more or less formulated depending on the following factors:

1) his own presence at the accident,
2) his knowledge of the person's prior health,
3) the information he has already been given by ambulance drivers, police or any other sources.

Although the fact of having been called to the hospital will delimit the range of expectable happenings, the alternatives may be unclear.

Sudnow (1967) has described the task of the 'announcer' in this situation as one which must be taken on by someone who, although he/she may have had no contact with the patient, by sheer virtue of his location in the social structure of the hospital experiences:

> "the obligation to behave with some degree of accountability for the occurrence of an event beyond his ecologically accessible jurisdiction, involving a set of persons with whom no contractual duties had been undertaken, and a corpse whose previous breathing, generally speaking was never witnessed. By the fact of a death somewhere in the neighbouring streets or residences, and the corpse's delivery to his station, he must at least for a short while, assume the status of a committed involved party."
>
> (p. 135)

The relatives of patients who were "DOA" at the hospital in which the observation took place, were shown immediately on admission to the doctor's office which also served as a relatives room.

No such announcement was observed during the period of observation, but Sudnow has described the pattern he observed used by announcers during a number of such announcements. He pointed out that as soon as the doctor entered the room his manner defined the scene as an occasion of the utmost seriousness. The announcement was generally made within the first two sentences. One feature of the announcements made concerning the DOA patient was that in nearly every scene witnessed by Sudnow the opening remarks contained an historical reference and also some medically relevant antecedent:

> "Apparently Mr. Jones had a heart attack this afternoon and his body was too weak to fight it and he passed away."
>
> (p. 133)

After the relative has been told of the patient's death at St. David's Hospital he/she is visited by the Coroner's Officer or the mortuary technician in order for certain details to be exchanged. The Coroner's Officer in particular appeared to be held in high regard by the nurses in the hospital in which the study took place:

> "He's very good with the relatives. He'll often take them home afterwards and things like that."
>
> (SRN)

During the period of waiting, either for the doctor or the Coroner's Officer, the relative may be accompanied by a nurse. This could be a problem for the nurse who, in some instances, held certain information concerning the patient which he/she were unable to share:

> "If you are staying with one of the relatives of patients who have been involved in a road accident in which you know there was a fatality, it is very difficult to try and answer their questions until they have been told about it by the doctor or sister. I don't like to answer because I'm afraid of showing my emotions. I think it is important to hold back my emotions."
>
> (SEN)

> "It's even more difficult in our situation because you've never met the relatives before, and you don't know what sort of relationship they had previously with the patient, so you can easily say the wrong thing."
>
> (SRN)

Death in most cultures is surrounded by rituals and ceremonies. In our culture dying traditionally took place in the home surrounded by the family. More and more people are dying away from this environment in some form of institutionalised setting, in which the families' control of this process is severely restricted, and the "ebb and flow of events is controlled by routine and by strangers" (Glaser and Strauss 1968, p. 152).

The data has indicated that certain accommodations are made concerning the relatives of dying patients by the staff in that they are given a status which is different to that of other groups of relatives. However, this accommodation is unlikely to be of much help to the relative coping with the catastrophic nature of the event itself, and the foreign and threatening milieu in which the death is taking place, unless the nurse is able in some way to replace the traditional support system provided by other relatives and friends if the dying process takes place at home. The indications are that although many nurses are aware that some 'support' is needed, there is some uncertainty concerning the way in which this should be offered.

It should also be pointed out that the nurse's role is a minimal one in the total readjustment which the relative has to make to his/her

new social situation following bereavement. Yet it is one of great importance for it is associated with the death event itself and the positive or negative attitudes to the nurse formed at the time of the death are remembered long afterwards. This was indicated in the interviews with relatives, some of whom described previous experiences concerning other patients and other nurses in other settings:

> "One nurse I shall always remember. She sat with me for what seemed like hours. She was really kind."

> "I don't like to complain but she (the nurse) was really abrupt every time we saw her. She seemed really cold and hard."

As was found with other aspects of the nurse-relative relationship, different nurses offered conflicting statements concerning their role vis-a-vis the relative, indicating the 'multiple realities' within which this relationship is constructed.

Conclusion

It has been shown in this chapter that nurses and relatives interact in a number of different ways during the different stages of the dying process. Some indication has also been given of the stress inherent in this situation, not only for the relative but also for the nurse. The particular difficulties of the nurse have been identified, concerning both the handling of such encounters and his/her lack of knowledge concerning 'how' relatives could best be helped. This perceived inadequacy of the nurse is consistent with the finding reported in Chapter 8 concerning the emotional needs of the relative.

Other studies, referred to in Chapter 2, have indicated that health professionals are still ill-prepared for this task. The findings of the present study, although they concern a very small sample of relatives

and nurses around the dying patient, would appear to support this proposition.

The data collected concerning the relationship between nurses and the relatives of dying patients appears to support the work of Glaser and Strauss (1965, 1967) concerning the social milieu in which dying takes place. In addition the data also supports the model described by Giaquinta of the reactions of families facing the crisis of death.

These models have helped to structure the data and have also helped to make sense of some of the utterances of the relatives in nurse-relative encounters taking place at this time.

We should now turn our attention to the socialisation of the nurse and relative.

CHAPTER 13

THE SOCIALISATION OF THE NURSE AND THE RELATIVE

Introduction

Throughout the previous chapters we have considered the different forms of encounter which take place between nurses and relatives in which the participants either adopt or are cast into a number of different roles. Before discussing the implications of these encounters we should turn our attention to the way in which nurses and relatives learn the specific behaviour appropriate to the different roles which they adopt or into which they are cast. We should also give some consideration to the different expectations held by the participants in the different forms of role relationships about how the 'self' and the 'other' should function within that relationship.

The process of learning to take on new roles, or socialisation, enables the novice to acquire the knowledge and skill to perform these roles. But this process also involves internalising certain values, beliefs and attitudes held by the members of the social group to which the novice aspires to belong. It was not possible, within the confines of this study, to explore sufficiently to be able to explain this process fully with regard to these two groups. However, some data was collected and this will be presented and discussed in this chapter in order to try and increase our understanding of this process.

The socialisation of the nurse

We have seen that in most of the encounters which take place between nurses and relatives the nurse adopts or is cast into an 'expert' role.

Some attention should therefore be paid to the way in which this 'expert' knowledge is acquired by the nurse. We shall at this stage, for reasons which will become apparent later, focus on the knowledge acquired by the nurse concerning the 'management' of nurse-relative encounters, by discussing how she acquires the interpersonal skills associated with the 'expert' role.

Each School of Nursing in this country interprets the syllabus laid down by the General Nursing Council and incorporates this interpretation into the curriculum for nurse training within the individual hospital. The curriculum within the School of Nursing, which was a part of the hospital in which the study took place, stipulates that all student nurses should be 'taught', that is given information concerning the role of the relative in hospital, focussing on 'family participation in care', 'visiting patients in hospital - needs, problems, behaviour' and 'bereavement'. The curriculum also included a section stipulating that student nurses should be given information concerning the 'nurse-patient-relative relationship - appropriate methods, expectations, problems and resolutions'.

It was not possible to discover exactly how much attention was given to these matters within the school, nor how the effectiveness of the teaching was evaluated. Nor would this have been entirely appropriate, for, although it would have given some indication of what student nurses at different levels of their training at St. David's at the present time were likely to 'know', it would not be relevant to those nurses who qualified in other hospitals, nor for those who qualified some years ago. However, it was considered that most would have some recollection of the way in which they had acquired 'knowledge' about different aspects of the nurse-relative relationship by 'formal' instruction.

All of the nurses who were interviewed were therefore asked whether they had received any 'formal' instruction, either by a lecture in the school, or during a teaching session on the ward, concerning, firstly, how to communicate with relatives and, secondly, concerning the specific needs of the relative of a patient admitted to hospital. This was followed by a question which focussed on 'informal' methods of teaching.

The results presented below need to be interpreted with some caution, but they do give an indication of the difficulties which nurses perceive in this area. A cautious interpretation is necessary firstly because the number questioned is small both in terms of nurses in this country as a group, and also in terms of nurses both trained and in training at St. David's. Secondly, it is now recognised that it would have been better to ask the nurse first of all to focus on communication skills in general, and then to ask a specific question concerning the relatives. Thirdly, a much more sophisticated tool should have been used in an attempt to overcome the "I can't remember" response proffered by 21 out of the 56 respondents. However, in spite of the methodological problems the responses were not very different from those reported in other 'communication' studies (detailed later in the chapter).

The results: of the 54 nurses questioned concerning 'formal' instruction:

a) 21 nurses "couldn't remember"

b) 12 nurses were positive that they had never received any formal instruction

c) 11 nurses recalled specific instances of formal teaching

d) 10 nurses stated that "you can't teach that sort of thing".

a) "Couldn't Remember"

Of the 21 nurses in this group, 15 were trained, and it is possible

that had they been asked this question earlier in their career they might have answered differently.

b) No Information

7 of the nurses in this group were trained, 2 of these more than 5 years ago. There appeared to be no difference concerning the location of the nurse's education; nurses who had been trained locally and those who had trained elsewhere appeared in all the groups in similar numbers.

c) Specific teaching

The 11 nurses who were able to recall specific examples of teaching were then asked to describe in as much detail as possible:

a) where this teaching had taken place,

b) the role-identity of the teacher,

c) the content of the 'lesson'.

"Where" - 2 of the nurses named the ward, the rest named the classroom as the location in which the specific teaching they had received took place.

"Who" - One nurse indicated that the ward sister had adopted the teacher role, and one nurse specified a clinical teacher as the instructor in the ward area. The teaching in the school was shared between tutors and clinical teachers.

"What" - The content of the 'lessons' as recalled by the nurses related to the identification of the needs of the relative rather than to specific instruction concerning 'how' these needs could be met:

> "Sister - explained to us how relatives get very upset, especially if the patient is an emergency, and how they need reassurance and comfort."
>
> (SEN)

> "We did some 'wishy-washy' thing about death and the needs of the relatives in the classroom. It was all a bit

> embarrassing really. There were things we wanted to say but couldn't bring ourselves to. It's difficult to talk about it isn't it?"
>
> (3rd Year Student)

> "We were taught in school to include the relatives. What we were taught related to the patients' and relatives' background, not how to deal with the family at the present time."
>
> (3rd Year Student)

d) "You can't teach that sort of thing"

This was a completely unexpected response as it preceded the researcher's discovery that Dodd (1974) had also elicited this response to similar questions concerning communication skills. Dodd posed the question "Can you recall any talk, discussion, lecture or official time anywhere in your training so far on how to relate to people?" The initial response to Dodd's question was a 96% "No", of whom 70% also added "but you can't teach relational skills". It is difficult to explain why nurses respond in this way. It is possible that other occupational groups would also respond in this way although no information concerning this aspect was located.

The lack of specific instruction in communication skills has been identified in a number of other studies. Faulkner (1978), Wood (1979), Macleod-Clarke (1980). Other studies have specifically drawn attention to the lack of teaching concerning communication with relatives. Frost (1970) has indicated that "talking to relatives" is an art which is not usually taught in schools of nursing, and that the nurse is expected to "pick up the necessary elements as she progresses in her career", while Leonard (1979) has reported that when talking to a group of third-year nurses on "the subject of dealing with relatives" she was "saddened to find that it was their first formal lecture on the subject" (p. 1310).

Some of the nurses interviewed identified their own needs for further teaching concerning this aspect of nursing practice:

"I don't think we do get enough help with this in our training and it's too late afterwards. I could certainly do with more training in counselling."
(SRN)

"It's very difficult to know how to talk to them and help with their problems. It should be possible to receive some guidance about this."
(SRN)

A very small number of nurses interviewed (3) were also qualified psychiatric nurses. They, and some of the other nurses who had observed nurses with this training in action, believed that this form of education prepared the nurse to carry out their 'expert' role vis-a-vis the relatives more fully than the nurse with a 'general' nurse education:

"Often the relatives feel guilty. I have to remind myself that projected guilt looks like anger against us. I didn't need to think about it when I was doing my "psychy" (psychiatric training) but when you're in this sort of situation it's not so easy."
(SRN)

"We sometimes get 'psychiatric' nurses working in the department. They have different attitudes to patients and relatives - more friendly, I suppose, less reserved. I don't know how to talk to patients that way."
(SEN)

After describing their formal instruction all the nurses were then asked to describe the other ways, apart from formal instruction, by which they believed they had learnt or were learning to communicate with patients' relatives. The replies fall into four groups, a small number of nurses naming two methods:

1) By making mistakes and/or by trial and error : 22
2) Picking it up as you go along : 19
3) Watching other people do it : 22
4) Don't know : 10

(There is probably no real distinction between (2) and (3) but they are classed as they were 'offered').

It would appear from these results that most of the skills which

nurses acquire in order to communicate with relatives are acquired in the ward itself, for as Bendall (1975) has pointed out, trainee nurses will follow the role models they find in the clinical situation rather than what they are taught in the school. 'Teaching by example' is the traditional method of nurse training. It is, however, haphazard. It is relevant that during the fieldwork, when 'senior' nurses were carrying out this task, it was observed that 'junior' nurses were in most instances occupied with other tasks so that they could neither see nor hear the encounters taking place between the 'knowledgeable' role-model and the relative. It is not, therefore, surprising that 22 of the nurses questioned (40.7%) believed that they had 'learnt' by 'trial and error' or 'by making mistakes'.

However, it should also be pointed out that very occasionally it was observed that a 'senior' nurse asked a 'junior' nurse to stay with her while she spoke to the relatives.

The trained staff who were interviewed, were also asked a question concerning their own teaching of students and pupils with regard to communicating with relatives.

All of the SEN's questioned stated that they had never taught students or pupils about this. Six of the SRN's believed that they did teach students and pupils about communicating with relatives, but that this was done informally rather than formally.

> "At report I try and make them 'aware' of potential problems rather than actually teaching them. In this way it is related to a real situation."
>
> (SRN)

The inadequacy of the 'teaching' was also recognised:

> "Most of the teaching we do is done spontaneously, but I probably don't put much emphasis on how this (talking to relatives) should be done. We probably accept that the school does this."
>
> "Did it do this for you?" (researcher)

"Well frankly No!" (SRN)

"I may mention it in passing, but it's an area of nursing that often gets forgotten." (SRN)

We have focussed so far on the "how to do it" knowledge required by the 'expert' nurse, pointing out that most nurses perceive that they are inadequately prepared to carry out this task. However, the knowledge base of the expert comprises not only "how to do it" knowledge, but also other forms of knowledge. These other forms of knowledge will be discussed in the next chapter.

We have so far limited the discussion concerning the nurse's socialisation to the 'preparation' she receives for her role as 'expert' in nurse-relative encounters. But this is a very small part of the nurse's socialisation process into the role of a health professional. A number of studies have been carried out concerning the socialisation of the nurse (see Anderson 1973 for bibliography) showing that he/she gradually absorbs the values, attitudes and beliefs shared by other health professionals within the hospital organisation. From these values, attitudes and beliefs the nurse develops a theory both of what nursing is and of the place of the relative within that structure. The nurse also constructs a model of what a 'good' relative is and what a 'difficult' relative is. Some indication has already been given that 'good' relatives "do not interrupt the routine" and "do not ask too many questions" There are, however, other dimensions to the 'good' relative and to the 'difficult' relative. These should be considered for they are the social constructs which occur as a result of nurse socialisation and which the individual nurse brings to each encounter with the relative.

Some nurses found it difficult to identify the characteristics which defined a good relative, although they all accepted that they

'labelled' relatives as 'good' or 'difficult'. Because the 'good' relative was not perceived as a problem, most nurses had not really considered how they came to be so defined:

> "Good relatives? You don't really notice them, do you?" (SRN)

> "I've never thought about what makes a good relative. I can tell you what makes a difficult one though!" (SRN)

The 'good' relative characteristics identified by the nurses interviewed related (a) to the relative as a person, (b) to the patient, (c) to the organisation, and (d) to the nurse.

a) The 'good' relative as a person is one:

"who is able to cope"

"who is able to use his/her common sense"

"who is 'tolerant' and 'nice'.

b) The 'good' relative vis-a-vis the patient is a person:

"who visits regularly"

"who shows an interest in the care of the patient and his/her treatment"

"who accepts that everything is being done for the patient's good".

c) The 'good' relative vis-a-vis the organisation is one:

"who accepts that the hospital cannot be as personal as home"

"who visits only in set hours"

"who leaves when asked".

d) The 'good' relative vis-a-vis the nurse is one:

"who lets the nurse get on with her job"

"who listens"

"who asks questions at the right time".

'Difficult' relative characteristics were much more easily identified by the nurses interviewed, and were also related to the same four categories as the 'good' relative.

a) The 'difficult' relative as a person is one:

"who expresses his guilt as anger"

"who worries unnecessarily".

b) The 'difficult' relative vis-a-vis the patient is one:

"who doesn't come when needed"

"who thinks that once the patient is admitted that that is the end of his/her responsibility"

"who brings all their personal troubles to the patient making him/her anxious"

"who is disinterested in the patient's treatment".

Some of the interview data concerning 'good' and 'difficult' relatives related to relatives who were the parents of children admitted as patients.[1]

'Difficult' mothers are those:

"who do not persuade the child to co-operate"

"who refuse to give consent for the child's treatment"

"who send children to the hospital on their own as out-patients, for uncomfortable procedures".

c) The 'difficult' relative vis-a-vis the organisation is the person:

"who cannot understand that there are other patients who need more attention than <u>their</u> patient"

"who becomes 'stroppy' if they have to wait, either in the Accident and Emergency Department, or outside the ward for whatever reason"

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1. The small amount of data concerning the mothers and fathers of children admitted following non-accidental injury is not included because the emotional response of the nurse to such a situation could indicate the perception of the nurse to the situation, rather than his/her response to the individual relative.

"who expects too much from the National Health Service, e.g. transport".

d) The 'difficult' relative vis-a-vis the nurse is the person:

"who is 'belligerent', 'rude', 'antagonistic' and 'demanding'"

"who will try and tell the nurse what he/she should do"

"who bothers the nurse with trivial things"

"who will interrupt even though the nurse is busy"

"who will 'shop around'".

Violent relatives were also classified as 'difficult', although such relatives were usually only found in the Accident and Emergency department. This mode of behaviour was always associated by the nurse with either extreme stress or with alcohol. Some relatives were also classified as difficult because they "encouraged others to be difficult", although no nurse specified 'how' this could happen.

The picture which emerges is one of a very well-defined model of the difficult relative, which develops as a result of the nurse's socialisation, in which certain characteristics are labelled as more desirable than others, and which is reinforced as a result of experience. However, it should be pointed out that while this model was applied by nurses to relatives, almost every nurse pointed out that difficult relatives are in a minority:

"Yes there are difficult relatives, I've certainly met a few, but on the whole most relatives are very good."
(SRN)

"You come across them now and again, they look at you as if you're a tyrant that they're determined to overcome, but I can't really say I have much trouble with them."
(SEN)

We have so far considered the preparation of the nurse for her 'expert' role as part of the socialisation process into the role of the nurse, and also briefly examined the way his/her socialisation could

lead to the development of models of 'good' and 'difficult' relatives.

We should now turn our attention to certain aspects of relative socialisation.

Relative Socialisation

Some attention has already been given to different aspects of relative socialisation throughout the text. It was indicated in Chapter 5 that the protocol of visiting was not left to chance but that certain measures were adopted by the organisation, and by the nurse as a representative of that organisation, to ensure that the relative adopted the 'correct' modes of behaviour commensurate with the role of visitor as defined by the organisation.

An indication was also given in Chapter 7 that the socialisation of some relatives prior to the patient being admitted to hospital, made them more likely to be successful in the role of 'information gatherer'. It was also pointed out that some relatives adopted the strategy of 'shopping around' in order to clarify or obtain further information concerning the patient.

'Becoming' a relative, unlike 'becoming' a nurse, does not admit the role incumbent to a tightly-knit social group with well developed values, beliefs and attitudes. However, there is a small amount of data which indicates that not only do some relatives have certain 'relative skills' before the patient is admitted, but that some relatives also develop relative skills during their relative career.

Some intimation was given concerning this in Chapter 6 in which the initiation of encounters was discussed. There it was shown that some relatives 'selected' an appropriate nurse based on their previous experience of encounters with a number of nurses. Other relatives also

'learnt' to select an appropriate nurse after a short period of being a relative, based either on the recommendations of patients and other relatives or on their own perception based on their acquired knowledge concerning the status in the hierarchy of different nurses.

During the period of the patient's stay in hospital some relatives not only talked to the patient, but also to other patients and their relatives. In this way the more experienced patients and relatives passed on the culture of the ward. Snatches of such conversations were recorded during the field work:

1) "The nurse won't be able to help you with that my dear, it's the social worker you need."

"How do I get hold of her?"

"Oh you'll have to ask the nurse first, she'll make an appointment for you."

2) "I always try and see sister in the afternoon, she's not so busy then."

3) "No, that one's a voluntary worker, not a nurse, the nurses wear hats."

It was also noted that when one relative left a ward to enquire about a patient, on his return other relatives in that small ward area would perceive that it was a 'suitable' time for such encounters to take place and would also try and initiate an encounter. Similarly it was also noted that when one relative in the Accident and Emergency department decided to leave the waiting area to try and find out what was happening, other relatives did the same.

It was not very easy for relatives to acquire the interactional skills they needed to be a 'successful' client, for they had little opportunity to observe other relatives in the client role. However, there is some evidence to show that as relatives become more familiar with the role of client they become more confident in using their new knowledge to formulate specific questions, and therefore increase the likelihood of their obtaining the information they required.

It was not possible to question relatives about their perception of the way in which they had acquired 'relative skills', but there is some indication in the numerous conversations held with relatives that they realised that they had made some positive effort to 'learn' the role:

1) "I asked my brother who I should see when my wife came in if I wanted to know anything. His wife was in last year so he knew the ropes."

2) "Well it's a bit strange when you first start visiting - you're not sure what to do or where you can go or even who you can see. But you soon see what others do."

One more point should be made concerning the roles of the nurse and expert and the relative as client. The socialisation process of the nurse prepares her to manage many different encounters with many different relatives concerning many different patients. The relative is socialised to become a client relating only to his/her and the patient's needs, he is therefore better placed to penetrate the strategies and assumptions which the nurse brings to the encounter. The relative can achieve a very powerful position in the encounter for he is in a position to by-pass the nurse by appealing to the doctor or to the hospital and if necessary to by-pass the organisation, by appealing to the Ombudsman. It is not, therefore, surprising that the relative may appear intimidating to the nurse, if he/she adopts

a form of behaviour which the nurse perceives as difficult. This of itself can be helpful to the relative in that he/she may achieve his/her ends, but it can also be counter-productive, for the nurse may react negatively.

Having considered, albeit briefly, the socialisation process of both the nurse and the patient's relative, we should now discuss the findings reported in previous chapters.

CHAPTER 14

DISCUSSION OF FINDINGS AND IMPLICATIONS FOR NURSING PRACTICE

Introduction

The first objective of this study was to determine the purpose and form of the encounters which take place between nurses and patients' relatives. This has been described in previous chapters. We must now turn our attention to the second and final objective of the study and try to account for the behaviours described, for as Weber has indicated, the task of the sociologist is to make sense of, or understand, the meanings and motives which people bring to their behaviour.

We shall begin by listing the main findings. This will be followed by a discussion of these findings which will enable us to consider their implication for nursing practice.

Summary of Main Findings

1. It has been shown that due to social change the roles of both of the participants in the nurse-relative relationship have undergone considerable change, particularly during the last twenty years. There is also some suggestion that these roles are still in transition.

2. It has been shown that the encounters between nurses and patients' relatives take place in a work setting in which the work of nurses is routinised, and that relatives as work objects are not easily incorporated into the routine. Therefore all aspects of

nursing practice vis-a-vis the relative are subject to work-flow uncertainty.

3. It was found that:

   a) most encounters between these two groups are purposeful interchanges engineered by one or other of the participants for a specific purpose, and that

   b) most encounters between these two groups are initiated by the relatives (75.5%).

4. It was indicated that in most nurse-relative encounters the participants either adopted or were cast into different roles relating to the purpose of the encounter, resulting in a number of role-specific forms of the nurse-relative relationship. In most of these role-specific forms of nurse-relative relationship the nurse adopts or is cast into the role of 'expert', while the relative adopts, or is cast, into the complementary role of 'client'.

5. The different forms of client-expert encounters which were identified are:

   a) the relative as a 'gatherer of information' - nurse in a complementary role,

   b) the nurse as an 'announcer/forewarner' - relative in a complementary role,

   c) the nurse as a 'counsellor', 'giver of advice', 'reassurer' - relative in a complementary role,

   d) the nurse as a 'collector of information' - the relative as a 'surrogate patient',

   e) the relative as 'patient's agent' - nurse in complementary role,

f) the nurse as 'teacher' - the relative as 'learner',

g) the nurse and the relatives of the dying patient,

h) the nurse as 'host' - the relative as 'visitor'.

6. It was found that many nurse-relative encounters which were engineered for a specific purpose, could be described as 'successful' in that the objectives for which the encounter was initiated were achieved. It was also found that, by the same definition, some nurse-relative encounters could be described as 'unsuccessful'.

7. It was found that in some nurse-relative encounters nurses would adopt behaviour patterns which can be described as avoidance strategies. The avoidance strategies identified were those of 'role-switching', 'making excuses' and 'making a non-response'.

8. Finally, it was shown that some relatives are more competent than others at 'gathering information'.

These findings will now be discussed in more detail, the first three in short individual sections, the next four together in one section for these would appear to be the most significant and that the other findings relate to these, and the last finding in a short final section.

1. The effect of social change on the nurse-relative relationship

The traditional nurse-relative relationship was constrained by organisational rules which defined the behaviour of both nurses and relatives within the hospital setting. The rules which governed the form of interaction which could take place between these two groups served to protect the nurse, for they helped to legitimate her authority within the hospital hierarchy and provided her with a secure

base from which she could operate. In this way they protected her from unwanted responsibility. Although the evidence is sparse concerning the traditional nurse-relative relationship, the indications are that the role of the nurse within that relationship was mainly confined to ensuring that the relatives conformed to the rules concerning both access and behaviour. This is supported by the indication that a 'conspiracy of silence' (Titmuss 1963) existed between the nursing and medical profession with regard to information concerning the patients' illness, and that little account was taken of relatives' psycho-social needs at that time. The one group of relatives who did appear to receive other attention from nurses were the relatives of dying patients.

Changes within society during the post-war years have altered this traditional relationship. Organisational rules have had to be relaxed in response to environmental pressure and relatives now have certain expectations concerning both their need for information and other needs. Many of these changes have taken place within the working life of nurses on duty in the wards at the present time, and in spite of administrative changes vis-a-vis the social position of the relative, traditional attitudes among nurses still, to some extent, persist.

Resistance to change is a well recognised occupational phenomenon. Johns (1973) has pointed out that "despite the adaptive characteristics of man as a biological organism, resistance to change is an endemic feature of the work environment" (p. 14). Individuals tend to resist change because they want to maintain an existing equilibrium. It has also been pointed out that it is not the change itself which causes the resistance, but the meaning of the change for the people involved (Sayles and Strauss 1966).

The meaning of the change for nurses is quite considerable. Firstly it has been shown in the text that the present-day role of the nurse

vis-a-vis the relatives takes many forms, in which the nurse either adopts, or is cast into the role of 'expert', while the relative adopts or is cast into a complementary role. Secondly, it has also been shown in the text that the nurse is not well prepared through her nurse training programme for this expert role. Thirdly, relatives are now in the ward itself for long periods of the day, and can therefore 'interrupt' the work flow. Finally, the role of the nurse vis-a-vis the relatives is still subject to a shifting definition, and the task of 'seeing the relatives', unlike other nursing tasks, is not yet clearly defined between doctor and nurse, nor is it a task which can be easily 'procedurised'.[1]

All of these factors give rise to uncertainties. The nurse is no longer in a well-defined role, nor does she have the protection of the rules to offer her security within the relationship. In this way although the changes have been beneficial for both of the participants in the relationship in that they allow the possibility of greater negotiation, they may, because of the lack of preparation for the 'expert' role, be undesirable to some extent for the nurse.

2. Work-flow uncertainty

Work-flow uncertainty was also traditionally controlled by the organisational rules which restricted the relatives' access to the ward. When this control was removed the nurse was forced to adopt the organisational task of 'smoothing the input' for as Mott (1972) has indicated "organisations abhor uncertainty".

The task of 'smoothing the input' can be difficult, for the needs of relatives cannot easily be predicted. Relatives are also present in the ward for long periods of the day, during which time there is always a possibility that they will 'interrupt' the work-flow. One

1. Many nursing tasks are carried out according to the 'procedure' for each individual hospital. The 'procedures' were drawn up by a Procedure Committee made up of senior nurses in the hospital in which the research took place.

way by which the work-flow can be maintained is to reduce the possibility of 'interruption'. 'Interruption' of the work-flow is deterred in two ways. Firstly, by the prevailing ethos of the ward, that of 'being busy', and secondly by the adoption of individual strategies.

'Being busy' is related to 'getting the work done' which of itself is related to the routine of the ward. This of itself creates a barrier between the relative and the nurse. If the relative perceives a need to interact with a nurse for some purpose, she/he needs to breach the barrier which is erected by this group strategy.

Nurses were also observed to adopt individual strategies which likewise effectively created a barrier which had to be breached by the relative. The two individual strategies adopted by nurses were those of the 'legitimate gait' and of 'seeing but not seeing'.

The use of such strategies was justified by nurses in terms of 'getting the work done' and relative who did not interrupt the work-flow were perceived as 'good' relatives.

3. Nurse-relative encounters as purposeful interchanges

Most of the encounters which take place between these two groups are engineered for a specific purpose, and most of them are also initiated by relatives (75.5%). However, because of the prevailing ethos of 'being busy', and the other strategies adopted by nurses which deter the relative from initiating encounters, the relative has to perceive that the purpose for which he desires to initiate an encounter with a nurse is important enough to breach these barriers. In some instances it was found that the relatives finally decided that their perceived 'purpose' was too trivial, compared to the nurses' 'busyness' which they needed to interrupt.

The importance of this finding cannot be overlooked and will be discussed again later in connection with the implications for nursing practice.

4-7. The nurse as an 'expert' and the relative as 'client'

We should now consider the other findings of this study, concerning the nurse-relative relationship as an expert-client relationship. It has been shown throughout the text that in the majority of nurse-relative encounters the nurse is cast by the relative into the role of 'expert'. She is cast as an expert in the role of 'information giver' in response to relatives' questions; he/she is cast as an expert 'counsellor', 'giver of advice', and 'reassurer'; finally, she is cast as an expert in the care of the relatives of the dying patient. In all the other forms of relative-nurse encounter the nurse herself adopts the role of expert.

It has already been pointed out that this is a comparatively recent development in the nurse-relative relationship, and there have been indications throughout the text that although the nurse may be cast into this role, there are times when she is unable to fulfil it.

It has been shown in previous chapters that in some instances the role behaviour of the nurse as 'expert', possessing such a body of knowledge, was commensurate with the relatives' expectations. But it has also been shown that in a number of encounters the nurse did not display 'expert' behaviour as expected by the relative, so that the original aim of the interchange was not necessarily achieved.

In order to understand the behaviour adopted by nurses when 'cast' into the expert role, some attention must again be paid to the socio-structural factors, described in the text, which appear to constrain the knowledge base of the nurse. It will be argued in this discussion that the conflict which occurs because of the relatives' expectations of the nurse, and her own lack of knowledge to fulfil these expectations, leads to role strain. It will also be argued that the avoidance strategies used by nurses in some nurse-relative encounters are chosen by him/her to minimise role strain.

Role strain occurs if, after being 'cast' into a role the role incumbent does not have the 'knowledge' to fulfil that role, for as Znaniecki (1940) has indicated "every individual who performs any social role is supposed by his social circle to possess the knowledge indispensable for its normal performance" (p. 24).

Before relating the notion that the nurse adopts certain strategies to minimise role strain to the evidence from the data, we shall first establish that the knowledge, which is necessary to fulfil the role of nurse as expert vis-a-vis the relative as client, is constrained in different ways. We shall do this by relating the socio-structural factors which have been identified in the text to the 'expert' role of the nurse as an 'information giver', for it was in this role that either all or a combination of these constraints could operate, although, as indicated in the text, some of these constraints could also operate on all of the other 'expert' roles into which the nurse was cast.

Before looking at these factors we should briefly state the 'knowledge' required by the nurse to carry out the 'expert' role of 'information giver'. In order to meet the relatives' need for

information it was suggested in Chapter 7 that the nurse required three different sorts of knowledge:

(a) she needs to 'know' the answer to the relatives' question(s),

(b) she needs to 'know' that she is 'allowed' to give the relative the information required,

(c) she needs to 'know' how to give the information in a way which is understood by the relative.

The factors which constrain this 'knowledge' will be considered under four different headings, although this is to some extent an artificial division, for there is some overlap between these different factor-groupings. Attention will first of all be paid to the 'patient factors', followed by a discussion of the 'doctor factors', 'nursing/medical practice factors' and 'nursing/practice factors' (see diagram overleaf).

Patient factors

The expert role of the nurse as information giver is to some extent constrained by two factors relating to the patient. In the first instance, the nurse can be constrained by the concept of 'medical uncertainty', and secondly, the nurse can be constrained by the notion of 'confidentiality'.

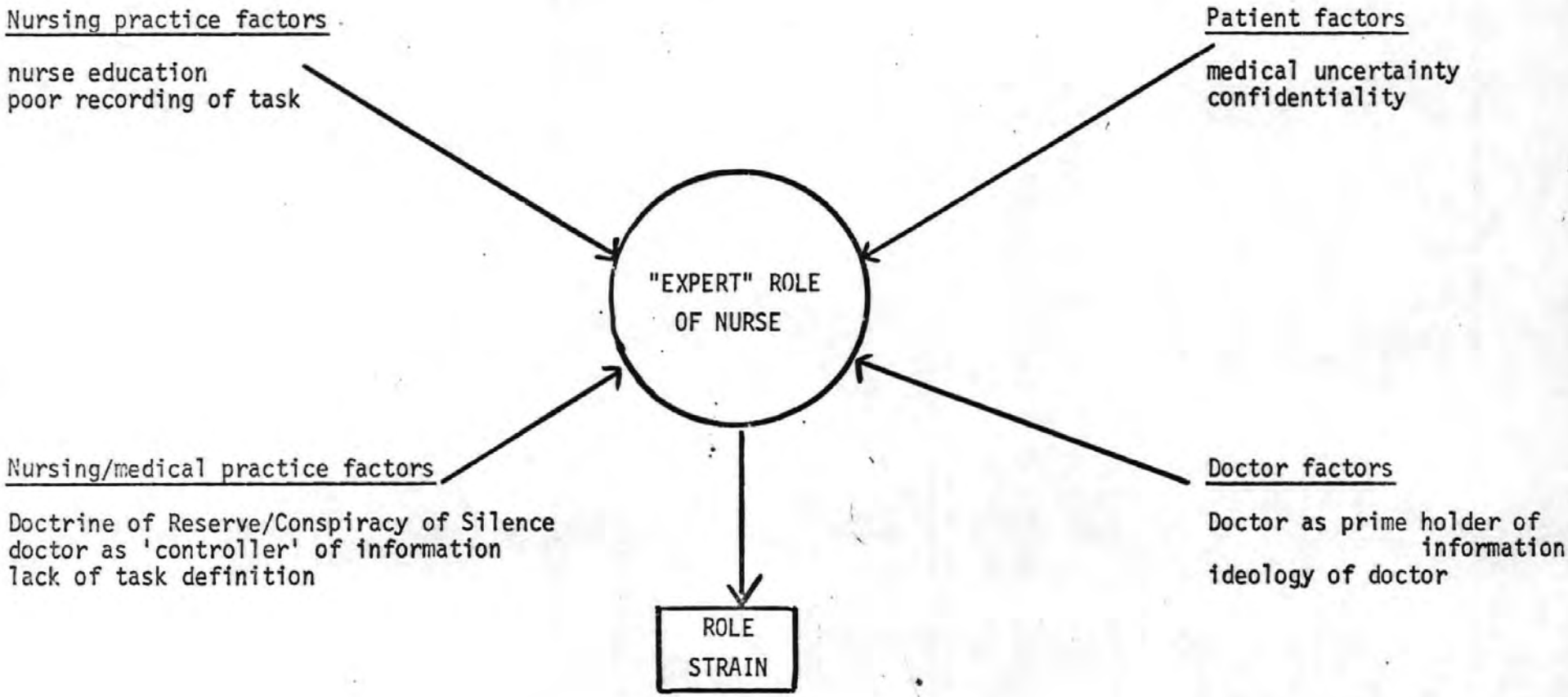
a) Medical uncertainty

There is an element of medical uncertainty associated with the treatment of illness which to some extent constrains all information concerning the patients' diagnosis. Although this element exists, a

TABLE 6

FACTORS WHICH CONSTRAIN THE 'EXPERT' ROLE OF THE NURSE

LEADING TO ROLE STRAIN



number of studies have indicated that this is not a central determinant of what is, or is not, communicated to patients and relatives (Davis 1965, McIntosh, 1977). Davis (1965) concludes that "clearly ... clinical (medical) uncertainty is not responsible for all that is not communicated to the patient and his family. Other factors, interests and circumstances intrude in the rendering of medical prognoses ..." (p. 318). However, medical uncertainty, while by no means the only factor which can constrain the knowledge base of the nurse, cannot be totally disregarded.

b) Confidentiality

Some information concerning the patient's illness will remain confidential to the patient himself, either at his request or because a professional judgement concerning the nature of the information is made. This was particularly evident in the gynaecological ward, in which nurses were given specific instructions concerning matters which the patient might wish to remain confidential.

The knowledge base of the nurse is constrained by these two notions, that of clinical uncertainty, and that of confidentiality in two different ways. Because of the former, the nurse may not 'know' the information requested by the relative and because of the latter she may 'know' the information but not 'know' whether or not she should share this information with the relatives.

Doctor factors

a) Doctor as 'prime holder' of information

It was shown in the text that the doctor as the director of the patient's care is the 'prime holder' of all the information available

concerning the patient's illness. Some of this information will be shared with the nurse, but there will be times when the nurse will be confronted by questions for information which she at that time does not 'know', although the information is 'held' by the doctor. This creates a problem because of the relatives' expectation that the nurse is of sufficient status within the hospital hierarchy to also 'hold' such information. This is not a universal expectation, for in some cultures nurses are not perceived to hold this status and would not be 'cast' into this role. The relative would, in such cultures, go directly to the 'prime holder' of the information, i.e. the doctor for this information.

b) The ideology of the doctor

There is some evidence that in addition to responding to the doctor as an individual, with individual preferences which can be accommodated, nurses also respond to the ideology of the doctor. Geertz (1964) has suggested that ideologies give cognitive and normative order to particular aspects of social realtiy, and that by 'naming' situations they entail an attitude towards them. He has pointed out that the construction and use of an ideology takes place in the public world where "people talk together, name things, make assertions, and, to a degree, understand each other". In this way, although 'the doctor', as perceived by nurses, means more than the individual doctor, this meaning may not be subject to standards of scientific rationality, but it serves to make sense of action in a particular situation.

Closely related to the 'doctor factors' are those factors which relate to medical/nursing practice. We shall therefore discuss the way that the 'doctor factors' constrain the nurses' knowledge base, after we have discussed this third group of socio-structural factors.

Medical/nursing practice factors

a) Doctrine of Reserve/Conspiracy of silence

It would appear that information concerning the patient's illness was traditionally withheld from the relative, and from the patient, and that a 'conspiracy of silence' could be detected between nurse and doctor in this matter (Titmus 1963). Withholding such information was legitimised as being in the patient's (and relatives) best interests, but as Schrock (1979) has indicated, this claim rested largely on "paternalistic assumptions of professional superiority" (p. 147).

A number of studies carried out in the early 1960's identified 'lack of information' as a major source of complaint among patients and relatives (McGhee 1961, Skipper 1965, Cartwright 1964 and others). In response to the discussion provoked by such studies it would appear that the traditional 'conspiracy of silence' no longer constrains information-giving to the extent which it did thirty years ago. This is not to suggest, however, that there is not some sort of 'conspiracy' between nurses and doctors concerning the withholding of information. It has been suggested in the text that from the data collected for this study, the indications are that a 'doctrine of reserve' operates, so that the amount and type of information given to patients and relatives is related to a 'professional judgement' concerning the 'suitability' of the patient or relative to receive such information. This proposition would need to be tested more vigorously before positive assertions could be made, but there is evidence to suggest that such a notion is perceived by some of the nurses interviewed, and as such constrains the nurses' 'expert' role.

b) The doctor as 'controller' of information

Closely related to the 'doctrine of reserve/conspiracy of

silence factor' is the doctor's institutionally defined status as 'controller' of the information to be shared with others. He/she makes the decision concerning how much information is to be shared with the relative, and, as has been indicated in other studies (Faulkner 1980, Rosenthal and others 1980), as well as in this study, nurses usually abide by this decision even in those instances when they privately disagree with it.

c) Lack of task definition

It was shown in the text that historically both doctors and nurses were involved in applying the rules which controlled the relative's access to the patient and his behaviour. At present the task of 'seeing' the patient's relatives is one which is still shared between doctor and nurse. In some instances the arrangements for 'who does what' were clearly defined, the doctor making a positive statement that he wished to 'see' certain relatives, likewise some relatives would ask to 'see' the doctor. But, as already indicated, most relatives expected the nurse to be able to fulfil this role. The problems which occurred related to the nurse's perception of whether or not this was a nursing or a medical task.

The lack of task definition is not unique to the task of 'seeing the relatives', but it acted as a constraint on the nurse's knowledge concerning whether or not she was 'allowed' to give the information requested by the relative.

It was not possible, within the confines of the present study, to discover exactly how 'who does what' was established, although this might have been a useful contribution to the present debate concerning the division of labour within the medical and nursing profession,

encapsulated in the concept of 'the extended role of the nurse'.[1]

The factors which arise out of the doctor/nurse relationship appear from the data collected for this study to be more significant than those which arise from the nurse-patient relationship and those which arise out of nursing practice.

It has already been suggested that the 'reality' may be less significant than the ideology, for as Dodd (1974) has indicated, although the consultant is a major influence on the social activity of a ward, there is little evidence to indicate that there is any direct interference by doctors into nursing 'work'.

In the present study the indications are that nurses were left, in most instances, to make the decision concerning which relatives they perceived should see a doctor, and which relatives they perceived they were 'expert' enough to manage. However, this somewhat over-simplifies the issue for the ideology of the doctor is very pervasive in this aspect of nursing practice. Likewise, nurses often have no option but to 'front' for the doctor, for the nurse is always geographically located in the ward and the doctor is not always 'available'.

The combination of all the factors which arise out of the nurse-doctor relationship appear to constrain both the nurse's actual 'knowledge' concerning information of the patient's illness, which may be requested by the relative, and her knowledge of whether or not she is 'allowed' to share this information with them.

Before we finally consider the effect of these constraints we must turn to the last group of factors which may affect the nurses' 'expert'

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1. For an account of the present state of the debate see the RCN publication "The Extended Clinical Role of the Nurse", 1979.

role. These are the factors which derive from nursing practice itself.

Nursing Practice Factors

a) Nurse education

It was shown in Chapter 13 that most nurses felt inadequately prepared for their 'expert' role vis-a-vis the patients' relatives. This finding relates to similar findings concerning the communication skills needed by the nurse to fully meet the needs of the patient (Faulkner 1980, Clarke 1980). This acted as a constraint on the nurse as an 'information giver' for she was not always able to give the information required in a way which was understood by the relative.

b) Poor recording of task

This would appear to be the least significant constraint on the expert role of the nurse, but it cannot be overlooked. If either a nurse or a doctor 'sees' the relatives, this fact is recorded in the patient's nursing notes. But very little indication is given in such notes concerning 'what' has been discussed. A brief phrase such as 'relatives seen by doctor' may summarise a five-minute interview. Nurses who are confronted by relatives at a later date will therefore 'know' that the relative has been seen, but in many instances will 'not know' what he/she has been told. This lack of knowledge can therefore lead to reluctance to discuss certain aspects of the patient's illness, because the nurse does not wish to give contradictory information.

We have so far in this section focussed on the socio-structural factors which can constrain the nurse's 'knowledge' as an 'expert information giver'. We should now consider whether or not these

factors can also constrain the other 'expert' roles into which the nurse is cast.

The two other 'expert' roles into which the nurse is cast are that of 'counsellor' (giver of advice and reassurance) and that of 'carer of the relatives of the dying patient'.

Nurse as counsellor (giver of advice and reassurance)

It was shown that this was a comparatively new role for the nurse, and that in most instances, nurses felt unprepared for this role. The 'knowledge' needed by the nurse in order to carry out this social role was more specific to the task, than the knowledge required as 'giver of information'. The nurse needed two sorts of interrelated knowledge for this role:

a) she/he needed 'knowledge' concerning the effects of illness and hospitalisation on the family,

b) she/he needed 'knowledge' of how to utilise such knowledge in order to effectively 'counsel', 'give advice to' or 'reassure' the relative.

This aspect of nursing practice was also to some extent constrained by medical/nursing practice factors and nursing practice factors. Firstly, it was constrained because of lack of task definition, not only between nurses and doctors but also between nurses and other members of the hospital organisation, for it was suggested by some nurses that relatives needing such help should be seen by either the medical social worker or the hospital chaplain. Secondly, the main constraint on this form of interaction with relatives was perceived by nurses to be the lack of preparation for this role in the educational preparation of the nurse. It was found that most nurses perceived that

they had little understanding of the psycho-social effects of illness and hospitalisation on the relatives, nor did they perceive that they had the necessary skills to intervene effectively in this situation.

The nurse as carer of the relatives of the dying patient

It was pointed out in Chapter 12 that only a few encounters between nurses and the relatives of dying patients were observed. Nevertheless, because of the amount of previous work in this area it was possible to relate the findings of the present study to these studies.

It was indicated in Chapter 12 that many nurses find that their encounters with the relatives of the dying patients are stressful. Some studies, for example, the study by Birch (1978), have indicated that nurses are ill-prepared for this role by their educational programme. Other studies have indicated that nurses, and doctors, not only receive little preparation for this task, but that they also receive little help or support to enable them to 'come to terms' with such situations. The main constraint in this area of the nurse-relative relationship would therefore also appear to be related to inadequate preparation for this role.

What we have done so far is to present a structural view of the setting in which nurses are expected by relatives to fulfil an 'expert' role. But although these structural factors constrain the limits of social action within a setting, the social actors within that setting are still able to determine what they choose to do, according to their definition of the situation within these limits.

The nurse cast into the role of 'expert' by the relative within the social structure described above will fall into one of three groups. This 'grouping' will of itself determine the behavioural options open

to him/her. The three groups are:

a) the nurse who has all of the knowledge required in order to fulfil the expert role,

b) the nurse who has none of the knowledge required in order to fulfil the expert role,

c) the nurse who has some of the knowledge required in order to fulfil the expert role.

a) The nurse with 'full knowledge'

The nurse with 'full' knowledge who is cast into the role of expert has two options open to her. She can either negotiate with the relative towards a successful outcome, or she can use avoidance strategies. It was found that most of the nurses with 'full' knowledge did attempt to fulfil this role in a way which was commensurate with the relatives' expectations. Few nurses with 'full' knowledge were observed to choose the latter option, except in the matter of withholding information concerning the patient's illness. If the nurse had all the knowledge required and used avoidance strategies he/she intentionally left the relatives' needs unmet. Other studies have indicated that intentional withholding of information in this way can be seen as a means of controlling the relationship by the nurse (or other professional).[1] Very few encounters were observed in which the nurse with full knowledge chose to act in this way, and while the indications are that in such instances information could have been withheld as a means of control, in the few encounters observed it was also possible to describe this choice of action as idiosyncratic.

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1. The literature concerning this aspect is reviewed by McIntosh (1977).

b) The nurse with 'no knowledge'

The nurse with no knowledge has only one course of action open to her, that of 'role-switching'. Although this has been described in the text as an avoidance strategy, it is also a strategy which, if the nurse has no knowledge, can be functional for the relative. The task of 'seeing the relatives' is associated with a certain level of seniority within the nursing hierarchy, although no clear distinction exists between 'being too junior' and 'being senior enough' to carry out this task. As indicated in Chapter 13 most nurses perceive that they learn to carry out this task by watching other people do it, so it would appear that 'being senior enough' is related to the amount of opportunity given to the nurse with regard to watching others.

It would appear that nurses who have full knowledge, or nurses who have no knowledge, are not subject to role strain for their choice of options is clearly defined. The group of nurses who appear to have most difficulty with this role are those in the third group, i.e. those with fragmentary knowledge. It is also into this group that most nurses fall, when they are cast into the expert role.

c) The nurse with 'fragmentary knowledge'

It would appear at first sight that the nurse with fragmentary knowledge can also either choose to negotiate or she can adopt avoidance strategies. But because of the constraints which set limits to her social action, if she chooses to adopt the former course of action she lays herself open to the possibility of 'making a mistake', that is 'making a mistake' as defined by the institution. Therefore, although, as we have shown, many nurses stated that they would have preferred to adopt the former course of action, most nurses solved the problem by adopting avoidance strategies. In this way they were able

to reduce the role strain associated with 'making mistakes', because of their lack of knowledge.

The association between role strain and the choice of avoidance strategies is further supported by considering the evidence concerning the encounters in which the nurse 'adopts' the expert role. In such encounters she has the knowledge to enable her to fulfil the role which has been adopted, and no evidence of either role strain, or the use of avoidance strategies were found in these encounters.

We should now turn our attention to the last main finding, that of the 'competent' relative.

8. The 'competent' relative

It was shown in earlier chapters that the 'relative gathering information' encounter was the most commonly occurring form of encounter between nurses and relatives. It was also indicated at the end of Chapter 7, in which this form of encounter was discussed, that some relatives were more 'competent' at gathering information than others. The notion of 'competence' in information gathering is an important one in the context of 'information exchange', for it was shown that the information revealed by the nurse depended to a large extent on pertinent questions posed by the relative. Generalised questions produced generalised replies, while specific questions produced specific information if the nurse had this knowledge.

However, the notion of the 'competent' relative has a much wider application when considered in the context of the relative as 'client' with many needs, not only the need for information. More and more clients are developing client skills as a result of knowledge dissemination in society. Lapota (1976) has suggested that as a result

of this dissemination of knowledge "more and more Americans are refusing to take passive and unquestioning stances vis-a-vis anyone, even the experts to whom they are forced to turn" (p. 128). Some indication of this change in British society was discussed in Chapter 5 where it was shown that the changes concerning access by relatives to the hospital came about largely because of consumer, that is client, pressure.

Lapota (1976) and others have also suggested that as clients become more skilful in expert-client relations new norms guiding these relations will emerge, but that before these changes occur "strain and protest by both client and expert will continue to grow".

The picture of nurse-relative encounters which has emerged in this study is one in which both strain and protest exist at present. The increasing expectations of the relatives have resulted in nurses being cast into expert roles which they are unable to fulfil because of the socio-structural constraints present within the organisational structure of the hospital. This has led to role-strain. On the other side of the relationship, relatives whose expectations are not fulfilled 'protest'.

The situation will continue until this mis-match between expectations and expertise is resolved.

We should now turn our attention to the implications of these findings for nursing practice if a solution to this mismatch is to be found.

Implications for nursing practice

After looking at the work of the nurse in an American hospital Mauksh (1973) stated that the unique challenge to nursing in the modern hospital, with its crowded heterogenous population, is how to

provide intimate personalised understanding relationships, despite the fleeting nature of interpersonal contacts which actually occur. This is the challenge to which we must now address ourselves.

This study has to some extent confirmed the findings of other studies, which have shown that the nurse working in hospital adopts the values, attitudes and beliefs of other professionals as part of his/her socialisation into the professional role. From these values, attitudes and beliefs the nurse develops a theory of what nursing is and the place of the relative within that theory.

Some indication of what the nurse's theory is can be seen in the dilemmas experienced by the nurse, and reported in this study, which occur because of the conflict between the ideology of nursing practice and the actuality. From one theoretical perspective the nurse attempts to maintain the social order of the ward by "getting the work done", in relation to the routine of the ward, yet his/her socialisation also directs him/her towards the notion of total patient care, which includes care of the relatives. This, it has been shown, can create problems in role fulfilment. In order to cope with this dilemma nurses minimise the 'problem' by the use of certain behaviour strategies.

The relative also has a "theory" of what nursing is and the place of each nurse within that theory. It has been indicated in the text that most relatives cast the nurse into the role of expert thereby defining his/her place within the relative's theory.

This 'positioning' of the nurse compounds the dilemma referred to above, and because the nurse is often unable to fulfil the expert role the relative's expectations are not met.

Unfortunately no easy solutions to these problems present them-

selves. As a result of other studies of interaction between nurses and patients it has been suggested that nurses should be taught 'communication skills' in order to overcome the problems which exist in such a relationship (Macleod-Clarke 1981). However, it would be over-simplistic in view of the findings of the present study to suggest that improved 'communication skills' would solve the problem identified in this relationship, although, of course, improved communication skills would enable the nurse to manage some of the distinct forms of encounter differently. Whether this would lead to 'better' care of the relatives is another matter.

In view of the findings already discussed it would appear that change needs to take place in two separate areas. First of all it would appear that there should be a change in attitudes and values so that the relatives' needs are no longer perceived as 'interruption'. Such needs would not only be identified, but they would also be catered for in the nursing care plan. This would necessitate a wholesale adoption within the nursing profession of the notion that "illness is a family affair".

Secondly, the task of 'seeing the relatives' needs to be more clearly defined between the medical and nursing profession. Because of this lack of task definition, it is difficult to apportion professional accountability and responsibility vis-a-vis the relative. Questions concerning these two concepts, accountability and responsibility, must be raised and answered before any change can take place.

Having begun this discussion on a rather pessimistic note it should however be noted that some change has already taken place in the relationship between these two groups in recent years, and it would

also appear that these roles are still in transition. But, it has been shown, most of this change has come from environmental pressure and not from within the organisation itself. It is possible, however, that some change may soon come from within the organisation. Many nurses are currently discussing documents such as "Standards of Care" (RCN 1981). The outcome of this discussion may result in change within the organisation generated by pressure from within and not from the environment. The question of how this is to be effected still needs to be solved.

Oleson (1981) suggested that one of the tasks of the researcher is to present research findings in a way which will result in some 're-ordering' of the reader's, or listener's, mental constructs. From such a 're-ordering' the solution to some of the problems in nursing practice may be found.

It is to be hoped that the findings of this study may lead to the 're-ordering' of the mental constructs of practising nurses so that possible solutions to the problems highlighted are suggested by those who are most concerned with 'good' nursing care, the nurse practitioners themselves.

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