NURSE AND PATIENT WORK:
COMFORT AND THE MEDICAL-SURGICAL PATIENT

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PLEASE NOTE

The greatest amount of care has been taken while scanning this thesis,

and the best possible result has been obtained.
ABSTRACT

This grounded theory study investigates the experiences and perceptions of comfort and discomfort of hospital patients admitted for medical-surgical conditions, with a focus on the post-acute stage of hospitalisation. In-depth post-discharge interviews were conducted with seventeen English-speaking adults who had been admitted to nine Australian hospitals. A substantive theory of finding comfort and of managing discomfort was generated. Processes of self-talk (anticipating, interpreting, accepting, making allowances and maintaining perspective) and self-care (self help and seeking help, which involved accommodating to the level and type of help available through deferring, avoiding, persisting or desisting) were used to find comfort and to manage discomfort.

Nursing interventions which were predominantly physical, psycho-emotional and social were comforting. Comfort and discomfort were not mutually exclusive and often co-existed on different levels of experience. Informants were comforted when they perceived nurses to be ‘experts’, who knew what they were doing and seemed to care.

The hospital convalescent experience can be seen as a period of transition in which patients continue to be vulnerable and in need of a different type of nursing care, rather than needing less nursing care. An analysis of transition revealed that both patients and nurses engaged in safety and comfort work, some of it through covert surveillance of each other. Findings suggest that remote and superficial assessment is unlikely to identify problems amenable to independent nursing care and that patients are not comforted by well-meaning, one-sided decisions to have them self-care with minimal nursing support. Patients need to know that they are being looked after and who is looking after them, as much in the convalescent phase of hospital care as in any other.
The study has implications for nursing practice, management, research and education. Existing practice in the areas of assessment, communication, individualised care planning and the management of discomfort need to be strengthened if nursing care is to make a difference for this category of patient. The study revealed that integrated caring by nurses perceived by informants as 'experts', contributed most to the experience of finding comfort and managing discomfort in this group of informants.
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CHAPTER ONE
The Need for an Investigation Into Comfort and Discomfort

Comforting is a significant human activity aimed at relieving discomfort on some level and at restoring a sense of wellbeing. The meanings of comfort and discomfort are broadly intelligible but not sufficient in the context of professional nursing, where activities associated with comforting must be better understood if they are to be satisfactorily attuned to individual needs, cultural sensitivities, and varied clinical and personal contexts. It is only recently that these important concepts have become the focus of serious study by nurses. Defining and making comfort and discomfort more explicit are essential steps in the development of a discrete body of knowledge which will then be accessible to members of the profession.

This short chapter provides an introduction to the study. It highlights the paucity of research into the subjective phenomena of comfort and discomfort, and supports the logic of an interpretive, patient-focused investigation.

1.1. Comfort In Nursing Practice And Discourse

Patient comfort and safety are primary responsibilities of the bedside nurse. For obvious reasons the hospital patient’s physical safety remains one of the most important aspects of care. However, patient comfort and comfort-related measures have gradually been given lower nursing priority, possibly because economic constraints and biomedical technology make increasing demands on nursing time, resulting in less attention being given to psychological safety and ‘hands on’ physical and other forms of comfort. Comfort itself has become ‘technologised’ through greater reliance on pain-relieving drugs and do-it-yourself gadgetry of increasing sophistication (Strauss, Fagerhaugh, Suczek &
Wiener, 1985). As a consequence, the notion of comfort is increasingly being linked only to the absence of severe or persisting pain.

Until very recently, comfort and discomfort were concepts of little interest to some pragmatic nurse leaders attempting to identify what is important to nurses in the pursuit of professional status. One example of such an activity is the development of nursing diagnosis terminology, which in my view, has fragmented the concepts of comfort and discomfort and dissipated their interlinked and global meanings. Nursing diagnosis terminology is characteristically reductionist. For example, ‘Alteration in Comfort’ is narrowly defined as either acute pain or chronic pain. Other discomforts are disguised under biomedical and pseudo-psychological labels (e.g., ‘alteration in buccal mucous membranes’; ‘noncompliance’). The use of ‘definitive’ diagnostic labels for complex human situations is in itself problematic, and doubly so when such labels are derived from a poor understanding of the human condition or when they are applied with only a superficial knowledge of the patient. For instance, a patient who is not self-caring when expected to be may be labelled ‘noncompliant’ or unwilling to self-care. Such a judgment may represent a failure to get in touch with or appreciate any subjective aspect of the patient’s experience and as such, represents a failure of assessment as well as of professional caring. Christensen (1990) describes two such situations of inadequate nursing assessment leading to failure to correctly identify the patient’s problem as strongly motivating her own research, while many similar experiences have motivated my own.

Comfort and discomfort are concepts important in nursing which have implicit and taken-for-granted meanings. Comfort is a term which subsumes a number of feelings, interactions and activities. While these are generally understood, their meanings need to be made more explicit and ‘real’. In discussing the nature of reality and of constructed realities, Lincoln and Guba (1985) propose that one
way that reality may be constructed is linguistically. Linguistic construction is most clearly seen through the study of a dictionary: "... what words are in it and what words are not - is a useful way to determine the characteristics of a culture" (Lincoln and Guba, 1985, p. 89).

Despite the assumed centrality of these concepts for nursing, the words 'comfort' and 'discomfort' have all but disappeared from nursing textbooks and dictionaries and from allied health dictionaries commonly used by nurses and published in the last ten or so years. There is, for example, no mention of the terms 'comfort' and 'comfort measures' in the index of Blackwell’s Dictionary of Nursing, 1994; Lippincott Manual of Nursing Practice (Suddarth, 1991) Mosby’s Medical, Nursing and Allied Health Dictionary (Anderson, 1991, 1994) Taber’s Cyclopedic Medical Dictionary (Thomas, 1985), but for an exception, see Taylor, Lillis and LeMone's Fundamentals of Nursing text (1989). Moreover, none of these or similar texts index or define the term 'discomfort'. This may be a response to information overload, the need to include more and more information, to be selective about what is included and to be faced with tough editorial decisions about what to leave out, yet there is a risk that these significant concepts, once excluded, may simply fade from nursing awareness and from the nursing culture. In the journal literature, in the last few years, comfort has been an occasional topic of interest, possibly due to increased use of interpretive methodologies in nursing research which facilitate a focus on phenomenological experience. However, discomfort receives little or no attention.

1.2. Discomfort: A Concept Awaiting Investigation

Discomfort is a private, subjective feeling of decreased well-being, sometimes regarded as less overwhelming than pain, an idea which can be firmly refuted. A number of writers have concluded that discomfort is a significant stressor, so
commonplace that it is frequently overlooked (Gorey & Warne, 1991; Jeans, 1988; McCaffery & Beebe, 1989; Roberts, 1982). Discomforts are exhausting and demoralising, possibly to a greater extent even than pain, because of their fluctuating intensity and multiple foci. It may not be appreciated that a surgical patient with negligible wound pain may have intense discomfort from wound drains or from some other cause, or that an elderly stroke patient may have intense discomfort from muscle spasm due to incorrect body alignment. Many discomforts which are not labelled or identified as pain by the patient may go unreported by them, or may not be recognised by the carer who asks only about obvious pain.

It is vital that nurses listen to their patients' concerns and hopefully will be in possession of some grounded theory from which to interpret the meaning of the patients' utterances. Patients seldom articulate in clear language what they want to communicate. Frequently their covert communication lies hidden in their behaviour (Holden, 1991, p. 13).

Nurses know in a 'commonsense' way what comfort and its opposite are. Finding ways to describe and express the isolation and suffering that are the concomitants of pain and discomfort is difficult and challenging, and even more difficult without a grasp of the subjective meanings of such phenomena which can help nurses tailor their assessments and nursing care.

Nurses are the people best equipped to confront this isolation and bring comfort to the suffering. To do so, they must have an understanding of the experience of suffering, the skills to assess its characteristics, and the tools to effectively reduce it - to provide comfort (Funk & Tornquist, 1989, p. 4).

To date, there has been little systematic investigation of these phenomena which exist in reality but around which, as Ellis points out, meanings are created and generated.

Of greatest importance are efforts to understand common everyday phenomena exhibited by persons under the care of nurses. In particular, the highest priority should be placed upon phenomena entrusted solely or primarily to the nurse for resolution, management or care (Ellis, cited in Algase & Whall, 1993, p. 71)
In relation to comfort and discomfort, the meaning of these phenomena are at the level of the tacit and the implied. In the nursing context, discomfort is accepted as a fact of life in hospital, with comfort widely assumed to be a prominent feature of the help available to patients. The complex interactional processes within the social environment of the hospital which have a bearing on perceptions of comfort and discomfort are not well understood, with the possibility, noted by Maguire (1985), that nurses may fail to recognise that patients actively seek comfort.

The theoretical literature on comfort, though sparse, is increasing but there is little scholarly or research material to be found on the subject of discomfort. The few studies which illuminate patient perceptions of comfort and discomfort have gone some way to describing those actions and attitudes which promote comfort and those which aggravate or do not relieve discomfort. Comfort and discomfort as taken for granted experiences of hospital patients, have become “sedimented” (Munhall & Oiler, 1986, p. xiv) in the conceptual understanding of nurses. The benefits of comfort and comforting ought to be obvious, yet discomforts which are amenable to nursing management persist.

Continued investigation into issues of patient comfort / discomfort is supported by nurse clinicians and theorists as a crucial professional need in one of nursing’s major domains of interest (Robinson, 1990). While the comfort needs of cancer patients and the institutionalised elderly have been investigated (Fleming, Scanlon & D’Agostina, 1987; Hamilton, 1989), most other studies have concentrated on individuals with severe or multiple health problems, who perceived themselves and / or were perceived as ‘ill’. Our current level of knowledge of the experience of non-cancer pain and discomfort in infants, children, adolescents and the middle aged, as well as in post-operative and post-acute patients, is inadequate (Ferrell & Ferrell, 1990).
1.3. Overall Plan Of The Project

The remainder of this chapter sets out the focus of the research, the research approach taken and outlines the thesis plan.

1.3.1. The focus of this study

Patient's experiences of comfort and discomfort in hospital are the focus of this study. No reported studies have focused on these issues for adults who were considered 'well' prior to the development of the condition necessitating admission to hospital, and who had a good medical prognosis on discharge from hospital after relatively short stays. The research question was, "What are the experiences and perceptions of comfort and discomfort of adults hospitalised for non-life-threatening conditions, with particular reference to the post-acute stage of care."

The choice of research method in this study relates to the nature of the research question being asked. The broad questions raised in this study are, 'How does this group of patients think about comfort? How important are comfort and discomfort to them?' The subjective nature of comfort and discomfort made it appropriate to use a qualitative approach to investigate the ways in which patients perceive and experience comfort and discomfort. Qualitative research methods which "focus on meaning and understanding in context" (Vancott, 1990, p. 224) have the potential for explaining complex concepts, and of adding to our understanding of the nature and dimensions of the subjective experiences of comfort and discomfort.

1.3.2. The research approach

The qualitative research methodology employed in the study was grounded theory. Its methodology facilitates the development of theory which is grounded
in and 'true' to the data. A number of investigators, including nurses, have found
grounded theory a fruitful way of investigating the reality and complexity of both
familiar and perplexing problems. Nurse researchers who have used grounded
theory in data collection and analysis include Bowers (1988), Cameron (1988),
Fagerhaugh and Strauss (1977), Hamilton (1989), Hutchinson (1984), Melia
(1982), Morse (1983), Nusbaum and Chenitz (1990), Swanson-Kauffman (1986),

Flaskerud (1986) notes that a lack of research relevant to patients and to nursing
practice has retarded testing of existing nursing principles and that (citing
Barnard, 1980) “the goal of theory development in nursing is to develop theories
that guide the care that nurses give to patients” (Flaskerud, 1986, p. 251). She
concludes that nursing research must be practice-related and patient-focused if
useful nursing theory is to be developed at explanatory and predictive levels.

Grounded theories are a type of theory which pre-eminently provide fresh ways of
thinking about and looking at the world around us (Botha, 1989). This present
study strengthens the links between patient-focused research and nursing practice
knowledge, by being able to provide an explanation of how and under what
conditions medical-surgical patients perceive, interpret and construct the meaning
of their comfort and discomfort experiences. In addition, the study seeks to
explain how this group of informants went about finding comfort and managing
their discomfort.

1.3.3. The value of a grounded theory study

Concepts are important cognitive structures for dealing with ideas. If something
can be conceptualised, it can be included in discourse. It may then be
investigated and its parameters further explored. A grounded theory study which
describes and interprets patients' subjective experiences of comfort and
discomfort in the post-acute stage of hospital care can add to the theoretical base of nursing. This study can contribute to a more comprehensive understanding of the concepts of comfort and discomfort, substantive phenomena which are clearly within the enabling domain of nursing. A grounded theory can provide description and explanation, allow for prediction of the occurrence of these phenomena, illuminate the strategies used by this group of adults and go some way towards guiding the selection of interventions to promote comfort, support patients' self-care efforts and so facilitate the reduction and alleviation of discomfort.

Grounded theory methodology was developed from the social psychological philosophy and theory of symbolic interaction. The theory of symbolic interactionsism focuses on and provides an explanation of self and society in interaction in particular social contexts. A patient-focused study of adult comfort and discomfort in a hospital setting must necessarily take into account the interaction between the subjective self, society and a particular context.

1.4. Thesis Plan And Summary

The plan of the thesis is as follows. Chapter Two begins with a justification of the place of a review of the literature in this qualitative study, provides the reader with some background to the study, then reviews the nursing literature on comfort and discomfort as well as reviewing selected aspects of nursing assessment, the nursing process, nursing standards and nurse-patient interaction.

Caring and empathy are significant nurse-patient 'connecting' processes in professional nursing which influence the level of comfort and discomfort experienced by patients. These related concepts are selectively reviewed in Chapter Three.
Chapter Four provides a brief overview and critique of the epistemological bases of the two major research paradigms, then discusses the relevance of grounded theory and symbolic interactionism as they were adopted for this study.

Chapter Five, the methodology chapter, outlines the three phases of the research plan and provides details of the manner in which the research was conducted, with reference to issues of investigative rigour and ethics.

Analytical findings on comfort and discomfort including the substantive theory which was developed, are presented in Chapter Six, while related themes of significance are addressed in Chapter Seven.

Chapter Eight contains an elaborated discussion of developed themes and their links to existing literature, notes the limitations of the study and concludes with recommendations for practice, education and research.

This thesis explores the taken-for-granted experiences of comfort and discomfort in a taken-for-granted group of patients who are often assumed to have few discomforts. Through a qualitative, theory-building approach which takes account of the subjective nature of patients' experiences, the interpretations they place on them and the context in which they occurred, this study can add to the understanding of significant concepts and processes relevant for the domain of nursing.
CHAPTER TWO

Review of the Literature: Comfort, Discomfort and Related Matters

This chapter is presented in four parts. The first begins with an overview of my nursing experience and some background to the study since both have strongly influenced my understanding of medical-surgical patient care and the issues being investigated here. It contains a brief commentary on the place of the literature in qualitative research. The chapter then provides support for the study by reviewing the nursing literature relevant firstly to comfort and then to discomfort phenomena. Finally, it summarises literature on matters such as assessment, the nursing process, conceptual models of care and contextual variables in the clinical setting, and links this material to the following chapter which continues and completes the pre-study literature review.

2. 1. Background To The Study

Some background is presented here to enable the reader to appreciate the circumstances which led to the study and my motivation for doing it.

2. 1. 1. Experiential background

Prior to this study, which began in late 1992, my understanding of comfort and discomfort was acquired from a number of sources. I had been in hospital as a child, as an adolescent, as a student nurse, as a parturient woman and as an adult medical-surgical patient. My children and other members of my family had occasionally been in hospital and I have been the family carer of parents hospitalised late in life. I have worked as bedside nurse and clinical teacher for more than thirty years, beginning nursing in an era of enemas, poultices and Wangansteen sets, of wet dusting, ‘tidy rounds’ and ‘doing the flowers’. Florence
Nightingale’s principles, doctors’ and tutor sisters’ lectures and a single Australian text on practical nursing procedures were the only formal authorities for nursing. Ward sisters and senior students, with their exacting standards, were the final arbiters of our conduct in the wards and at times, in the nursing residence. With all its difficulties, institutional living provided us with opportunities at shift’s end to engage in intensive story-telling about our patients and our work. Lacking any sophistication, we did not realise that we were engaging in debriefing, dialogue and discourse about our nursing practice in these sessions.

Early post-registration work and study as a nurse in Canada brought me into contact with the writings of American nursing scholars and theorists of the period. These nurses, exploring the nature of comfort, nurse-patient communication and interaction and the nursing role in pain management, were influential in further shaping my understanding of what clinical nursing practice could be. Later studies in Australia brought more exposure to nursing theory and nursing research, to social psychology and to sociological concepts such as bureaucracy, alienation, deviance, dyadic interaction, altruism and the sick role. Over the succeeding years I nursed in a variety of specialty areas. As a clinical teacher and later as a university-based nursing lecturer, I developed my interest in teaching nursing assessment and the care of people experiencing pain, discomfort and distress. I continued to work casual shifts in medical-surgical, post-natal, gerontological and high dependency wards in various hospitals and became increasingly conscious of a lessened nursing awareness of patient discomfort, and of fewer comfort interventions, even of the most elementary kind, being provided.

As part of my post-graduate work I had intended to explore factors which mediated the provision of comfort by nurses, using a quantitative approach. This study was developed to proposal stage to meet the requirements of a Masters Degree by coursework. An extensive review of the literature contributed to an
original conceptual framework which I developed to account for variations in the quality of assessment of comfort needs and in the comfort care provided by nurses. The study was not carried out, but the literature review informed the current project, particularly the ideas of sociologist Anselm Strauss and his nurse colleagues concerning the kinds of work done by patients and staff in hospitals (Strauss, Fagerhaugh, Suczek & Weiner, 1981). Other notions in the conceptual framework which had emerged from an extensive review and critique of the literature, and which seemed crucial to understanding comfort and discomfort in the hospital context, were self-disclosure, empathy, mutual expectations and patient assessment.

2.1.2. The place of the literature review in qualitative research

Qualitative research methodologies are widely used in studying phenomena of interest to nursing. They offer "... a way to discover meaning, develop understanding and explain phenomena in the most thorough way possible" (Mariano, 1990, p. 356). They are inductive, descriptive, interactive and context-dependent. There is an implicit open-mindedness in these approaches. This openness to focusing on the perspectives of others and to discovering the meaning of the unique experiences of others may be difficult to achieve and to maintain unless one’s own knowledge and experience are acknowledged at some point early in the research.

In some phenomenological studies there is a formal requirement to surface and ‘bracket’ or set aside one’s own knowledge, ideas, assumptions and biases and enter into dialogue with the study informant with as much of an open mind as it is possible to achieve (Walters, 1994).

All information, including a review of the literature, and any meaning
that the phenomenon has for the researcher, should supposedly be set aside (Ray, 1991) and referred to later in the study as needed.

Glaser and Strauss (1967) who originated grounded theory methodology recommend that qualitative researchers suspend all assumptions, and discard or put aside any preconceived ideas about what findings will emerge from the research, while not ignoring the reality of one's discipline-based perspective. In interpretive inquiry generally, the operation of acknowledging and consciously putting aside one's own understandings (whether this is called bracketing or some other other term) is said to enable the experience of another to be brought into clearer focus. This is facilitated by a willingness to relinquish one's own certainty about a phenomenon, to have an attitude of genuinely wanting to understand and to listen to another, to reflect, muse, wonder and - for a time - tolerate uncertainty and confusion (Oiler, 1982).

Reference to the literature in qualitative research, particularly in grounded theory, is usually integrated with data collection and analysis (Strauss, 1987) in order that what is already 'known' does not exert unrecognised influence. However, there are precedents for reviewing the literature prior to undertaking qualitative research. For example, Swanson-Kauffman (1986, p. 60) conducted "a fairly exhaustive review" of literature related to loss, perinatal loss and miscarriage prior to her study, finding very little which added to her understanding. Madjar (1991) undertook an extensive review of the historical and clinical literature on pain prior to her phenomenological study of clinically inflicted pain in adult patients. This review aided her research design process. Morse and Johnson (1991) recognise that finding a topic about which little is known may be difficult. They recommend that literature be reviewed as a way of narrowing the topic and of finding out what is known. This should then be set aside. As the study progresses and the need arises, further library work is done. As noted previously
I had already undertaken an extensive review of literature I regarded as pertinent for an earlier project which is reported in 2. 2 below.

2. 1. 3. **Surfacing and bracketing pre-study assumptions**

The literature review in this chapter, and in the one following dealing with caring and empathy, reflect my understanding of a number of clinical and theoretical issues affecting patient comfort and discomfort at the commencement of this study. I undertook a further review to determine if any similar studies to the one I planned had been published or were in progress. This was also intended to assist in the process of surfacing my assumptions and to help me focus on what I took for granted. A few studies had highlighted particular elements of comfort, but none described the comfort experiences of relatively well, post-acute adult hospital patients. It was clear from my experience as patient, nurse and teacher not only that their discomforts could be intense and persisting, but that these were either trivialised, ignored or simply not recognised. Theoretical sensitivity (Glaser, 1978) as well as “insights, hunches and generative questions” (Strauss, 1987, p. 12) came from my experience as patient and nurse. During the study reference was made to the literature when each new or salient concept emerged, or when concepts were thought about in a new way as the analysis proceeded.

As the study progressed, I sought to explore, clarify and understand issues as they were identified in the data, and to link them to existing theoretical literature at each stage of the investigation and analysis as will be outlined in the methods and discussion chapters. I continued to question what I might be taking for granted. I attempted to acknowledge biases and to be open to original insights resulting from researcher-informant interaction through personal and theoretical memoing. Finally, during the months it took to draft and polish the thesis, the literature was consulted for reference and integration into the discussion chapter.
At this point, I feel comfortable in reporting and reviewing, literature which was relevant at the proposal stage of this study. As well as having some support for this from experienced qualitative researchers, common sense suggests that a nurse with my particular experience, professional education and research interest must necessarily have read widely and have developed a number of ideas on matters related to the topic which need to be acknowledged. The issue of how much of the pre-study literature was relevant to the findings will be taken up in the discussion chapter.

2.2. Review Of Relevant Literature On Comfort

Material in this review includes information on the components of comfort, the benefits of comfort, the environment in comfort, nursing comfort measures and research into comfort.

2.2.1. Comfort: An overview

Comfort, according to a non-nursing dictionary definition (Wilkes & Krebs, 1991) is both a noun and a verb. It is a state of relief from pain or discomfort, something that affords physical ease or relaxation; a feeling of relief or consolation. A comfort is someone or something which affords or causes relief and satisfaction. To comfort is to soothe, cheer, to inspire hope and restore a cheerful outlook, to make distress seem lighter by means of kindness and thoughtful attention; to aid, to encourage, to make physically comfortable; to strengthen.

In the nursing literature comfort is characterised as a goal of therapeutic nursing practice (Morse, 1983; Richeson and Huch, 1988), a primary nursing function (Lorenzi, 1991), the domain of interest for nursing (Robinson, 1990) and an outcome of care (Morse, 1992). Leininger (1988) clusters comfort with
surveillance, presence, empathy, touch and compassion as critical components of nursing care. Comfort and discomfort are among a number of concepts important to and associated with nursing which need to be made explicit if practice, theory and research in nursing are to maintain coherent links (Ellis, 1969; Jacox, 1979; Morse, 1983).

Historically, comfort was broadly understood as the tender, loving and caring ministrations of the family, lay or professional bedside caregiver. The professional nurse’s responsibility for comfort management occupied an important place in modern nursing literature until the early 1980s. It was assumed to be part of the normative care nurses provided (Verran, 1981, cited in Verran, 1986). Even though the number of nursing publications was less than now, patient comfort and comfort measures were strongly, if briefly, emphasised, more or less explicitly, particularly in texts written for the beginning student nurse. These comfort measures were predominantly physical because physical comfort and hygiene were seen to be important for a sense of well-being which in turn was necessary for rest and sleep and for ‘feeling better’. While we did not then explore ontological notions of healing, connection or presence, and the literature was relatively pragmatic and unsophisticated, comfort was clearly an essential part of nursing care. In practice, comfort could include trying to ‘cheer the patients up’, or to reassure relatives but for the most part, it meant leaving your patient clean, dry, warm, with a fresh mouth, empty bladder, smooth bottom sheet and snugly tucked in, with a bell handy.

2.2.2. The literature on comfort

As has been pointed out, comfort and discomfort as discrete concepts are all but absent from the index pages of most current foundational nursing textbooks. When present, these concepts are discussed in a reductionist way, viewing comfort and discomfort only as physical sensations. Text chapters headed
“Comfort” focus on related but distinct phenomena of acute and chronic pain and on the provision of analgesia in order to prevent hypoventilation and promote earlier ambulation. Typically, a small section in such chapters advocates physical comfort measures and promotion of sleep and rest (e.g., Kozier, Erb, Blais, & Wilkinson, 1995). Aside from textbooks, useful references to comfort are found in the journal literature where ideas about comfort in clinical practice are expanded. An initial stage of the process of making comfort and discomfort explicit involves a review of the literature on each concept. The following sections are devoted to this task.

2. 2. 2. 1. Components of comfort

While comfort is “most often equated with assessment and intervention for physiological needs” (Ferrell & Ferrell, 1990, p. 68), other aspects of comfort - psychological, social, spiritual and emotional - are identified in the journal literature. They include social interaction (Eland, 1991; Hamilton, 1989; Moss & Meyer, 1966), reassurance (Teasdale, 1989), support for coping repertoires (Geach, 1987), personalised care, feeling safe, feeling valued, having some control (Elms & Leonard, 1966; Morales-Mann, 1989; Morse, 1992), listening, coaching, encouraging (Christensen, 1990; Farrell, 1991), respect for religious and cultural rituals (Ferszt & Taylor, 1988), providing information (Engstrom, 1984; Porter, Moschel, Liederman & Pope, 1977), giving care promptly and cheerfully, (White, 1970), humanistic caring (Leininger, 1977) and interpersonal confirmation and validation (Engel, 1980).

Comfort is characterised as “a multi-dimensional concept involving physical, psychological and emotional needs” (Ferrell & Ferrell, 1990, p. 68), and as a sense of well-being on a number of dimensions and in a number of contexts of experience: social, physical, spiritual (Hamilton, 1989). Thus it can be seen that comfort has been conceptualised more recently in terms of feelings of relief
experienced by care-receivers in response to caregiver actions and attitudes. In summary, the literature seems to suggest that any nursing interaction with patients is potentially comforting and therapeutic.

2.2.2.2. Benefits of comfort

The benefits of comfort have been alluded to by relatively few writers. Comfort and relaxation are important in reducing muscle tension and tissue oxygen demand, improving the effectiveness both of oxygen therapy and analgesia (Beland, 1970). Comforting and comfort care by hospital staff is likely to reduce the number of complaints and litigation directed at the hospital (Doll, 1979).

Comfort promotes rest, relaxation and normal sleep patterns, which consist of alternating periods of rapid eye movement sleep (REM sleep) important in maintaining psychological orientation and restoring emotional equilibrium, and non-rapid eye movement sleep (NREM sleep) which promotes protein synthesis and tissue healing (Chuman, 1983). Bonica (1989), a noted authority on pain, asserts that comforted patients benefit more from analgesia and that a combination of comfort measures and adequate analgesia reduce the likelihood that acute pain will become chronic. Miller (1991) confirms that comforted patients are likely to require less analgesia and, other things being equal, to have shorter hospital stays.

Medical-surgical patients experience multiple discomforts which comfort measure may significantly alleviate (Gardner, 1985; Porter, Moschel, Liederman & Pope, 1977; Richeson & Huch, 1988; Roberts, 1978; Schoenhofer, 1984; Teasdale 1989). Christensen (1990) noted numerous patient situations of discomfort (in addition to others mentioned elsewhere in this review), which required ‘comforting’ work from the nurse. To Christensen, comforting is professionally challenging in that it effectively demands a demonstration of nursing
competence. It takes (or should take) precedence over most other actions, yet nurses, she claims, underestimate its importance for patients and for nursing.

Nowhere is comfort more emphasised in practice than in oncology and palliative care nursing. When the focus of care for oncology patients becomes palliation rather than cure, symptom control and holistic nursing comfort measures assume even higher priority in order to improve quality of life. With unpleasant physical symptoms such as pain, fatigue and nausea well controlled through nursing and team intervention, the person and family are freer to work through important relationship and spiritual issues (Hodder & Turley, 1989).

The development of neonatal care as a medical and nursing specialty has produced a number of clinical studies which have identified the benefits of comfort and comforting to neonates. Comfort is thought to speed recovery and contribute to earlier discharge in hospitalised neonates (Sparshott, 1989). Sick newborns subjected to painful, invasive procedures during hospitalisation have been shown to have significant stress responses leading to hypoxia, bradycardia and tachycardia and raised intracranial pressure. These babies benefit from comfort measures which minimise stress, pain and repeated disturbance (Long, Lucey & Philip, 1980), principles which guide the nursing care of any precariously ill person.

2. 2. 2. 3. The environment in comfort

In the clinical nursing literature, ‘environment’ is more often regarded as external and physical, and may include aesthetics. Watson (1979) identifies the environment as an external variable the nurse can control to promote patient comfort. Comfort is ultimately achieved through comprehensive comfort measures. Echoing Nightingale (1860 / 1965), Beland (1970) emphasised the nurse's manipulation of the patient's environment as a way of controlling noise,
light, odours, ventilation, clutter and any number of intrusions into the personal space and restful state of the ill or convalescing person. The nurse’s task is to find ways to encourage rest, sleep, appetite, mobility and optimism. However, Williams (1987) argues that with the delegation of house-keeping and ward maintenance to non-nursing personnel, concern with the patient’s immediate physical environment, in so far as it bears on the experience of comfort, has become less important to nurses.

Noise is a major environmental stressor. Its effects on sleep, rest, relaxation and perception of well-being in the critically ill patient are well-established (Roberts, 1976). Noise stress has recently been linked to an endocrine aspect of stress response, and the to effect of increased plasma cortisol on specific phases of wound healing (McCarthy, Ouimet, & Daun, 1991).

Environment is part of nursing’s theoretical metaparadigm of person, society, environment and health. Within this schema, Levine (1973) characterised the external environment as perceptual (sensory) operational (physical) and conceptual (symbolic). As such, environment is everything which bears on the patient, from society and culture to the social and physical features of the immediate surroundings. The patient and the environment are seen to be in constant interaction. This offers opportunities for preventive and remedial nursing intervention.

The concept of the health care environment has been extended to take in the socio-political elements of an organisational matrix of staff, other patients, medical officers, work demands, ethos and sub-cultural influences which may impact on individuals (Fagerhaugh & Strauss, 1977). In a similar vein, critical social theory has been proposed as a tool to illuminate oppressive social, educational, political, legal and organisational factors which have negative consequences for health, and for full participation in society (Allan & Hall, 1988;
Meleis, 1991). This broader view of environment permits the identification of political, bureaucratic and philosophical perspectives (for instance, in health care institutions) which influence the way nurses come to view comfort, and the way they assign their work priorities and resources of time and energy in relation to it.

2.2.2.4. Nursing comfort measures


Nursing comfort measures encompass a range of activities which promote and enhance biological and psychosocial well-being by affording relief from a variety of unpleasant phenomena including pain. They include supportive positioning and frequent changes of position, maintaining good body alignment, removing noxious stimuli, giving sensory, procedural and orienting information, relieving the patient of having to make decisions when very ill, clustering interventions to provide for rest and providing pressure area and oral care (Beland, 1970). A number of strategies for achieving comfort should be utilised, rather than a single approach such as analgesia (Harrison & Contanch, 1987; Lascelles, Cunningham, McGrath & Sullivan, 1989). Comfort and comforting can only be achieved through skilled interpersonal contact, and by effective communication which facilitates problem-solving (Miller, 1991).
Other comfort approaches recommended in the literature include being considerate of the patient's family (Meijs, 1989; Webster, 1986), providing some sense of control (Dennis, 1987), ensuring adequate and appropriate communication (Ashworth, 1979, 1984; Turnock, 1989), use of affective or expressive touch (Oliver & Redfern, 1991) and use of appropriate humour (Groves, 1991; Rosenberg, 1991). Sociocultural comfort measures relate to patient behaviours, habits, customs and beliefs, and the nurse's willingness to acknowledge, respect, and be sensitive to individual patient values and goals (Kerslake, 1988). Spiritual comfort needs may be partially met by appreciation and respect for the patient's spiritual practice, beliefs and concerns (Stiles, 1990).

The theoretical literature on comfort has largely been generated from clinician observation and experience, with a relatively small contribution from nursing research. Interest in the notion of comfort has resurfaced in the last few years and is at least a minor focus for nursing discourse as is demonstrated by the review of published research on comfort which follows.

2.2.3. Comfort: nursing and other research studies

There are a small number of nursing studies on comfort. Researchers have used mostly qualitative approaches to investigate general notions of comfort (Morse, 1983), the comfort perceptions of patients (Cameron, 1988; Cameron, 1993; Hamilton, 1989; Hester & Barcus, 1986 cited in Hester, 1989) and comforting behaviours of nurses (Fleming, Scanlon, & D'Agostino, 1987; Morse, 1992; Taylor, 1992). A semantic analysis of the concept has lead to the development of a taxonomic grid for the concept of comfort (Kolcaba & Kolcaba, 1991; Kolcaba, 1991). These studies are presented in approximate chronological order in the following sections.
In her 1983 review of the literature, Morse found no evidence that comforting, *per se*, had been researched. She found studies on touch and empathy as two nursing approaches to providing comfort. Nurses used touch (six studies conducted between 1964-1979) and empathy (three studies, conducted between 1972-1977), to comfort patients. Comforting measures were selected as appropriate for the circumstances which initiated the need for comforting and were mediated through the nurse-patient relationship, the gender and culture of those in the relationship, and self-disclosure by the person in need of comfort.

2.2.3.1. Adult and child comfort

Morse (1983) attempted to identify the components and context of the act of comforting in Anglo-American culture through an ethnoscientific analysis of comfort. Using a sample of two married, full-time mothers and two single female nurses, Morse found three dimensions of the domain of comforting: touching (silently, sometimes with hugging), talking (sometimes with touching) and listening/responding. A few self-comforting strategies were identified, with further research needed in this area. Self-comforting was achieved through praying, distracting oneself, and reassuring and consoling oneself. These led to a change of mood and a feeling of being at ease and comfortable.

In her report, differences in the way adult and child comfort needs should be met were identified. Children need immediate physical comforting and require more touching than adults. Children are likely to be comforted more quickly than adults, who in turn, and depending on the level of their distress, respond better to verbal interventions, and to privacy, in an atmosphere of trust and rapport. Morse perceived *caring* as the motivation behind comforting. Referring to ‘comfort’ and ‘comforting’ as a single phenomenon, an ‘art,’ Morse stated that comforting is a culturally-learned disposition which is transmitted, mostly non-verbally, from early infancy (Morse, 1983).
Children in pain have clear views on comfort. Hester and Barcus (1986, cited in Hester, 1989) interviewed hospitalised American children aged between five and fifteen years. From interview data, researchers developed lengthy lists of childrens' descriptions of staff caring and non-caring behaviours in relation to their pain. These children also described their self-initiated comforting strategies which included being with someone, talking with someone, resting, distraction, breathing deeply, verbalising the pain and finding a comfortable position. These authors suggest that each child’s developmental stage, personality and family circumstances require individual assessment and understanding if the staff are to meet their needs for comfort.

2.2.3.2. Comfort in advanced cancer

Fleming, Scanlon and D’Agostino (1987) asked nurses in an accredited American palliative care hospital, working with adult patients with advanced cancer, what they did to provide comfort, which was defined for their study as minimising biopsychosocial distress. Through an open-ended self-report questionnaire, they attempted to identify comforting nursing activities and behaviours used most frequently or considered to have high priority. All activities and behaviours identified reflected key components of the institution’s philosophy of patient care. Nurses used psychosocial and physiological comfort measures most frequently, with other measures being used but less often. These other measures included reducing the severity of illness impact, comfortings family and friends and spiritual comforting.

2.2.3.3. Comfort in serious illness

Cameron, a Canadian nurse working in the United Kingdom, investigated patients’ perceptions of the nature of comfort during hospitalisation using a grounded theory - phenomenological approach. She used unstructured interviews
and participant observation to collect data from ten patients hospitalised with medical and surgical conditions. All informants were either seriously or chronically ill, with life-threatening or disfiguring and disabling conditions, or had had radical surgery. Some informants were discharged and re-admitted during the course of her study which took several months. Cameron found that, contrary to current thought which relegated comfort to a passive soothing by others, patients engaged in dynamic comfort-seeking activity. She described a process of 'integrated balancing' through which her informants achieved movement along a continuum from low to high-level comfort (Cameron, 1988).

2.2.3.4. Comfort in extended care facilities

Hamilton (1989) used semi-structured interviews with institutionalised elderly patients in Canada, to determine the meaning of comfort to them, and what helped them to achieve comfort. Hamilton's thirty informants were residents of a large geriatric hospital. Content analysis of informants' descriptions in this study yielded the following themes of comfort: physical functioning (mobility, manipulative capacity, elimination), self-esteem (feeling independent and worthwhile, having faith in God, being able to make decisions, getting information), positioning (with cushions and foot-rests properly placed which facilitated independent activities, as well as being returned to bed when tired) and the approach and attitudes of staff. Some informants defined comfort in terms of the nurse-patient relationship: empathic, caring nurses who did what they promised to do, helped them feel comfortable.

This study built on and compared earlier research (Hamilton, unpublished, 1985) on the comfort perceptions of Canadian patients in a palliative care unit. The dimensions of comfort were similar for the two groups, although less emphasis was placed on positioning by terminally ill patients. Comfort was found to be multi-dimensional, individual and subjective, and concerned with feelings,
relationships, and the environment. Nurses were an important part of patient comfort.

2.2.3.5. Comfort - concepts and meanings

Kolcaba and Kolcaba (1991) analysed the semantic meanings associated with comfort in ordinary language, both contemporary and historical, then went on to examine historical and contemporary nursing literature for common understandings of the term. Six ordinary language meanings were derived and three technical senses of comfort, linked to comfort needs of patients, were identified: comfort as ‘state’ - a condition of ease and contentment; comfort as ‘relief’ from conditions which cause discomfort such as pain, mental anguish or other discomfort; and comfort as ‘renewal’ or being strengthened and assisted with personal growth.

Kolcaba (1991) went on to examine nursing literature on holism and holistic practice models for the contexts and dimensions of comfort. Comfort contexts commonly cited in the literature echoed to some extent the areas of comfort needs identified in Hamilton’s (1989) study, that is, physical, social, psychospiritual and environmental. These four contexts and the three technical senses of comfort identified by Kolcaba and Kolcaba (1991) were combined in a taxonomic comfort grid of twelve cells representing the “total Gestalt of patient comfort from the perspective of patients’ needs and the fulfilment of their needs” (Kolcaba, 1991, pp. 239-240).

Morse (1992) challenged the notion held by Leininger, Travelbee and Watson (all cited in Morse, 1992) that caring is the major focus of nursing. Morse now considers caring to be inadequate as nursing’s central paradigm. She believes that caring is an essential moral affect, necessary to direct comforting, but one that is subsumed under comfort. Morse argues that shifting the focus of nursing from
caring to comfort also shifts the focus of research from carer disposition to patient outcomes, as these are more measurable. She defines comfort as “… the label for the end-state of therapeutic nursing actions for a patient”, having temporal qualities of transitory relief and a more enduring and constant sense of optimal physiological and psychological wellbeing (Morse, 1992, p. 93).

2.2.3.6. Comfort in the Emergency Department

In the work leading to the above conclusions, Morse (1992) used non-participant observation to investigate the patient-comforting role of nurses in an Emergency Department of an American hospital. She contributes to our understanding of the several ways nurses work to comfort distressed and frightened people in their care. To date, Morse has identified several types of nurse-initiated comforting targeted at making patients feel psychologically safe and thus psychologically comfortable. Nurse behaviours included working to promote a relaxed atmosphere around patients, attending to their most urgent needs and maintaining skilled observation, acting with efficiency and competence, responding flexibly to individual needs for comfort; giving procedural and sensory information and support through painful or strange procedures and generally enhancing patients’ comfort through such behaviours.

2.2.3.7. Comfort ‘work’ of patients

Sociological investigations using grounded theory have uncovered a number of types of comfort and discomfort work done by hospital patients. An early study by Fagerhaugh and Strauss (1977), provides a valuable sociological perspective on patient management by hospital staff, which they term ‘work’. Nurses engage in many different kinds of work such as ‘pain work’, ‘relief work’, ‘death work’, only some of which is physical. Fagerhaugh and Strauss (1977) characterise pain work as a process of staff interacting with patients who are having, and who may
be recalling, a variety of pain and discomfort experiences, present and past. Pain work is different from pain relief because it involves staff handling of expressions of pain and patient reactions to pain. Pain work also involves the patient who has to decide to seek help. This involves finding the appropriate staff member, selecting the right approach to staff, and expressing discomfort or pain in ways considered appropriate by the staff. It involves the patient in the unfamiliar work of negotiation with others for personal relief, at a time when he/she may feel least able to do so. Because of the patient's vulnerable and relatively powerless status in the context of hospital and treatment situation, the negotiation and interaction process needed to achieve relief are additionally uncomfortable.

Diagnosing, limiting, even inflicting pain during procedures, enduring it with the patient, legitimating it and balancing care priorities, are salient dimensions of pain work (Fagerhaugh & Strauss, 1977). These writers argue that hospitals and staff in acute medical-surgical situations are geared up for physical care, but are less geared for social or psychological care of patients in acute situations, or for non-acute or chronic aspects of those patients.

These dimensions could be shown to be differentially salient in different wards (Bond & Bond, 1986) such as in intensive care, oncology, paediatric, renal, coronary care, burn injury, and general medical and surgical wards, and with different age groups (Burke & Jerrett, 1989; Calderone, 1990). These 'salience differentials' relate to staff understandings of pain, derived from pain trajectories

Pain trajectories are the expected or usual amount of pain for patient conditions which staff from particular areas are familiar with. For instance, the pain relief needs of the patient with angina pectoris will probably be better understood in a coronary care ward than in a gynaecology ward. Later studies of people with chronic conditions confirm that the work that patients do in hospital is largely unrecognised. However, 'body work' takes energy, time, courage and will (Strauss, Fagerhaugh, Suczek, & Weiner, 1985). These researchers also found
that comfort is being technologised, that nursing comfort tasks are being routinely scheduled and that they are given a lower priority than medically delegated work when nurses are busy (Strauss et al., 1985; Strauss, 1987).

As can be seen, the literature on comfort and comfort measures has increased in the last ten years. The obvious benefits of comfort and comforting highlighted in this growing literature should flow on to patients experiencing discomfort. However, as will be noted below, very little has been documented about the nature of discomfort, except where the term is used to indicate pain and pain relief.

2.3. Review Of Relevant Literature On Discomfort

Because the body of research and scholarly literature on discomfort is small, the following review is brief in comparison to the foregoing section on comfort.

2.3.1. Discomfort: an overview

Discomfort, like comfort, has noun and verb forms. Discomfort is defined as inconvenience, distress or mild pain, something that disturbs or deprives of ease, an absence of peace. To discomfit someone (an old-fashioned term) is to make them uneasy, confused or embarrassed; to be uncomfortable is to lack mental or physical ease or comfort (Wilkes & Krebs, 1991). In nursing literature, discomfort is associated almost exclusively with pain though it is considered less overwhelming than pain. Discomfort and pain are thus characterised as the opposites of comfort (Norris, 1985).

In much of the nursing literature comfort, discomfort and pain are inextricably linked and have implied, global and taken-for-granted meanings. In some instances, the term 'discomfort' is used interchangeably with pain, in others
comfort is synonymous with pain relief. In practice, it is my impression that discomfort, if noted at all, is narrowly conceived as a mildly painful physical sensation, for which a simple analgesic may be offered and nothing else. In the very extensive literature on pain, mention of discomfort is rare and recommended relief measures are exclusively pharmacological.

Discomfort is a physiological, biological and environmental stressor (Fischer & Connolly, 1970). Unrelieved discomfort is exhausting and demoralising, leading to a generalised increase in muscle tension (Beland, 1970). The ability to tolerate any type of discomfort is affected by anxiety, fatigue and a number of factors which include its duration and intensity, the expectation both of its temporary relief and of its recurrence, and the meaning of the discomfort for the individual. Discomfort is complex and is experienced on more than a physical level, making comfort difficult to achieve (Jacox, 1979; McCaffery & Beebe, 1989; Walker, 1989).

A short list of physical and other discomforts which may be experienced by patients in hospital includes soreness, itching, nausea, anorexia, stiffness, mal-positioning and poor body alignment, constricting bedclothes, spasm, shortness of breath, fatigue, impaired sleep, sore gums, dry mouth, dysphagia, tube displacement, traction or pressure, odour, feeling unclean, constipation, immobility, disfigurement, anxiety, lack of information, unexplained waiting, unpredictable or noisy environment, insensitivity, rough handling, lack of interest, lack of warmth or encouragement (Beland, 1970).

2.3.2. Research on discomfort

While it seems obvious that interventions to decrease discomfort should be described and evaluated by both patients and nurses, to date, few patient-centred research studies have been published. Tucker-Cartlett and Holditch-Davis (1990)
discovered that not all touch intended to comfort critically ill neonates is in fact comforting to them, judging by increases in their physiological distress parameters and overt flinching when touched. Donovan's (1990) investigation revealed that about one third of a sample of hospitalised patients reported either no relief or actual increase in physical discomfort, from a number of interventions such as bed rest, sleep, heat, cold, massage, distraction and moderate activity.

Since discomfort and pain are often used as interchangeable terms, a patient may not report pain, or if asked if pain is present, will deny it. However, if asked if he / she is uncomfortable, will often agree (Eland, 1991; Jacox, 1979). Differences in terms used by patients and nurses in labelling painful or uncomfortable experiences were studied by Jacox (1979). Discomfort also had to do with psychosocial situations. Patients were hurt by unkindness, or made anxious when waiting for unfamiliar procedures for which they had not been prepared.

2. 3. 2. 1. Discomfort in caregiver-patient interactions:

Feeling excluded from meaningful interaction as a patient in the health care system - depersonalisation, is an aspect of discomfort which has been studied by a number of researchers. Caregiver unwillingness or inability to recognise suffering, distancing and avoiding behaviours and lack of nurse involvement (Flaskerud, Halloran, Janken, Lund & Zetterlund, 1979) were characteristic of some nurse-patient relationships.

The phenomenon of exclusion using patients' descriptions was investigated by Anderson (1981). The main mechanism of exclusion was found to be emotional distancing (manifested through diminished affect in facial expression, tone of voice, verbal style, use of silence, use of touch). Caregiver actions which aroused feelings of helplessness, anger and exclusion were those such as not looking at the patient, talking past or over the patient, remaining inappropriately silent or openly
doubting the patient. Responses to exclusions were withdrawal, passivity, crying, or assertion. Anderson believes that exclusion is a persistent characteristic of health care, and suggests that respect for patient privacy may be taken too far, suggesting that being left alone is qualitatively different from being left out.

Another glimpse of exclusion and its opposite, confirmation, in caregiver-patient interactions is reported by Drew (1986). Informants described caregivers who made them feel excluded as lacking emotional warmth, and as uncaring. Caregivers could create a confirming, caring and healing environment with verbal and non-verbal communication. This resulted in a relaxed and supportive atmosphere, reduced emotional and physical distance and conveyed genuine concern.

2.3.2.2. Discomfort relief as a need

Two major kinds of needs which impinge on nursing care, and which indirectly relate to comfort have been identified. The first need is to stay well or to recover from illness with minimal suffering. The second is a personal/individual need for respect, information, personal space, support and autonomy (Bergman, 1983). The nurse should understand the patient's human needs in order to provide care and to order the environment to control discomfort. Nursing activities which comfort and assist the patient include providing relief from physical discomfort such as nausea, vomiting, chilling, thirst, hunger, pressure, itch, fatigue, muscle tension, breathlessness and pain.

In a study of elderly patients who were labelled difficult by nursing staff, English and Morse (1988, p. 37) found that "... the key variable preceding the onset of difficult behaviour was unmet comfort needs" and that proactive recognition and intervention to decrease discomfort were an important and obvious solution.
In summary, while there are relatively few references to discomfort in the nursing literature, it is apparent that pain and comfort are topics of increasing interest to nurses, judging by the useful descriptions which have emerged concerning the context, incidence and characteristics of these important phenomena. Discomfort and ways of alleviating it are a critical area for continuing nursing investigation (Robinson, 1990). The significant issues of the accuracy of nursing perceptions and of recognition of comfort and discomfort are dealt with in the following section.

2.4. Review Of The Literature On Related Matters

A fundamental aspect of providing comfort care is determining through some form of assessment whether a patient is comfortable or uncomfortable, deciding how to proceed and later, re-assessing the situation. Patient assessment tasks have been incorporated into the nursing process as part of a formalised and systematic approach to care delivery, but the application of nursing process sometimes falls short of the standard promulgated by educators and required by administrators. In practice, it is common to find that the nursing process is seen, particularly in ‘general’ wards, as creating unnecessary documentation and as time-consuming, at the same time as the value of careful assessment, record-keeping and evaluation of care is acknowledged. The nursing literature on the nursing process, nursing models and nursing quality assurance standards where relevant to comfort and discomfort are reviewed in the following section.

2.4.1. Issues in assessment and management of comfort/discomfort

Clinical assessment of comfort and discomfort is a far from simple task. Some of the difficulties relate to the severity of the discomfort which can make description difficult for the patient, the perceptions of the patient as to what is appropriate to
disclose (often age, culture and gender related), the meanings attached to discomfort descriptors, time pressures of nurses and the knowledge, sensitivity and skill of the assessor. Compounding this, common physical discomfort may be underestimated. Farrell (1991) for instance, gives the example of the discomfort of a dry mouth as being so commonplace that it is frequently overlooked.

While advances in pain magement have occurred, many nurses still do not adequately assess comfort, discomfort or pain. Nurses and doctors are still overly concerned with addiction risks associated with analgesic drugs. This influences their judgments of patients’ pain so that they are still likely to label as malingering or manipulative, those whose pain problems are complex, difficult to diagnose and therefore to solve. The multiple and challenging problems associated with assessing and managing pain and discomfort have been identified as including caregiver lack of knowledge of pain, of pharmacology, and of alternatives to analgesia (McCaffery & Beebe, 1989; Sofaer, 1992), stereotyping of patients as complainers and malingerers (Davitz & Davitz, 1980; Deveills, Adams & Devellis, 1984), reliance on a disease-focused, cure-oriented medical model of care (Halfens, Evers & Abu-Saad, 1990; Taylor, Skelton & Butcher, 1984), over-concern with drug addiction (Cohen, 1980; Dalton, 1989; McCaffery & Beebe, 1989; Seers, 1987) and distorted expectations of patient bravery and stoicism (Connor, 1988; Teske, Daut & Cleeland, 1983).

2. 4. 1. 1. Approaches to comfort assessment

A number of pain assessment approaches have been developed and are in various stages of clinical validation (McCaffery & Beebe, 1989), however very few frameworks for assessing comfort and discomfort are found in the literature. Mitchell and Loustau (1983) outline a brief assessment of the patient’s state of comfort and rest which includes a decision algorithm. Milliken and Campbell
(1985) direct the beginning nurse to observe the patient's sleep patterns and to note whether the patient is resting, or is experiencing pain. Ferrell and Ferrell (1990), having identified the comfort needs of the elderly, focus on assessing and evaluating pain relief, hygiene, skin care including pressure sore management, mouth care and promotion of restful sleep. Dalton (1989) proposed an assessment of pain / discomfort, with respect to their effects on sleep, appetite, elimination, activity and mood and including an evaluation of the frequency and effectiveness of usual relief measures. Kolecba's (1991) Taxonomic Comfort Grid could be utilised as an assessment guide for nurses working with different patient groups in identifying and alleviating various discomforts.

Distress is an aspect of emotional or physical discomfort triggered by loss, pain or threat (Reid-Ponte, 1992). A method of assessing distress in upset infants and children in paediatric intensive care units, using the COMFORT Scale (Ambuel, Hamlett, Marx & Blumer, 1992) is relevant to this review for its emphasis on scrupulous observation of non-verbal manifestations of discomfort such as muscle tone and bodily movements. Hurley, Volicer, Hanrahan, Houde and Volicer (1992) developed a scale for assessing discomfort in non-communicative patients with Alzheimer's type disorders, focusing on behavioural indicators such as body posture, fidgeting and restlessness, facial grimacing, facial expression and breathing patterns (Hurley et al., 1992). Given that patients sometimes do not report their discomfort, this approach has relevance for the nursing assessment of patients in all age-groups and situations.

2. 4. 1. 2. Nursing diagnosis: help or hindrance in discomfort?

Nursing diagnosis as a basis for care planning has been criticised as reductionist (Benner, 1984; Masso, 1990) and only useful if assessment and documentation are systematic and thorough (Donovan, 1990). The risk is that patient care problems may be identified in a routine and superficial way because of limited
time to search for adequate information (Henderson, 1982; McHugh, 1991). A perceptual base shared by nurse and patient is a necessary starting point for optimal nursing care and for care planning. Roberts found major differences in the type and number of problems identified by nurse-patient dyads (Roberts, 1982). Molzahn and Northcott (1989) concluded from a review of pertinent literature that there may be little or no relationship between the perceptions of nurse and patient of a number of variables such as pain, anxiety, patient needs and patient satisfaction with care. They suggest that nurses who spend abbreviated periods of time with patients may form inaccurate perceptions of their physical discomfort or of other concerns which can lead to unreliable data collection, faulty problem identification or diagnosis, poor communication and inadequate and inappropriate treatment, all of which have legal, professional and ethical implications.

The nursing diagnosis categories of ‘Alteration in comfort: Acute pain’, and ‘Alteration in comfort: Chronic pain’ describe acute episodic or severe persisting discomforts, of physical, emotional or psychological origin (Lederer, Marculescu, Gallagher & Mills, 1986). Nursing diagnoses designed to address patient problems comprehensively tend to fragment the problem of patient discomfort into a number of pieces, each requiring an entry in a care plan. The entire approach of Nursing Diagnosis, inferred from the language used, seems to be one of behaviour modification. A common nursing goal specified in texts which outline nursing care plans is to reduce the instances of patient reports of pain / discomfort (a behaviourist approach), rather than to ascertain from the patient whether relief has been obtained (an interactionist approach). Many of the discomforts patients experience receive scant attention and unless the patient reports severe or persisting discomfort, most will not be documented or referred to in hand-overs.
2. 4. 1. 3. Other variables in discomfort

Examples of inflexible or ill-informed perspectives which cannot accommodate unexpected pain trajectories, or variability in the patient's pain/discomfort experience, can be found in the literature. Women, for example, have chronic pain experiences attributed to frailty, neuroticism and guilt and may find it difficult for their claims to be believed (Crook, cited in Copp, 1986). Johnson (1976, cited in Craig, 1989) found that nurses underestimate discomfort, basing their estimations on patient age, gender, and the amount of pain they associate with specific conditions rather than on the findings from individual patient assessment.

Organisational variables such as unit policies, staffing and the work demands of the setting influence the time available for involving the patient in decision-making, for clinical judgement and choice of intervention, and for opportunities to find out about and support the patient's usual coping methods (Infante & Mooney, 1987). In a health care environment dedicated to getting the work done patients may be reduced to the status of work objects (Reed & Bond, 1991).

Clinical care standards for all nursing activities including comfort, rest and sleep have been published (Snowley & Nicklin, 1987; Australian Society of Critical Care Nurses, 1989) but are not widely publicised. Quality assurance may focus only on what has been initially documented about comfort, rest and sleep disturbances, with little emphasis on continuing surveillance or provision for documentation of persisting, emerging or changing discomforts.

2. 4. 1. 4. Nursing models and comfort/discomfort

The use of models and conceptual frameworks is a way of linking theory and practice. However, models and theories by themselves do not guarantee quality
of care and have been criticised for failing to address the complexity of actual situations (Gordon, 1984). Many do not address the assessment of comfort and discomfort in any meaningful way, although the mind-body-spirit model proposed by Burkhardt (1989) goes some way to focus on holistic care. However, the palliative care or hospice model, providing as it does for multi-disciplinary and multi-modal management of pain and discomfort, and Travelbee’s (1966) focus on patient suffering and nursing as an interactive activity, are appropriate models in situations where comfort and discomfort are to be assessed. Each is person-centred and concerned with the subjective reality of the individual, in addition to what might be thought of as their clinical or pathophysiological reality.

Roper’s (1976) model of nursing is one of the few which place significant emphasis on the assessment and management of comfort. Roper asserts that physical, psychological and social comfort are important for health. Roper’s model identifies four ‘need’ components. The first relates to needs associated with activities of daily living: the nurse intervenes after assessing dependency needs. The second component is aimed at preventing a wide variety of common physical and psychosocial problems, including discomfort and pain. The nurse is proactive in anticipating and minimising these. The third component is identified as ‘comforting’ in circumstances which compromise patient well-being, that is, disability (physical pathology, injury or deterioration) and any other threats which may be present in the physical, psychological or social environment. The fourth component of the model relates to medically prescribed nursing activities, with the nurse providing interventions which relieve one or other form of distress. Roper’s model is one of the few which place significant emphasis on the explicit assessment of comfort. More recently, Christensen (1990) describes the nurse-patient relationship as a partnership. In a partnership model of care, the nurse focuses on the broad health and comfort needs of the patient and works with the
patient/family using both technological and non-technological nursing skills, as coach and facilitator.

Nagy, Crisp and Brodie (1992) found that relatively few nurses practicing in New South Wales, the most populous state in Australia, read professional nursing journal literature. They concluded that this constituted a major obstacle to dissemination of scholarly nursing insights and nursing research findings, as well as limiting consideration of research implications for improved nursing practice which might result from greater exposure to clinical and theoretical literature. These findings, when applied to the developing scholarly and research journal literature on comfort, suggest that it may be some time before there is a flow-on of substantive research and scholarly insights to the clinical practice of assessment of comfort and evaluation of patient comfort interventions.

2.4.2. Chapter summary

The literature on measures which promote a broad range of comforts is relatively sparse, while that on discomfort is largely static, and in the main is associated with physical pain. It is clear that comfort and discomfort can be experienced by all patient groups, on a number of levels, over a range of intensities and for varying periods of time. Pain is but one type of intense discomfort and a nurse should not assume that the patient is comfortable in the absence of pain or of reports of pain. Interpersonal skills which convey empathy are likely to assist patients to reveal subjective information about their concerns. Skills of observation assist the nurse to identify and interpret comfort/discomfort cues unhampered by stereotyped expectations.

There remains a significant gap in the research literature on patient perceptions of comfort and discomfort. No studies to date have focused on the perceptions of adult patients following short-stay hospitalisation for acute but ultimately non-
life-threatening, non-disabling conditions. This large group of hospital patients have a number of discomforts and that these may be unrecognised and/or under-reported, for a variety of reasons which may include the pressures under which nurses have to work. Another reason may be that these patients are regarded as the ‘walking wounded’ who require little nursing care once they are pronounced medically or surgically well. This reductionist view of wellness dominates acute care facilities which focus resources, including time and attention, on the more critically ill. The less acutely ill patient may be nursed via what I term a ‘hotel’ or ‘call us if you need us’ model of care.

The preceding review of the literature justifies the need for a patient-centred study to determine the nature and intensity of the discomforts of this sub-set of patients, and how (and if) their comfort needs are met. These concerns form the central theme of this thesis. However two other areas of the literature I considered intrinsic to the provision of comfort and to identifying and managing discomfort, namely caring and empathy, will be reviewed in the following chapter.
CHAPTER THREE
Selective Review of The Literature on Caring and Empathy

This chapter presents a selective review of the literature on caring and empathy, concepts which have a strong bearing on the provision of comfort by nurses. As previously stated, my awareness of existing literature could not be denied and is presented here as knowledge which motivated and informed the present investigation into comfort, discomfort and the medical-surgical patient.

3. 1. Review Of The Literature On Caring

The literature on caring is extensive and the material presented below has been selected for its relevance to comfort and discomfort.

3. 1. 1. Theoretical perspectives on nursing as caring

Nursing is widely considered to be a humanitarian occupation concerned with assisting people, ill or well, who are in need of the broad range of professional services that nurses provide. Nursing theorists either explicitly or implicitly regard nursing as a process of caring, protecting or enabling. There is support for an approach to the patient/client which is essentially sympathetic and which is based on knowledge of health, illness, and human behaviour, within the context of nursing as both art and science. The recent work of Leininger (1988), Watson (1988), Benner and Wrubel (1989) and others has served to give recognition to the importance of caring and to emphasise caring as integral to professional nursing.

Definitions of nursing-as-caring characterise nursing as interpersonal and therapeutic (Peplau, 1952), acting to meet needs and alleviate distress (Orlando, 1961; Weidenbach, 1964), complementing deficits (Henderson, 1966; Orem,
1985), alleviating stress (Johnson, 1961; Neuman, 1982; Roy, 1976), interpersonal and transactional (Travelbee, 1966; King, 1981), scientific and humanistic (Paterson and Zderad, 1976; Rogers, 1988) with transcultural elements (Leininger, 1977), a caring ideology translated into practice (Watson, 1979), and if it is truly nursing, as skilled activities which contribute to healing (Benner, 1984; Gardner, 1985).

The meaning of caring in nursing has evolved from an ideal of selfless service to a more balanced and rational appreciation of caring. Caring can be seen as a way of meeting the genuine needs of people in vulnerable situations for human caring practices such as support and comfort, as well as for competent technical care. In western societies, health care providers focus on activities with a growing social value, such as fostering autonomy and self-care. However, these values are not universally esteemed. Interdependence and mutual reciprocity are more appropriate in low socioeconomic groups and in many non-western cultures (Leininger, 1988). Thus, patients’ and nurses’ perceptions about what constitutes caring may differ, depending on culture, needs and context. Hospital health care has changed with the introduction and escalation of sophisticated technology. Patients are sicker, the work of the nurse has become more demanding, hospital stays are shorter, transfers are common and nurses may not have the satisfaction of seeing their patients recover or even improve.

In a comprehensive review of the concept of caring Morse, Solberg, Neander, Bottorff and Johnson (1990) identified caring as a human state, a moral ideal, an affect, as interpersonal relationship and as nursing intervention. They criticised a continuing focus by theorists and researchers on the nurse to the exclusion of the patient.
3.1.1.1. Generic caring and caring skills

Mayeroff (1971) identified aspects of caring centred on knowing the self and the other, moderating one's own behaviour as needed by the situation, humility in being able to learn from others, and hope. While this generic model of caring is often cited in the nursing literature, aspects of the model which suggest that the caring relationship is dependent on mutual growth and development, on an 'I-thou' level of intimacy and which implies more than brief relationships, have been criticised as inappropriate or unrealistic for nursing (van Hooft, 1988). This had led other other nursing scholars to focus more closely on caring skills and attitudes.

The literature emphasising nursing as caring as distinct from nursing care which is procedurally and technically focused, is relatively recent. Watson (1979) defined nursing as a cognitive, technical, affective and interactive process which involves being with and doing with, and for, the patient. Lewis and Timby (1988, p. 3) define caring as the "concern and attachment that occur from the close relationship between one human being with another" and caring skills as those which "restore or maintain an individual's highest state of functioning". Caring is strongly linked to comfort through specific clinical caring skills which incorporate elements of ministering, responding, conserving and harmonising, coaching, encouraging and interpreting, as well as specific actions, attitudes and behaviours which promote comfort and relieve multiple discomforts (Christensen, 1990). Appropriately facilitating laughter and tears to reduce perceptions of stressful hospital environments and to promote emotional healing and well-being (Dugan, 1989), and meeting patients' needs in a timely fashion (Chipman, 1991) are but two ways of expressing intentional caring through skilled nursing.

The concept of 'being with' the patient to help in meeting health care needs is referred to by Paterson and Zderad (1976) as 'presence' and reflects humanistic
and phenomenological philosophies. Presence is linked to empathy, support and to therapeutic use of self within the personal space of the patient who is in need of closeness and comfort (Gardner, 1979, in Bulechek & McCloskey, 1985). Caring in this stream of the literature means ‘being there’ physically and psychologically for another. Focused on the patient and making some sort of difference, ‘being there’ symbolises for many the essence of professional nursing and the nurse-patient relationship (Boyd, 1986). The patient sees in the nurse the possibility of help, comfort and support and has an expectation that the nurse will relate with warmth, caring, respect and interest (Gardner, 1979, in Bulechek & McCloskey 1985).

Patients also expect the nurse, in ‘being there’, to be up-to-date, knowledgeable, competent, available and accepting of differences. The nurse should allow the patient to participate in decisions, should teach health maintenance and health promotion, should listen to and believe the patient, and should communicate in understandable language (Lewis & Timby, 1988). Caring which individualises the nurse’s approach reduces the psychological and social discomforts experienced as a patient.

A pre-requisite to caring, according to Benner (1984) is perceptual sensitivity, involvement and attentiveness which support conceptual reasoning and promote creative problem solving. Benner associates the notion of power with caring. Transformational power helps the client mobilise coping skills, regain control, make choices. Advocacy power removes obstacles, is enabling and supportive. Healing power provides support and mobilises faith, hope, confidence and optimism (Benner 1984). These attentive, assistive activities of nursing are powerful vehicles for achieving patient comfort.

In later work, Benner and Wrubel (1989) provide a number of clinical exemplars of caring as ‘making contact’ or connecting with the reality of the illness
experience and its meaning for the patient. Nurses do this by ‘presencing’ - paying attention, being concerned and thorough, seeking to become aware of the uniqueness of the individual, choosing and enacting behaviours showing sensitivity and consideration, coaching a person through an ordeal, enabling, supporting and reassuring. The possibilities for comforting patients and families are maximised through these unique caring ‘connections’.

3.1.2. Patient and nurse perspectives on caring

Watson (1979) classified nursing actions as instrumental (procedures, medications) or expressive (psychosocially oriented behaviours such as listening). Patients cannot be expected to recognize and appreciate the subtleties of the skills nurses use to communicate: listening, talking, educating, facilitating, encouraging and explaining, in their efforts to individualize care and to provide psychosocial comfort. Acutely ill patients need first to be assured that the nurse will know what to do so that perceptions of the nurse as caring are closely tied to the nurse’s perceived instrumental competence (Komorita, Doehring & Hitchert 1991).

Brown (1986) used a critical incident technique with non-critical care medical-surgical patients to document experiences in which they felt cared for by a nurse. Several care themes were found where nurses recognised individual patient qualities and needs, provided desired information, were professionally knowledgeable and skilful, gave assistance with pain both directly and through supporting the patient’s coping mechanisms, spent time with patients, promoted independence and autonomy, and maintained a protective watchfulness. Each of these comforting nursing behaviours was construed by patients as caring (Brown, 1986).

The literature on caring in relation to variables which may affect perceptions of caring, such as gender and age differences, is minimal. However, one study, albeit involving a small number of male nurses, found that caring in nursing is not
exclusively a female trait (Ingle, 1988). Swanson-Kauffman (1988) researching perinatal nursing contexts, elicited from patients the nursing actions which were seen as caring, and thus, as comforting. These had conceptual similarities with those of Watson (1979), Benner (1984) and Christensen (1990) and were classified as ‘knowing’, ‘doing for’, ‘being with’, ‘enabling’ and ‘maintaining belief’.

3.1.2.1. Burnout and its effect on caring and comfort

Burnout is increasingly recognised as a problem in service-related occupations. It is characterised by physical exhaustion, emotional exhaustion, loss of sympathy, respect and positive feelings for patients, and a ‘blame the victim’ perspective. There is decreased concern for patients’ personal and subjective well-being, including their comfort and discomfort, which amounts to a loss of human caring. Burnout influences patient care so that patients wait longer and receive less attention (O’Keefe, 1985). Early signs of burnout may manifest as distancing and depersonalisation, referring to patients by symptom or disease, ignoring the individuality of patients, and spending little time with patients (Anderson, 1981; Drew, 1986; Wimbush, 1983). Actions and attitudes such as these have been clearly identified in the previous chapter as sources of patient discomfort.

Causes of burnout in nurses include excessive and constant stress such as long stretches of shift work, rotation to unfamiliar environments, appetite and sleep pattern disturbances, lack of colleague and institutional support and difficulty in developing and maintaining relationships with such demanding work schedules (O’Keefe, 1985). Poorly-managed and scarce resources, and lack of time which inhibits the provision of interpersonal support and psycho-emotional care to patients are implicated in burnout (Clarke & Wheeler, 1992). Thus burnout, in part a consequence of workplace pressures, can be seen to diminish the energy, enthusiasm and commitment to caring required for comforting patients.
Roles of the nurse now explicitly include those of patient advocate, teacher, technician, manager and change agent with responsibility for cost containment and quality assurance. There is the expectation that nurses engage in continuing education and that they will find ways of integrating the latest technology and research findings into their practice. At the same time, there is the paradoxical expectation that the expanding repertoire of skills and knowledge will require no additional nursing time in which to master and apply them. Increasingly, nurses spend less time providing care and more time documenting and organising it. While time constraints partly explain reduced time available for direct caregiving, and thus for assessing comfort and intervening for discomfort, they do not fully explain caregiving patterns where nurses focus more on technical tasks and non-patient care activities in apparent preference to direct, personalised patient care (Leininger, 1988).

3.1.2.2. Rejection of caring

For some nurses, status, technology and rational economics have become the dominant ethos, despite popular rhetoric about holistic nursing care (Leininger, 1988). A supposed shift in values has led to decreased regard for altruism (Redmond, 1985) and increased self-interest among nurses in search of greater autonomy and need satisfaction (Leininger, 1988), at the expense of patient comforting activities. Instances where nurses had not valued caring nor believed that it was an essential component of nursing were identified by Leininger (1988) as ‘care resistance factors’. These nurses asserted that nursing was a business enterprise that needed to be cost effective; that nursing was the manipulation of stress factors, the alleviation of medical stress, or energy control and physical regulation of the environment. Perhaps in search of a more ‘professional’ image, they avoided the use of the term ‘care’ and preferred language thought to be neutral and objective to describe patient-care activities. Care in the 1960s and
1970s was perceived by some nurses as a mainly female activity with low status and prestige. Because this was demeaning for nursing, care and caring became, at least for a few years, almost a cultural taboo (Leininger, 1988). Paradoxically, at about the same time, the ‘female’ way of knowing and being-in-the-world was beginning to be asserted and valued by a small but growing number of feminists immersed in an existential, humanistic and post-positivist view of the world (Rudge, 1992).

Caring may be interpreted by some as conflicting with concepts and theories utilised in addiction recovery programs, which emphasise personal responsibility and self-care, and reduction of care-taking activities by significant others. Thus, nurses working with co-dependents may perceive caring behaviours in professional nursing as compromising or dysfunctional (Chappelle, 1990, cited in Chapelle & Sorentino, 1993). Taking care of others has been found by some to be counter-productive when it leads to dependency. Professional helping is now redirected to become supportive facilitation, which is a more complex and difficult task. It is difficult because the facilitator may be perceived as not doing anything and may get less recognition from working with a participation model of health service associated with notions of partnership and collaboration (Davidhizar, 1990). However, planned activities such as helping others to find solutions and to become more independent and confident can be applied to the complexities inherent in patient discomfort, and are consistent with Mayeroff’s (1971) view of generic caring.

3.1.3. Summary and critique of caring literature

Caring is broadly perceived as an essential element of humanistic care. Much of the professional nursing literature on caring has come from a phenomenological perspective and from exemplars - if relatively few - of best practice in nursing, or is idealised in terms of ‘ought’ and ‘should’. Caring behaviours are described in
terms of the highest ideals and aspirations rather than as context-dependent possibilities for caring. Theorists advocate closeness and a degree of professional nurse-patient intimacy. Practitioners, on the other hand, have evolved ‘arms-length relationships’ which may serve a useful function for both nurse and patient by reducing patient dependency and a sense of discomfort and indebtedness for care provided (Chapman, 1976). Part of the persisting theory-practice dichotomy relates to contemporary theory development mostly by North American nurses, and its difficulty in being utilised by nurses in other countries, who may share a common language, but not necessarily common meanings, contexts or culture. Having said this, it is important to emphasise that caring is still highly valued by practicing nurses, although it may be operationalised in different patient care settings in distinctive and pragmatic ways.

Patients feel cared for - and comforted - when tangible evidence of alleviating the physical problem which brought them into hospital is present. Variables which affect perceptions of caring may be patient gender, age, expectations, degree of wellness/illness. In addition, a number of health care trends have combined to influence the quality of patient care and perceptions of nurse caring in the last two decades. In particular, illness monitoring and investigational technology of increasing sophistication requires nurses to understand and interact with machines as well as patients, sometimes to the detriment of patient comfort.

Caring in nursing has at times been disparaged as personifying female subordination, as obscure and mythical, as betraying professional goals, as economically unaffordable, as irrelevant in a medically-dominated and cure-orientated health care milieu and therefore, as dysfunctional for nursing. Alternatively, caring is characterised as a cultural mechanism for human survival and critical for human development, as a moral imperative, even as having a mystical and spiritual dimension. In the main, nurses continue to affirm that nursing and caring are inseparable, that caring dispositions and activities are
therapeutic, protective and facilitative of people in both health and illness, that
caring is comforting to patients and families, and as such, that caring, however
actualised, is ultimately functional for nursing.

Just as caring is seen as intrinsic to nursing, and to patient comfort, empathy has a
similar link to dyadic interaction, perception of patients’ needs and a concern to
meet those needs. Empathy enhances the therapeutic effectiveness of the nurse in
promoting patient comfort and relieving discomfort. The following section
reviews efforts by researchers and theorists to explain the relationship between
empathy and helping, and discusses selected studies on nurse empathy and
therapeutic effectiveness.

3. 2. Selective Review Of The Literature On Empathy

Empathy is one of a number of important concepts linked to comfort. In the
following pages, selected aspects of the literature on empathy are presented for
their relevance for patient comfort and discomfort. They focus on empathy as it
pertains to helping, perceptions, nurse-patient interaction, the fostering of
empathy and nurses’ inferences of suffering.

3. 2. 1. Theoretical perspectives on empathy and helping

The nursing literature views empathy as central to, and the most important
facilitator of, therapeutic relationships for without empathy there is no basis for
helping. It is the primary and most critical ingredient of helping (Carkhuff, 1970;
Dunlop, 1983; Kalisch, 1975; Reynolds, 1987) and is one of a number of
important concepts directly linked to comfort (Leininger, 1981).

Definitions of empathy fall into two broad categories. The first emphasises
cognitive understanding of the emotions, perspectives or situation of the other,
and having a detached awareness of what the other is experiencing. The second definition focuses on empathy as a process where the emotions, perspectives or situation of one person elicit emotional responses in another. The type of emotional response is coloured by the observer's personality, by factors in the interpersonal situation, by assumptions made by the observer based on a variety of cues and by the perceptual set of the observer (Stotland, Mathews, Sherman, Harrison, & Richardson, 1978). Given the paucity of literature on discomfort, invalid assumptions by nurses about the wellbeing and comfort of the hospital patient may be held.

3.2.1.1. Is empathy state or trait? Can it be taught?

Empathy has been variously perceived as a trait or human quality (stable over time) or a state, a way of communicating, which suggest that empathy can be taught and learned as an interaction skill. A number of studies have examined the possibility that empathy could be acquired through education and training. The results of some training programs indicated increased empathy reported by nurses and educators, but limited or no increase in perception of caregiver empathy by patients (Reynolds, 1987).

Trait empathy appears to be a stable quality in adults which is resistant to change. State empathy may be responsive to experiential learning approaches which include skills analysis, practice and feedback. Central to this strategy is an emphasis on vicarious learning through modelling and reinforcement in an environment of minimal threat, tension and anxiety. However, Reynolds (1987) found that nurse educators had differing views about the nature of empathy and how it could be taught and assessed. Teachers who were unclear about whether empathy could be taught would be unlikely to reinforce empathic behaviours and attitudes in nurses. Those who viewed empathy as an interaction skill would be likely to facilitate student practice of empathy. Sellick (1991) suggests that
nurses in a wide range of clinical settings lack even minimal levels of warmth, empathy and genuineness as a function of lack of formal training in communication skills. If we accept the importance of communication skills for empathy and the importance of empathy for the ability of a nurse to discern the comfort state of patients, then nurse educators and clinicians acting as role models for undergraduate and newly graduated nurses have a strong potential to influence nurses' skill in empathic communication with patients and thus to enhance the provision of comfort.

3. 2. 1. 2. Perceptions and stereotypes

Various factors influence our perceptions of others and therefore our ability to perceive feeling states, including comfort and discomfort, in others. These factors include our own feelings, beliefs, attitudes, experience, culture, gender, status and expectations. Our expectations may be coloured by stereotypes, which persist or are modified with further contact. In addition, the first information we get about someone (primary effect) substantially shapes our overall impressions (Hilgard, Atkinson and Atkinson, 1976). Information given to nurses at shift handover may colour the nurse's view of particular patients, and may exert a strong negative primary effect if patients are described as complaining and difficult or as having a high psychological component to their pain (Lane and Rae, 1983). Handover labels that describe patients as ambulant and self-caring convey an impression of minimal need for further nursing nursing assessment or for comforting nursing interventions.

3. 2. 1. 3. Empathy in nurse patient-relationships

Empathy is generally referred to in the nursing literature as a skill in helping, a skill actualised by identifying and responding to patients' feelings. It is the ability
to understand what a person is feeling and to communicate that understanding to him/her, while remaining objective enough to see why he/she feels as he does and to be able to assist. It is a process involving both intellect and emotions (Fish & Shelly, 1978) which are of particular importance in recognising and responding to patients experiencing discomfort.

A small number of studies on interpersonal qualities and communication skills of nurses have yielded mixed results. When nurses were asked to estimate the amount of suffering and the nurses’ likely pain-relieving interventions from vignettes describing patients, those patients with chronic low back pain, depressed patients and those with no obvious pathology were likely to receive little sympathy or attention (Taylor, Skelton, Butcher, 1984). Macdonald and Bridge (1991) found that nurses planned different care for male and female patients, expecting they would give males more analgesia and emotional support than females with similar diagnostic labels. The link between physical vulnerability and dependent status of the patient is thought to account for positive bias in rating caregiver empathy, that is, the more vulnerable the patient, the more likely they are to rate carers highly on empathy.

3.2.1.4. Nurse-patient communication

Nurse-patient communication has been studied extensively. Quality and quantity of communication are dynamic factors in any interaction and are dependent on cues which elicit on-going responses. Patients register and interpret a variety of cues emanating from the nurse. Patient self-disclosure is influenced by gender and culture (Kennedy & Garvin, 1981) and is facilitated by the expectation of carer empathy. Patients may not disclose problems which have an emotional component, for example, anxiety, frustration, powerless, hopelessness if they do not experience, or even expect, empathy from the nurse (Dawson, 1985). Barriers
to self-disclosure are set up by new and unfamiliar experiences and the perceptions by patients of caregivers as too important or too busy to be bothered, leaving communication at the level of social exchange, with main concerns unexpressed (Sheard, 1980; Twycross & Lack, 1986; Zaner, 1985). Discomfort here is present on two levels - the original problem and the difficulty in securing an empathic hearing from professional carers.

Most interactions studies have been descriptive, observing and noting overt behaviours such as linguistic characteristics and number and quantity of interactions. In many instances, researchers concluded that interaction and communication was often unplanned, task-focused, stereotyped and nurse-centred. It was also found to be limited to the social and superficial, evasive of difficult and sensitive issues, and impaired by stressful environments in which medical-surgical patients in these studies were nursed (Ashworth, 1979; Bond, 1982; Clark, cited in Wilson-Barnett, 1983; Davitz & Davitz, 1980; Graffam, 1970; Turnoch, 1989).

3. 2. 1. 5. Empathy: characteristics of patients and nurses

The literature has linked comfort with empathy through a number of reciprocal processes which occur between patient and nurse, such as perception and interaction. Characteristics of nurses as well as patients influence the level of empathy in interactions. Patient characteristics are known to influence the level of empathy shown by nurses, but the direction of that influence is not consistent. Nurses studied by Davitz and Davitz (1975) and Stockwell (1972) liked uncomplaining patients and had less sympathy for people with ‘minor’ illnesses. Student nurses were found to like caring for people in pain and for people needing high levels of nursing care. Nurses like brave, stoic patients who are good-humoured, uncomplaining and polite and take more interested in patients needing
complicated or high levels of nursing care, than in people with minor illnesses or who seem to be recovering (Baer & Lowery, 1987). Informants in this present study may well have been characterised as having 'minor illnesses' and of little clinical interest.

3.2.1.6. Nurses' interpretation of patients' suffering

Mason (1981) attempted to identify selected factors which influenced nurses' inferences of suffering by examining nurses' educational preparation, full-time or part-time employment, place of employment, position held, age of nurse, ages of patients. Length of nursing experience was the only factor found to be related to the empathic interaction. Nurses with less nursing experience (measured as age of nurse) inferred greater physical suffering. The greater exposure to patients' physical suffering (as with six to ten years of nursing experience) may lead nurses to desensitise to suffering. Cues from the other, or in the other's environment or situation, have been shown to influence the perceptual set and the degree of empathy experienced. Nurses who have desensitised through long exposure to pain and suffering in others may have developed a neutral and detached perceptual set (Stotland et al., 1978) which in turn may compromise assessment of patient discomfort.

Steeves, Kahn and Benoliel (1990) set out to describe assumptions, beliefs and ideas held by nurses about the suffering they met with in clinical practice. Their qualitative data revealed themes of progressive understanding of patient suffering. In providing new insight into ways nurses respond to and give meaning to patients' suffering this work identified caring as a process which takes time to develop.
3. 2. 1. 7. Negative outcomes of empathy

Sympathy has been actively discouraged by nurse educators in recent years, presumably on the grounds that by engaging the nurse’s emotions too deeply, it may render the nurse incapable of offering patients constructive help. Empathy is seen as a cognitive rather than emotional response, less likely to overwhelm the novice, less likely to lead to emotional exhaustion and burnout and thus, a more appropriate stance for nurses to adopt. Empathy is not without its problems for patients and nurses, however, as some studies have suggested.

One way to reduce empathic distress would be to help, or to try to help, the other. In theory, at least, the decision to help reduces one’s own pain, and will, in addition, be influenced by a perception of being competent to help. Another way to deal with negative emotions aroused in empathic interaction is emotional or physical protective distancing, especially if there is a perception of being unable to help, or of not being responsible for helping (Stotland et al., 1978). Davitz and Davitz (1975) identified the need to explore ways in which hospital organisation and communication patterns impinge on caregiving situations to make them more stressful for nurses and patients. The costs are not only in the strain of the situation for both the nurse and for the patient who is experiencing some form of discomfort, but in the decrease in therapeutic effectiveness of the interactive processes of nursing (Marck, 1990).

Concerns have been raised about nursing’s uncritical acceptance of the concept of empathy from the discipline of psychology, and whether empathy is always a suitable vehicle for getting in touch with another’s experience, as distinct from sympathy, consolation and commiseration. Empathy may be inappropriate, even impossible, in some nurse-patient interactions (Morse, Anderson, Bottorf, Yonge, O’Brien, Solberg, McIliveen, 1992). Gordon (1987, cited in Morse et al., 1992)
suggests an undesirable link between stereotyping and empathy which may limit nurse-patient exploration and understanding of a situation, through the nurse making inferences and assumptions prematurely. Thus, the nurse may not be open to new information and a further unfolding of the problem, particularly in relation to a patient with discomfort.

3.2.2. Summary of nursing literature on empathy

Empathy is generally considered to underpin continued, effective helping. In general, patients are likely to believe that nurses are empathic. In so far as empathy is a component of interaction, it may be fostered by teaching and reinforcing skills of verbal and non-verbal communication. The perceptual ‘set’ of the nurse, which leads to selective observation and interpretation is influenced by a number of factors including environmental cues, cultural origins and culturally-mediated expectations of nurse and patient. The length of exposure to patient suffering, the processual development of empathy over time and personal experience of discomfort and of being comforted have been identified as important ingredients of a disposition to help. Finally, while empathy is seen by nursing writers as fundamental to any helping relationship and a major influence on the quality of nursing care, there may be reasons to critically re-examine the notion of its blanket utility in all helping relationships. The literature supports the need for a patient-focused study on comfort and discomfort since activities of nurses, however well-intentioned, may not necessarily be interpreted by patients as either caring or comforting.

In summary, this selective review of the literature on comfort, discomfort, caring and empathy has served to indicate the level of understanding I had at the beginning of the study. It also assisted me in identifying that some pieces of the puzzle of persisting, unmanaged discomfort in a particular group of patients were missing. There was helpful description but little explanation.
The central question of this research project, the nature and importance of comfort and discomfort to medical-surgical patients convalescing in hospital, still needed to be asked. The question was investigated using a grounded theory approach and a symbolic interaction framework. The next chapter explains and justifies the study’s methodology.
CHAPTER FOUR

Grounded Theory and Symbolic Interaction: Perspective and Critique

This chapter provides an overview of grounded theory, the qualitative methodological approach chosen for this study and of symbolic interactionism, the generative theoretical framework of symbolic interaction. The chapter begins with a brief discussion of both quantitative and qualitative research approaches. Quantitative methodologies have, until recently, constituted the dominant approach to research in most disciplines. However, with the development of other perspectives, such as interpretive methodologies, broadly termed 'qualitative', considerable criticism of qualitative and quantitative approaches has been generated by polarised supporters of each perspective. These criticisms and later developments in the epistemological dialectic will be briefly discussed. Grounded theory procedures are then explained, as are aspects of symbolic interactionism. Grounded theory and symbolic interactionism are not without critics, and their criticisms are noted and addressed. The chapter is then rounded off by consideration of social structure and the agency-structure debate, both of which are pertinent to the way individuals are conceptualised as acting and interacting in society.

4.1. Background Issues

Qualitative and quantitative research paradigms and their respective assumptions and criticisms are outlined below, followed by a brief discussion of the language of the continuing epistemological debate and of attempts to reconcile polarised views concerning these two paradigms.
4.1.1. Quantitative research

Quantitative research is concerned with theoretically neutral observation, the etic (observer) perspective, and with the testing or verifying of theories. The major tenet of quantitative research methodology, briefly stated, is that physical science, conceived in terms of the logic of the experiment, is an adequate model for all research, including social research. According to this view, explanations obtained via deductive logic have a strong probability of applying across all circumstance, with a high value being placed on generalisability of findings (Hammersley & Atkinson, 1983). The quantitative perspective seeks facts about or causes of phenomena and is relatively unconcerned with ideas, feelings, motives or subjective states of individuals (Taylor & Bogdan, 1984). Quantitative methods derive data which is numerical and which can be interpreted deductively through statistical procedures. There is emphasis on external reality with less attention paid to the nature of intrinsic processes in human phenomena (Kirk & Miller, 1986).

4.1.2. Qualitative research

Qualitative research is a comprehensive term which covers a variety of methodologies and procedures. Researchers from a number of social science disciplines with different theoretical perspectives engage in qualitative research. Qualitative methodologies draw on a number of sociological, psychological and philosophical ideas, both established and evolving. These include varieties of symbolic interactionism, phenomenology, hermeneutics, ethnography and linguistic philosophy (Denzin & Lincoln, 1994; Hammersley & Atkinson, 1983). Qualitative inquiry seeks the emic perspective, that is, the perspective of the problem from the point of view of those experiencing a phenomenon, analysed within a cultural/social context (Field & Morse, 1985). Qualitative research approaches are aimed at describing and explaining patterns of interaction and
thought in the context or natural setting of informants. Data are primarily approached and analysed inductively although deductive approaches can be used. Because social phenomena are regarded by qualitative researchers as quite distinct in character from physical phenomena, distinctive inductive methodologies specifically suited to those investigation have been developed (Hammersley & Atkinson, 1983).

4.1.3. Assumptions of quantitative and qualitative research perspectives

Quantitative researchers use knowledge and methods designed to study the natural or physical world. This world is assumed to be mechanistic and orderly, and so studies are conducted analytically, through processes of intuition and deduction. Quantitative methods generate hypotheses intended to test theories deductively, from existing knowledge, in order to confirm and sometimes to disconfirm established theories. While there are limitations to this mechanistic view of the universe, the quantitative approach has led to outstanding achievements in the physical sciences (Capra, 1983).

The assumptions underlying qualitative approaches have been generated within human or social sciences and stem from a dissatisfaction with the capability of the objective, scientific method for generating knowledge about human behaviour, interaction and subjectivity. A mechanistic view of human beings as being predictable, and of human behaviour as a reaction to the environment, both to be studied through experimental techniques, has been challenged by an alternative set of assumptions. These assumptions are that human beings "not only react but act upon and create meaning of their experience so that inner and external 'realities' interact and cannot be separated" (Hunt, 1991, p. 120) and that these realities can be more fully understood in context and through an appreciation of the symbolic language used to communicate the perception of 'realities'. These
assumptions then, mandate different approaches to data collection, which do not rely on a preconceived framework. They point to discovery and to inductive analysis and theory development (Field & Morse, 1985).

4.1.4. Criticisms of both methodologies

Criticisms of qualitative methodologies have in the main, orginated from those espousing the values of the quantitative perspective. The research values underpinning the natural and physical sciences result in research in these areas following prescribed scientific method. This method aims to reduce bias. Quantitative methods have a preference for objective, value-free observation, precise measurement and controlled experiment. The goal is to be able to generalise findings without variation across different populations. According to Capra (1983) many quantitative researchers have been influenced by the early Cartesian view, and later, that of Hume, that all knowledge is contained within the boundaries of science. Thus, any research not using the scientific method to obtain answers is criticised as lacking scientific credibility. There is a strongly held belief in this community of scholars that the scientific method is the only way of understanding the universe (Capra, 1983; Suppe & Jacox, 1989). Quantitative researchers have contrasted their prevailing research values with non-quantitative values and have found them wanting. They have discounted qualitative research methods as ‘soft’ science (Carr, 1994), without rigour, whose findings cannot be generalised, and whose studies cannot be satisfactorily replicated. Both these inabilities are deemed, by quantitative researchers, to discredit qualitative research on the basis of rigour (Clarke, 1992).

From an opposing stance, critics of quantitative perspectives would claim that quantitative methods have not dealt adequately with human interactions, understandings or responses, that is, of human experiences in social contexts. They would claim that the search for meaning, which is at the heart of qualitative
approaches, is irrelevant to those with a mindset of objectivity and control (Munhall, 1991) or has been neglected by them (Gage, 1989). They would affirm that the essential meaning of the term ‘scientific’ as rigourous and systematic is a value no less strongly held by qualitative researchers.

4.1.5. The epistemological debate

At the heart of methodological polarity is epistemology, the underlying philosophical world-view or paradigm which directs and supports the assumptions of adherents in the matter of the type of knowledge to be valued and sought.

4.1.5.1. Language and the epistemological debate

For some time, proponents of qualitative and quantitative perspectives have ranged in often bitter opposition to one another’s epistemologies, with harsh criticisms emanating from each side of the epistemological divide. The heated language of the debate has had a polarising effect on the research community. One of the problems has been a tendency to confuse methodology with method and to apply to qualitative methodologies and processes terms such as empirical testing, validity and reliability from a dominant, sometimes narrow, quantitative perspective. For example, qualitative researchers emphasise validity in their research, but validation takes a different form from that in quantitative research. In relation to replication, qualitative researchers insist that replication as understood in quantitative research is simply not relevant to the qualitative methodology, while affirming the need for rigour in qualitative research.

Issues of reliability and validity in qualitative research will be more fully discussed in the following chapter. The point to be pursued here is the use, and possible misuse, of language in the epistemologic debate. This debate, often
impassioned, has been characterised by over-reaction, ambiguous language and sometimes, provocative disputation, all leading to undervaluing - and in many instances - outright rejection, of the purposes and outcomes of opposing methodologies (Gage, 1989).

Such turmoil is inevitable as new epistemologies challenge established ones. Kuhn (1970, cited in Melzack, 1991 in relation to pain theories) has demonstrated this. Furthermore, Melzack (1991) reviewed the manner in which 'normal science' (that is, that relating to existing pain theories) is challenged by a critical mass of empirical anomalies which build to crisis and result in revolution. Valuable elements of older theories about pain are eventually incorporated into new theoretical and clinical understandings, and a period of relative calm ensues, to be followed by a further spiral of anomaly, crisis, revolution and calm.

The early epistemological debate had been framed more in terms of fundamental differences in underlying assumptions than, as more recently, in terms of difference in techniques and methods. The view that quantitative and qualitative approaches represented mutually exclusive research perspectives reflected a purist stance on either side, and in accord with Kuhn's (1962) definition of 'paradigm', an acceptance of inherent links (implied as inextricable) between methods and assumptions (Kuhn, 1970, cited in Goodwin & Goodwin, 1984).

4. 1. 5. 2. Developments in the epistemological debate

For some, the 'purists', paradigm distinctions remain all-important: the philosophical assumptions underlying each perspective are incompatible and irreconcilable (Bednarz, 1985). A further group identified as 'situationalists' are open to either method, but reject any synthesis of quantitative and qualitative approaches. A middle position holds that all methods of data collection and analysis have knowledge development as their goal, and that one methodology
may be more useful than another for answering a given research question (Johnston & Bennett, 1994). Kuhn’s work has been critically challenged by writers cited in Meleis (1991) such as Laudan, Shapere, and Toulmin, who regard the development of knowledge through research as simultaneously collaborative, competitive and evolutionary. The exclusivist view has been challenged by those looking for a way around the dichotomy.

The choice of research procedures - including design, sampling plan, instrumentation, data collection methods, and data analysis techniques - should match the research question and be optimally efficient, powerful, valid and reliable ... Trying rigidly to link paradigm with method ... will produce findings which lack credibility (Goodwin & Goodwin, 1984, p. 379).

4. 1. 5. 3. A way forward for nursing research

In attempting to achieve credibility as researchers, early nurse researchers laid emphasis on the scientific approach through the use of the dominant quantitative methodology. Research which did not produce numerical data and widely applicable results was accorded by medical colleagues a lower status than statistical studies (Hunt, 1991). The quantitative approach later came to be regarded as less appropriate for the substantive area of nursing, leading to qualitative methods ultimately being seen as the only useful research technology for nursing research (Corner, 1991; Hunt, 1991).

Many researchers now believe there are advantages to using both quantitative and qualitative methods, either singly or in some form of triangulation (Corner, 1991; Gage, 1989; Goodwin & Goodwin, 1984). Triangulation is “a method of obtaining complementary findings that strengthen research results and contribute to theory and knowledge development” (Morse, 1991, p. 122). Morse (1991) provides examples of ways in which quantitative and qualitative approaches can be combined to strengthen research outcomes. This is a pragmatic stance which sees research methodologies as tools which can be used by the versatile
researcher to facilitate understanding, and for whom paradigmatic dichotomies are irrelevant. Qualitative approaches seek to understand human feelings such as loneliness, frustration, hope, satisfaction and the human meanings embedded in behaviour. Quantitative approaches also have their place, and has been indicated, the epistemological dichotomy debate may be resolved, in part, through some form of triangulation (Denzin, 1970; Fielding & Fielding, 1986).

A view of rigour which lies at the heart of the debate is that disciplined inquiry is conducted and reported openly, and on public inspection is found credible (Cronbach & Suppes, 1969; Smith, 1981, cited in Lincoln & Guba, 1985). According to Smith (1981),

> For an inquiry to qualify as disciplined, it must be conducted and reported so that its logical argument can be carefully examined; it does not depend on surface plausibility or the eloquence, status or authority of its author; error is avoided; evidential tests and verification are valued; the dispassionate search for truth is valued over ideology. Every piece of research or evaluation, whether naturalistic, experimental, survey or historical, must meet these standards to be considered disciplined (Smith, 1981, cited in Lincoln & Guba, 1985).

4. 1. 5. 4. Relevance of a qualitative approach for this study

Direct caregiving in nursing is an interactive activity in which, as part of a process of understanding and caring for patients in a health care context, “empathic and intuitive awareness are deliberately and purposefully employed” (Oiler, 1982, p. 178). Qualitative methods are appropriate for those questions in nursing which primarily require inductive analysis, through description and interpretation of a variety of human experiences, including those of comforting and being comforted. The central research question of this study has the goal of understanding the meaning of experiences and perceptions of patients in interaction with a particular environment. It focuses on process, on subjectivity, on context and on analysis of narrative language, and therefore the questions lends itself to a qualitative approach.
4.2. The Research Methodology

The qualitative research methodology employed in this study, a grounded theory approach, is discussed at some length in the following pages.

4.2.1. Grounded theory

Grounded theory is a method which outlines a strategy for handling data in order to generate theory which can be used to capture the complexity of reality and make convincing sense of it (Strauss, 1987). It focuses on the discovery of concepts, the identification of core processes and the development of substantive theory related to such processes.

Grounded theory employs both an inductive approach and a process of data analysis which involves constant comparison between segments of the data (Stern, Allen, & Moxley, 1984). It derives from a philosophy based on the symbolic interactionist school of social psychology of George Herbert Mead, which is concerned with understanding the meaning of events for people in everyday situations and with understanding the symbols they use to convey this meaning (Baker, Wuest, & Stern, 1992). Grounded theory was developed in 1967 by sociologists Glaser and Strauss (the latter an adherent of Mead) who were then teaching in the then new doctoral program in nursing at the University of California San Francisco.

Grounded theory has in some measure influenced the development of nursing theory (Suppe & Jacox, 1989) and is seen as having distinctive features in relation to sampling and coding which do not necessarily tie a researcher to "specific kinds of data, lines of research or theoretical interests" (Strauss, 1987, p 5). Strauss and Corbin (1990) acknowledge that grounded theory need not be linked to social psychology or to an interactionist perspective. The extent to which grounded theorists in nursing research have utilised the underlying theoretical
framework of symbolic interactionism in analysis, as distinct from the research methodology and procedures of grounded theory, has varied. A number of qualitative researchers have used the style of grounded theory, or variations of it, without necessarily adhering to the underlying theoretical framework of symbolic interactionism (Morse & Johnson, 1991). Grounded theory without symbolic interaction has been used to investigate nurses and patient interaction in a methadone clinic (Chenitz & Swanson, 1986), parental perceptions of caring following perinatal loss (Lemmer, 1991), and patient satisfaction with nursing care (Rempusheski, Chamberlain, Picard, Ruzanski, & Collier, 1988).

From the foregoing it can be seen that grounded theory is a method increasingly used in nursing research and is a theoretical approach which need not necessarily be linked with symbolic interactionism. This lends support to the notion that grounded theory methods are flexible and applicable in a variety of research situations, where concepts are inductively derived from qualitative data and linked in meaningful ways in the development of substantive theory.

4.2.2. Overview of grounded theory

Grounded theory is a theory-generating methodology which uses a number of interactive, concurrent steps of data-gathering, inductive reasoning, hypothesis formation, further purposeful data-gathering and logical deductive reasoning to generate explanations of complex behaviour (Hinds, 1984). Grounded theory methods help to uncover basic social/interactional processes to account for problematic patterns of behaviour through process analysis. Reality is conceived as dynamic, not static, a process rather than an outcome (Chenitz & Swanson, 1986). Using grounded theory method, a researcher attempts to understand the meaning of concepts, things, events and situations from the perspective of the research participant. The goal is to discover basic social and psychological processes as individuals interact with and attempt to make sense of, their object
world. Data collection and interpretation in grounded theory focus on what is happening within the individual, and between individuals or groups of individuals, in particular contexts. The desired outcome of a grounded theory study is a substantive theory which offers an explanation of interactive processes in particular contexts.

4.2.3. Relevance of grounded theory for this study

Grounded theory was the method of choice for this study for several reasons. Grounded theory is an appropriate method when there is limited information on a topic or on particular aspects of a topic, and when there are aspects of the subject area or phenomenon which need to be re-examined (Strauss & Corbin, 1990). In this regard, few studies have investigated patient’s perceptions of comfort and none have focused on patients in the post-acute stage of hospitalisation. Most other studies have concentrated on individuals with severe or multiple health problems, who perceived themselves and/or were perceived as ‘ill’. In this study informants - adult patients - were relatively well (if sometimes vulnerable and acutely uncomfortable) and had a good medical prognosis on discharge after comparatively short and uncomplicated hospital stays.

This sub-group constitutes a large proportion of acute hospital admissions (NSW Health, 1993.) Individuals in this group have few complications and make minimal demands on the system and on staff. They are often assumed (wrongly, in my view) to have few nursing or health education needs, but there are no descriptive or explanatory studies relating to them and no substantive nursing theory which may be usefully applied in guiding nursing care.

Grounded theory is useful when concepts have not been fully identified such as in this instance where the nature of comfort and discomfort as perceived by this sub-group of hospital patients has not been described. Similarly, when relationships
between concepts are not understood or fully developed such as, in this instance, where the relationship between comfort, discomfort and post-acute nursing care, is not understood. Finally, grounded theory is useful where there is the intention to seek fresh insights into familiar phenomena, again as in this instance, where the nature of post-acute hospital convalescence in adult patients is being studied from a new research perspective. By using grounded theory together with a symbolic interaction approach, it was hoped to develop a substantive theory which could be applied in similar situations by practicing nurses to understand the kinds of comfort and discomfort likely to be experienced by their patients, and which could consequently inform and enhance their nursing care.

4.2.4. Steps in the methodology of Grounded Theory

In grounded theory an inductive approach is used to identify phenomenon more fully and to discover patterns in the data, but reasoning swings between inductive thinking and deductive strategies and is guided by the emerging theory; that is, theory is derived via relational hypotheses from data analysis (Field & Morse, 1985).

4.2.4.1. Data gathering methods

Data is collected through focused, open-ended interview alone or through a combination of fieldwork methods which may also include observation, participant observation and document review. When recorded and transcribed, these yield narrative / linguistic material for analysis. Data gathering and analysis are ongoing interactive processes; indeed, the interpretive reading of interview transcripts is, per se, interaction (Denzin, 1992).

Initially, nursing research questions about patient data are prompted by personal experience, by nursing practice and by the nursing literature. A researcher may
be familiar with the literature and aware of gaps in it, but must not allow this understanding to pre-determine what will be discovered in the research. There is no pre-conceived study hypothesis in this approach, and relevant literature is consulted selectively. However, it may be argued that “a researcher’s understanding of the phenomena influences the way the research is conducted and interpreted” (G. J. Mitchell, Internet discussion, Qualitative research for the human sciences, 25th May, 1993).

4. 2. 4. 2. Reference to the literature throughout the study

Selective reference may be made to the literature as the researcher interacts with the data inductively as well as deductively. The technical and theoretical literature concerning the processes of analysing and theorising, ought to be consulted (Strauss, 1987; Richards, 1991) especially by the inexperienced qualitative researcher. It is appropriate to consult the literature in order to gain a general knowledge of the topic, to supplement and enrich one’s conceptualisation through literature which is either directly or closely related, to trigger broader and deeper theorising (although this can stifle creativity if the study is not sufficiently advanced) and to integrate, critique or relate the findings of any preceding studies to the one being conducted (Strauss, 1987). In contrast to this view, Hutchinson (1986) places the literature review between final saturation of codes, categories and constructs, and just ahead of writing the theory. In other words, a study is virtually in its final stage before any literature is consulted. This approach was deemed inappropriate for the present study for reasons which have been discussed in Sections 2. 1. 2 and 2.1.3 (Chapter Two).

4. 2. 4. 3. Integration of data collection and analysis

There is no single approach to grounded theory and experienced researchers have found that too much prescription may be actually be ‘anti-method’. Nevertheless,
data collection, analysis and theorising about the data and its meanings are more
or less integrated processes in grounded theory method. A preliminary analysis
after each interview or group of interviews guides successive data collection and
directs the researcher’s lines of enquiry. Variations on this procedure can be seen
in practice, such as when the transcribing of interviews has been delayed, and
successive interviews must proceed as scheduled (Field & Morse, 1985). Other
instances of variation occur when a team of researchers collects data from more
than one site, or when a design decision is made to collect data from several
informants before beginning analysis (Strauss, 1987). While grounded theory
offers procedures, these are not intended to be prescriptive and an emphasis on
rules rather than on broad guidelines have the potential to stifle the creative
possibilities of this method.

In analysing narrative data, that is, data derived from unstructured or semi-
structured interviews, the grounded theory researcher develops commonsense
understandings of the events and experiences recounted by informants, then
moves on to more abstract conceptualisations of the material. By uncovering and
making explicit strong relationships between key concepts, the researcher hopes
to generate a substantive theory which is grounded in those experiences.

Analysis proceeds via a coding process, where labels are given to concepts, ideas
and phenomena which appear in the transcripts. Labels may be simple
descriptions or may reflect some deeper level of abstraction. Initial substantive
coding is followed by a theorising strategy of distancing oneself from the
particulars of the narrative and asking in general terms, “What is going on here?”
Strauss (1987), Strauss and Corbin (1990) and Wilson (1989) among others,
recommend memoing, in addition to the constant comparative method and to a
strategy of theoretical sampling. Memoing means that the researcher records all
reflections on and theorising about the data in various types of personal,
methodological and theoretical notes or memoranda (memos). These serve to
capture and track even ephemeral thoughts and provide, if properly dated and identified, an audit trail for the reader of the research (Burns, 1989; Strauss & Corbin, 1990; Sandelowski, 1986; Wilson, 1989).

4. 2. 4. 4. Concurrent data gathering and analysis

The remainder of this discussion will focus on data gathered during open-ended interviews in which grounded theory terminology (shown in italics) will be further explained. A critical part of the analytical process is reflection on the data and recording of these reflections in written memos, as a way of maintaining some order in the data analysis. During and after any field work, the researcher makes notes and may begin identifying the substance of what is occurring. Observations and responses are recorded in a variety of ways, as personal notes, methodological notes, observation notes or thesis notes (Wilson, 1989). Interviews are commonly audiotaped, then transcribed. The transcriptions are examined line by line for concepts, interactions, sequences, and meanings. These processes of inductive reasoning, hypothesis formation and deductive reasoning are concurrent throughout data collection and analysis. The goal is to generate credible explanations of what is happening.

Initial substantive coding is done so that events in the narrative, informant comments and the relationship of these to the context in which they occurred are identified and labelled. Any passage may have a number of substantive codes attached to it. This is termed open coding and it guards against too early closure or too early saturation of categories. In grounded theory, data analysis is usually done using the constant comparative method which is conducted concurrently with data collection (Stern, 1980; Field & Morse, 1985). This means that segments of data within and between interviews are compared, with the researcher looking for exemplars, exceptions, similarities and differences.
Constant comparison allows for progressive focusing of the data (Chenitz & Swanson, 1986).

Categories are clusters of codes which appear to have a relationship to one another. They are abstractions of phenomena observed in the data which are then defined, developed, linked with other categories and arranged to form one or more hierarchies of conceptual importance to the evolving theory. Categories are discovered by a process of continually asking questions of or about the data - who, what, why, how, when, where, how often? The researcher tries to identify basic social or interpretive processes embedded in the data, and is assisted in the abstraction process by the use of linguistic devices such as similes, metaphors and gerunds (Miles & Huberman, 1984).

Another strategy to be utilised is that of theoretical sampling, which means moving to another site or group of interviews on the basis of what has evolved so far. Questioning of the data and its meaning and significance continues until saturation occurs, that is, until no new information or categories emerge, and a satisfactory integration and explanation of the phenomena being studied has been achieved (Strauss, 1987).

Finally, interpretation of the data is tested, if possible, against informants’ reactions to the abstracted formulation. This test of the ‘fittingness’ of the interpretation may take a number of forms. If feasible, the findings generated are taken back to one or more of the original informants, or possibly to individuals representative of informants and a response sought. Alternatively, the theory can be peer-reviewed by qualified colleagues, who test the ‘fit’ of the theory to their experience and understanding. A confirmatory response is one where informants or reviewers have little or no difficulty recognising their own or similar experiences in the findings (Bowers, 1988; Strauss, 1987).
4.3. Some thoughts on theory

Theory has an uncomfortable place in nursing’s scheme of things, at least among clinical nurses in Australia. The meaning of theory is not understood and any attempt to discuss theory or apply some theory in a practice setting is likely to be regarded with either suspicion or derision. Hospital trained nurses returning to study find theoretical perspectives in nursing one of the most difficult and, initially at least, uninteresting and irrelevant areas of their program. Having been in that position, and later having had to teach nursing theory subjects, I see some value in teasing out the cognitive difficulties one meets when attempting to understand and utilise nursing theories which have been deductively derived in an earlier time and in other countries, and in finding ways to nest grounded theories less tenuously in the day to day practice of clinical nursing. In a brief but necessary digression, therefore, types and levels of theory and their place in nursing are addressed below.

4.3.1. Aspects of theory

‘Theory’ is from the Greek word, *theorein*, meaning “to gaze upon” (Wilkes & Krebs, 1991). Theory is systematically derived abstract knowledge about phenomena and their inter-relationships which is more likely to be assumed by contemporary scholars to be speculative and tentative in its explanatory power, rather than incontrovertibly factual and final. A theory is a statement which attempts to explain relationships between concepts, constructs or events of importance to a discipline so that they may be better understood (Meleis, 1991). It may be developed through a number of intellectual and other cognitive processes, including inductive and deductive reasoning and through intuition. Either inductive or deductive reasoning may predominate in a particular research approach (Field & Morse, 1985). Levels and types of theory have been
distinguished (Dickoff & James, 1968). Formal theory is developed from a broad area of social inquiry whereas substantive theory is developed from a circumscribed area of empirical inquiry and can provide direction for the development of formal theory (Glaser, 1978).

Levels of theory, from grand, through middle range or substantive, to simple theory are defined by their degree of abstraction and their ability to describe, explain, or to predict and ultimately, to provide practitioners with some degree of influence or control over the elements of their practice. Nursing theories, which are also referred to as conceptual models or frameworks developed (for the most part) deductively, ought to be distinguished from the broader notion of nursing theory as abstract, articulated knowledge which is developed on a number of levels. Empirical knowing is a pattern of knowing drawn from the traditional ideas of science in which reality is viewed as an objective entity which can be verified by observation (Chinn & Kramer, 1991). A total emphasis on this type of empiricism reflects a positivist view of the world which nurses are beginning to question in terms of the extent of its validity in nursing. A recent definition affirms the conjectural nature of nursing theory and hints that a variety of paradigms can usefully inform nursing.

We define nursing theory as a tentative body of diverse but purposeful, creative and logically interrelated perspectives that help nurses to redefine nursing and to understand, explain, raise questions about, and seek clarification of nursing phenomena in their research and practice (Silva & Sorrell, 1992, pp. 14-15).

Ingram (1991) has cited some purposes of theory. Theory should enhance nursing practice and patient care, aid deliberate action and provide rationales for action when challenged. Theory should enhance nursing autonomy by guiding practice, education and research. Finally, theory should facilitate communication between nurses via a common base of theoretical knowledge on which practice is built. Morse (1992) effectively urges nurses to run nursing theory/theories
through the fine filter of their practice and scholarly knowledge in order to further refine, clarify or even reject those theories which are unsuitable for use.

Theory which names and describes concepts and which searches for and isolates concepts for description and labelling, aids in the understanding of real but difficult-to-describe everyday phenomena (Field & Morse, 1985). Nurse researchers are increasingly likely to use approaches such as grounded theory which lead to greater understanding of the lived experiences of nurse and patient, as well as of broader phenomena such as relationships, well-being, chronic illness, dying, to name but a few, in developing theories of some utility for nursing.

4.3.2. Theory in grounded theory

Grounded theory - substantive theory - emerges via the concurrent collection, coding and analysis of data collected about a substantive area of disciplinary interest. Theory building in qualitative research methods emphasises initial inductive strategies and is understood as a process. In grounded theory, the strategy of constantly comparing segments of data with one another and attending to their similarities and differences generates conceptual categories and their attributes and characteristics. The researcher interacts with the data and becomes an instrument for substantive theory development through systematic efforts to reason both inductively and deductively (Glaser & Strauss, 1967). The researcher hypothesises relationships among the categories and their properties and then attempts to test those relationships for endurance and recurrence in the data. These categories and the relationships between them constitute the elements of theory which emerges from and is grounded in the data (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Theory thus ‘grounded’ in the data, generated by induction and tested deductively by the researcher in a complex process of
reflexivity, is substantive theory, capable of interpreting, predicting and explaining phenomena, albeit in a limited way. For these reasons, substantive, middle-range theories about phenomena of interest to nursing are likely to achieve greater acceptance by nurse clinicians.

Five criteria for writing grounded theory are suggested (Benton, 1991; Burns & Grove, 1993; Strauss & Corbin, 1990). The theory ought to describe the basic social and/or interactional processes which account for most of the variation in the data; and it ought to be understandable to others. Categories must be saturated, be strongly supported by data-based evidence, must state the conditions under which they exist or operate, and be meaningfully connected via propositional statements. The theory generated must relate to existing knowledge or if it does not, discrepancies must be explained; and propositions or hypotheses, if developed, should be stated in a way which will allow them to be tested and expanded in future research.

An alternative to the discovery of theory from data is the extension and refining of substantive theory to the level of formal theory, using an emergent fit mode. In this mode, the researcher uses an existing theory and grounded theory field procedures to study concepts systematically and to test their empirical validity. This approach to grounded theory has pitfalls for any but experienced researchers because it cannot be assumed that the core variable for the phenomenon being studied necessarily has a relationship with the basic social and interactional processes being uncovered at the site, time, place and context being freshly studied (Chenitz & Swanson, 1986).

Benton asserts that the most important theoretical outcome of grounded theory research is that it “should offer new insights into practice, situation or event under study” (Benton, 1991, 137-138). Accordingly, it was the purpose of this study to
uncover new insights into the experiences of comfort and discomfort of hospitalised medical-surgical patients.

4.3.3. Empirical testing of theory

For researchers using an interpretive research methodology the notion of the testability of grounded theory at first may seem to be a contradiction in terms, given the association of ‘testing’ with a positivist research tradition and the requirement to generate observable, measurable evidence. Confusion about the meaning of the term ‘empirical’ is at the heart of this apparent contradiction. Historically, empiricism is linked to the fundamental assumption that all knowledge comes from experience and to experiential methods of collecting and evaluating data. Empirical research and experiential methods of data collection once referred exclusively to controlled studies and to a received view of science and truth. However, over time, these terms have acquired diverse meanings and usage. There is the specialised meaning of ‘empirical’, where the terms are synonymous with ‘experiment’, and a more generalised meaning, where ‘empirical’ and ‘experiential’ relate to experience in general (Reber, 1985).

However, over the last two decades it has been increasingly accepted that important human cognitive and social phenomena cannot be reduced to the observable and measureable. As Lowenberg (1993) points out, the methodological approach for contemporary social sciences is informed in part by a symbolic interactionist tradition and is defined as ‘empirical’. Data considered ‘acceptable’ now includes, as well as observable behaviour, narrative, text, self-reports, perceptions, experiences and symbolic meanings located in particular social, cultural, historical and political environments. Glaser and Strauss (1967) embed their grounded theory, which comes from a variant of symbolic interactionism, in just such empirical data.
Because of the differences in scope between grand and middle range theories several methods may be used to test nursing theories (Fawcett, 1993). Theory testing is understood to include -

one or more processes through which one verifies whether what was purported or experienced is indeed so, or whether what was purported or experienced solves problems of significance in one's discipline or practice (Silva & Sorrell, 1992, 14).

Building on Silva's earlier (1986) work, Silva and Sorrell elaborate four approaches to the testing of nursing theory: traditional empiricism, description of personal experiences, critical reasoning and lastly, problem solving. However, this requirement to verify something as fact, or as truth, inevitably leads to questions such as, "What is truth?", "What knowledge can be trusted?" and "What truth is relevant for nursing?" and returns us to the epistemological debate outlined earlier in this chapter.

Another consideration is pertinent here. If the theory generated in this research project was a nursing theory as understood by Fawcett (1993), perhaps the problem solving approach could be employed. This approach, is claimed to lend itself to the evaluation of the usefulness of substantive nursing theory for nursing interventions using some form of outcome measurement. But as will become evident to the reader of this thesis, the substantive theory which was generated is more a theory for nursing about patients' expectations about and responses to experiences, interactions and routines in a health care context. It is not directly about nursing, although many inferences may be drawn from it about what might constitute therapeutic nursing interventions for convalescing patients, which could in turn influence the choice of interventions.

Nurses need to understand phenomena such as illness, wellness, comfort and discomfort, pain, transitions into, and out of, the sick role, satisfaction with care,
and the differential social support needed by various patient sub-groups
encountering health/illness care. The value of this study’s substantive theory for
nursing lies in uncovering patients’ expectations, perceptions, responses and the
constructed meanings of their experiences. Knowledge such as this is then
capable of being integrated into the intellectual, philosophical and practice base of
nursing (Meleis, 1991). However, the extent to which such substantive
knowledge is being integrated may be judged in part by the lack of literature
which explicitly describes and evaluates how knowledge generated through
grounded theory studies is subsequently utilised in clinical nursing practice. One
notable exception to this is the extension of the notion of ‘trajectory’ and its
incorporation into a model of care applicable to people with a chronic illness
(Corbin & Strauss, 1992). However, given a clearly articulated theory whose ‘fit’
with the data and the substantive area is validated by informants and colleagues,
translation into practice of a grounded theory must ultimately depend on
educators and clinicians (Strauss & Corbin, 1994).

To return to the notion of ‘testing’ a grounded theory generated for nursing, it
seems possible that broadening the traditional empirical meaning of the term to
include related notions of ‘putting it to the test’ by evaluating its applicability and
utility for clinical practice, will go some way to resolving this paradox.

Grounded theories are systematic statements of plausible relationships. They call for exploration of each new situations to see if they fit, how they
might fit, and how they might not fit. [Limited predictability can be claimed] in the sense that if elsewhere approximately similar conditions
obtain, approximately similar consequences should occur (Strauss &
Corbin, 1994, pp. 278-279).

The findings of this study could be ‘put to the test’ by triangulation, using another
qualitative methodology such as phenomenology or ethnomethodology and an
informant base drawn from a similar population. It would be confirmed by if
generally similar findings were generated. The findings of a grounded theory
study ought to have enduring relevance and in a sense, be replicable (Stern,
1991). This is in contrast to other interesting but less durable findings emerging from such studies. While these latter may be of immediate or contemporary interest, they might well change over time with changes in health care policies which may lead to changes which affect clinical practice, such as staffing levels.

Secondly, the theory could be ‘tested’ by evaluating the strength of the linkages between existing, established theory and the substantive theory, in particular, the extent to which the substantive theory is able to fill gaps in existing nursing knowledge in a manner deemed credible by expert nursing practitioners and scholars. Thirdly, a substantive theory could be tested by evaluating the transferability of the findings to “another similar context or situation ...” while still preserving “... the particularised meanings, interpretations and inferences” (Leininger, 1994, pp. 106-107) providing that the evaluative criteria used as referents are consistent with the epistemology of the approach used to generate the theory (Silva & Sorrell, 1992). Finally, segments of the theory could be tested by the original researcher or by other researchers in order to strengthen and extend the theory’s applicability for nursing, possibly through an action research project (Bower, 1994) or a mini-ethnographic study (Leininger, 1985).

4.3.4. Criticisms of grounded theory

Grounded theory has been criticised as an over-reaction to positivism. Glaser and Strauss, its originators, have been criticised for implying that grounded theory, once developed, is ‘more or less beyond doubt’. They are thus seen to under-rate the value of the testing of theory. Glaser and Strauss, it has been claimed by ethnographers, overlook the variety of purposes that different research methods can serve, in particular, descriptions of the perspectives or patterns of interactions of a particular category or group of people (Hammersley & Atkinson, 1983). In regard to the former criticism, that a well-developed grounded theory does not require testing, it could be said with some justice that a theory strongly grounded
in data and meeting tests of fittingness, auditability and credibility has been adequately tested. The second criticism, that Glaser and Straus, may be seen to disparage ethnographic studies, is countered by the persistence of symbolic interaction as a credible epistemology in ethnomethodology and cultural studies (Denzin, 1992; Denzin & Lincoln, 1994) and by the correspondence between the techniques and procedures of grounded theory and those of ethnography. These include participant observation, interviewing of key informants, concurrent data collection and analysis and constant comparison of data segments. Indeed, a grounded theory study in nursing or by nurses, about nurses or about consumers of nursing services comes close to Leininger’s (1985) definition of ‘ethnonursing’ and of ethnographies “which are used to generate both real life (grounded) theories about people and general phenomena” (Leininger, 1985, p. 36).

Grounded theory has also been criticised as being inappropriate for nursing research on two grounds (Mitchell & Cody, 1993). The first is because its theoretical origins of symbolic interactionism constitute a world-view that is psychological and sociological in character. Mitchell and Cody (1993) suggest that nursing research ought to have a distinctively nursing perspective as its theoretical base, rather then relying on ‘borrowed theory’ since a discipline’s theoretical underpinnings specify the basic assumptions and beliefs about the nature of reality for that discipline. However, much earlier, Glaser (1978) warned that if concepts are ‘borrowed’ from the literature of other disciplines, it is the duty of grounded theorists to justify the place of such concepts in their analytic schema. The extent to which I have been able to do so in this thesis will be evident from Chapter Five onward. Any suggestion that nursing is not strengthened by knowledge of principles of behavioural and social science and their application to practice ignores the reality that nursing is an applied social science discipline which utilitises knowledge and theory from a number of other disciplines.
Mitchell and Cody’s second criticism is related to the claim that nursing knowledge is “that knowledge which is possible only through the formal study of nursing theory” (Mitchell & Cody, 1993, 171). This narrow definition overlooks other ways of acquiring knowledge (Benner, 1984; Schon, 1983), other ways of knowing, (Agan, 1987; Carper, 1978; O’Brien & Pearson, 1993) and other ways of developing nursing theory (Meleis, 1991). It also ignores the reality that most nursing theorists have themselves consistently borrowed concepts from other disciplines as they saw fit.

However, the role of theory may be obscured by imprecision in the use of methodological descriptors, as claimed by Mitchell and Cody (1993). They justly criticise, with Brink (1991), Stern (1985) and Charmaz (1990) the confusion which may be created by the language of grounded theory, as seen in the early writings of Glaser and Strauss (1967). Critics refer particularly to terms such as codes, coding, clusters and stages which were not always clearly defined, and were sometimes used in contradictory or circular ways.

Although the language of grounded theory has been somewhat clarified in more recent works (Bowers, 1988; Strauss & Corbin, 1990; Stern, 1985; Strauss, 1987) some ambiguity persists. Strauss and Corbin, for instance, recommend “not running to published literature to find validation for everything you are seeing ... as this would hinder progress and stifle creativity” (1990, pp. 52-53), yet suggest that reference to the literature during a study “can contribute to its forward thrust” (p. 56). More recently, Morse (1994) asserts that ignoring the findings of others by not critically analysing the literature impedes the development of a qualitative study, and that “the researcher should learn everything possible [about the setting] if he or she is to avoid re-inventing the wheel” (Morse, 1994, 26). Obviously, experience is helpful in distinguishing the most appropriate time during the study for consulting the literature, and it is just that kind of experience which a beginning researcher lacks.
Other criticisms of grounded theory refer more to the way grounded theory methods are used. Premature commitment to categories has been identified as a usage problem (Charmaz, 1990). The latter may be offset by deep familiarity with the setting or phenomenon, a familiarity which can only come from experience, the literature, and reflection on both. Even then, the researcher must always be mindful of the risk of prematurely deciding upon categories.

Miles and Huberman (1984) and Wilson (1977) encourage the development of metaphors in grounded theory analysis as a way of capturing the complexity of abstracted concepts through creative imagery (Miles & Huberman, 1984; Wilson, 1977). A number of grounded theorists have done this evocatively (see for instance, Fagerhaugh & Strauss, 1977; Hutchinson, 1984; Wilson, 1983, cited in Chenitz & Swanson, 1986). The function of metaphors is to convey the latent meaning of an experience beyond the literal meaning of the words used. As such, metaphors have a quality both of ‘is not’ (literal meaning) and ‘is’ (latent meaning) and need to be understood on at least these two levels. Metaphors have both shaped and obscured understanding and many of those poetic, religious and military metaphors which have been satisfactory and useful in the past for thinking about the body, health, illness and disease, may even be ‘anti-explanatory’ and stigmatising for contemporary research (Sontag, 1988).

Charmaz (1990) raises as a possible problem the labelling of categories and processes with similes and metaphors. The difficulty arises when the metaphoric label and the processes it describes are dis-articulated, diminishing the meaning of the label and decreasing the utility of the theory for clinical practice and education. In developing the grounded theory of this study, I have chosen to label the core processes using pragmatic language which is non-metaphorical and hopefully, more accessible to clinical nurses.
4. 4. Symbolic Interaction - An Overview

Symbolic interaction, grounded theory’s generative theoretical framework, is a theory of human society and the self in interaction. This theory’s useful concepts aid the work of exploring the patient ‘self’ in interaction with others in a hospital sub-culture of society, and for analysing processes within those interactions. This research uses grounded theory methods and adopts symbolic interaction as its orienting perspective since they afford the opportunity to investigate meaning in the context of patients’ experiences of comfort and discomfort. These perspectives, by focussing on process, subjectivity and an analysis of textual data relating to social and clinical experiences of adults in hospital, offer the possibility of developing a more complete understanding of post-acute hospital convalescence which can shed light on poorly understood aspects of this experience. This next section provides an overview of symbolic interaction.

4.4.1. Symbolic interaction

Symbolic interactionism is rooted in the discipline of social psychology, and is claimed by adherents to “... provide the theoretical underpinnings of a sociological social psychology concerned primarily with activities that are uniquely human as they are exhibited in social interaction, structure and institutions” (Lindesmith, Strauss & Denzin, 1977, pp. 30-31). Its central question is, “What common set of symbols and understandings have emerged to give meaning to people’s interactions?” (Patton, 1990, p. 88). Because of its central concerns - social interaction, social structure and institutions - symbolic interactionism is a perspective which can assist nurses to better understand nursing as a dynamic interactive process occurring between nurse and patient in the particular context of health care. ‘Institution’ is intended here both in its broad sense of health care as a societal institution, and in its narrow sense, as a hospital or place where care is provided. A symbolic interaction perspective can
help in discovering the meaning of phenomena important in and for nursing, and for the clients of nursing. The study of the subjective phenomena of comfort and discomfort experienced in particular hospital contexts and mediated through nurse-patient interaction can be facilitated by a symbolic interaction perspective.

The concepts of self, the social world and objects, symbols, social interaction, symbolic interaction and role, are central to symbolic interactionism and will be reviewed below. George Herbert Mead, an American social psychologist working from the University of Chicago in the early decades of this century, is reliably credited with presenting a verbal statement on the elements of symbolic interaction and with explicating the nature of reflexivity (which in the context of symbolic interaction refers to intersubjective dialogue within an individual) and interpretation in human interaction (Blumer, 1962, in Wells, 1978). James, Cooley, Parkes, Thomas and other social psychologists of the era contributed significantly to Mead’s understanding of the objective and subjective ‘self’ (particularly Cooley) and the ‘definition of the situation’ (particularly Thomas), but Mead is recognised as having more fully developed and integrated such concepts as ‘the generalised other’ and ‘taking the role of the other’ within symbolic interaction (Lauer & Handel, 1977). Although Mead wrote and lectured extensively on the various elements of symbolic interactionism (for example, see Mead, 1925, 1934) he did not formalise and publish his theory as such. This task was undertaken largely by Herbert Blumer (Meltzer, Petras & Reynolds, 1975; Lindesmith, Strauss & Denzin, 1977). The term ‘symbolic interactionism’ was, in fact, finally coined in 1937 by Blumer, who had been one of Mead’s doctoral students and who went on to become an important critic of and advocate for symbolic interactionism and to systematise Mead’s work (Lauer & Handel, 1977).
In the years since Mead, Blumer has further explicated the concepts of self, symbolic meaning, and interpretation. He has clarified the three basic premises of symbolic interactionism, namely that

1. Human beings act towards things on the basis of the meaning that the things have for them. 2. The meaning of things arises out of the social interaction one has with one’s fellows. 3. The meanings of things are handled in and modified through an interpretive process used by the person in dealing with the things he encounters (Blumer, 1969, cited in Patton, 1990, p. 76).

The second and third premises distinguish symbolic interaction from other analyses of human behaviour. Symbolic interactionism “... stresses the necessity of discovering processes of interactions, meanings and interpretations ... [and these are] the foundation for all analysis of social reality” (Lauer & Handel, 1977, p. 304).

4. 4. 1. 1. The self

Symbolic interactionists characterise the self as having two components, a ‘Me’ component which can be reflected on described and talked about (self as object), and an ‘I’ component which is the reflector (self as subject). The ‘Me’ component of the self experiences doing, thinking, acting, interacting and being, in multiple social contexts, from the time of birth. Every person’s ‘I’ component of the self receives, accumulates and interprets social cues from the environment and attempts to understand how others view the ‘Me’ of him or her self. This is done through an ability to imagine oneself in other social roles, ‘to take the role of the other’ and to have an internal dialogue with ourselves (Abercrombie, Hill, & Turner, 1988).

Individuals ... engage in reflexive behaviour; they become self-conscious and conscious of consciousness; they become participants in and observers or spectators of the interactions in which they are involved (Lindesmith, Strauss & Denzin, 1977, p. 30).
“For the interactionist, the self is socially constructed” (Bowers, 1988, p. 37) and according to this view, self construction is an active process, an outcome of interaction between the self and the social context, and continually evolving. This is in contrast to the more passive functionalist notion of the “socially determined self, enacting or conforming to a role which has been pre-determined or pre-defined” (Bowers, 1988, p. 38). Symbolic interactionists assert that individuals continually elicit, interpret and create meanings and define situations, that these processes are negotiated between the socially constructed self and the socially constructed environment (Morse & Johnson, 1991).

4. 4. 1. 2. The social world and objects

The social world consists of ‘objects’. Objects are anything which can be reflected on such as physical items, persons, feelings, gestures and behaviours, concepts and events. It is argued that objects have no inherent meaning since meaning is derived from the way that others in the social world act toward an object. Meanings are able to vary over time and with different contexts. Thus each person’s cumulative experience of reality, their interaction with the object world and the meaning of an experience, are likely to be different (Bogdan & Taylor, 1975; Bowers, 1988). This difference is balanced by the learning and sharing processes of socialisation. It is through socialisation within the subcultures of family, school, church, work groups and the wider society, that we attempt to view the object or social world as others do, and to respond to social situations and social demands as others do. We conform, and conformity creates a degree of regularity and order. This allows us to expect people in our social world to behave in broadly predictable ways. We can anticipate and predict to some extent how people will act, or act towards us.

From the symbolic interactionist point of view, all interaction with the object world, is a continuous and simultaneous process of attempting to interpret and
define our own and others’ realities, and to act in a way which has meaning for us. As with ‘self’, meaning is essentially a product of our interaction with others and with their way and our way of acting towards particular phenomenon, in particular contexts (Wood, 1982). In this regard, all understanding is interpretation and each new interaction is integrated into the individual’s prior schema of meaning.

4.4.1.3. Interacting with the social world

Symbolic interactionism is a theory which proposes that humans interact with symbols to construct meanings. The social world is essentially a world of learned symbols. Symbols are “the basic tools of thought and experience ... the vehicle of communication ... central to any meaningful interaction between persons” (Wood, 1982, p. 66). Symbols are constituted by language, behaviour, cultural norms and values and emerge from human interaction. Shared meanings become attached to verbal and non-verbal language symbols, and through interaction and communication, we learn to interpret the meanings of actions and to take many things for granted (Blumer, 1969).

Symbolic interaction is a process of attempting to understand the meaning of what is happening when we interact with the social or object world, in order to decide how to act. It is a process of interpreting social cues, designating meaning to language symbols, calculating the place and status of self in a particular social context (that is, attempting to judge how others perceive us) and making a prediction about how the other will behave. Based on this assessment, we maintain or alter our responses to the situation, according to the meanings we assign to it (Bowers, 1988).

Individuals assign meaning to (that is, they define) situations and interpret the language and actions of others in the light of symbolic meanings, and of beliefs,
which have been acquired in interactions with others, usually through interacting in one or more specific cultural contexts. Individuals do not simply react to a situation in culturally defined, normative ways, although they may act at times out of habit, a manner of interacting which is designated as ‘non-symbolic’ (Blumer, cited in Lauer & Handel, 1977, p. 305). Symbolic interaction is not reaction, but definition, interpretation and response. These processes lead to self-definition and to definition of the roles of others in the interaction.

4.4.2 Interaction and role

Interaction is a central concept in the theory of symbolic interactionism. Socialisation is an interactive process which involves the acquisition of shared meanings evident in language, attitudes and behaviours prevailing in the social group. Resocialisation, a life-long process, occurs with entry into new or different groups which enables us to function as part of that group, in part by initial recognition of others’ roles (Lauer & Handel, 1977). Roles are expected behaviours determined mainly by the position occupied in a group or society rather than by characteristics of the individual. A role may be momentary, temporary, enduring or permanent, and it may be gained through effort, chance or birth. Role assignment sets up expectations of behaviour (Stryker, 1967, cited in Van Riper, Pridham, & Ryff, 1992) so that individuals and groups in a given society come to rely on being able to predict, with moderate certainty, the broad behavioural parameters within which others in a given recognisable role, will operate. As such, roles become public, shared symbols which convey information (Abercrombie et al., 1988) however limited, mythical or stereotypical that information is, and in doing so, they limit unpredictability, insecurity and social chaos. It is this shared meaning which facilitates initial interaction, and it is through interaction that situations are defined and role behaviours modified (Lauer & Handel, 1977).
4. 4. 2. 1. Role from a symbolic interaction perspective

Through previous interaction in society, human beings develop common understandings of how to act in various situations, and develop general expectations of how others will act. But while social organisation is the framework within which interaction and action takes place, symbolic interactionists assert that social organisation is not the determinant of action. Culture, social systems and roles all shape situations and supply symbols which are useful in defining a situation, but this does not mean that situations and symbols have single meanings for all the individuals in a group or society since "interpretations of new situations are not pre-determined by antecedents to the situation, but depend on what is taken into account and assessed in the actual situation in which the behaviour is formed" (Blumer, 1962, cited in Wells, 1978, p. 97). What one takes into account in a given situation, then, will vary with personality, experience, expectations, pre-occupations, thoughts and feelings, all of which influence perception and thus the way a situation is interpreted and defined. This perspective is particularly relevant for a study of the comfort and discomfort experiences of hospitalised adults.

From a symbolic interaction perspective, role involves not only the attributes and behaviours associated with particular positions held in society, but also involves the tentative outcome of interaction with other roles, for example, 'mother' is a set of role behaviours in relation to a set of role behaviours of 'child'. Similarly, 'nurse' is a role conceived in relation to 'patient', to 'doctor', to 'hospital administrator' and so on. Symbolic interactionism postulates that expected behaviours are guided by sometimes vague cultural norms, are subject to varied interpretations, and are modified in interaction. Blumer (1969), while acknowledging the reality of common and pre-established meanings of how to act and how others will act, asserts that interaction is a creative process and that
actions are freshly constructed with each encounter on the basis of definition and interpretation,

... even in the case of pre-established and repetitive joint action, each instance of such joint action has to be formed anew. The participants still have to build up their lines of action and fit them to one another through the dual process of designation (defining) and interpreting. Repetitive and stable joint action is just as much of an interpretive process as is a new form of joint action that is being developed for the first time. ... The meanings that underlie established and recurrent joint action are subject to pressure as well as reinforcement, to incipient dissatisfaction as well as indifference; they may be challenged as well as affirmed (Blumer, 1969, pp. 18-19).

Doctors, nurses, and patients, for instance, are expected to behave generally as their occupational role suggests that they will, and there is an element of ‘taken-for-grantedness’ about this. But from the perspective of symbolic interactionism, in each encounter between a patient and a professional carer, the situation is freshly re-defined and re-interpreted. The person whose behaviour is different from that suggested by their current role calls forth a new definition, a new interpretation and a new meaning. Responses are made not to behaviour but to meanings attached to behaviour. Mead defined ‘gesture’ as not only the initial element of an act, but also as a sign for the whole act (Wallace & Wolf, 1980). Symbolic interaction was seen by Mead as:

... a presentation of gestures and a response to the meaning of those gestures. A gesture is any part or aspect of an ongoing action that signifies the larger act of which it is a part. ... Such things as requests, orders, commands and cues are gestures that convey to the person who recognises them an idea of the intention and plan of forthcoming action of the individual who presents them. ... When the gesture has the same meaning for both, the two parties understand each other. ... Gesture, according to Mead's triadic nature of meaning ... signifies what the other person is to do; it signifies what the other person making the gesture plans to do; and it signifies the joint action that is to arise out of the articulation of the acts of both (Blumer, 1969, p. 9).

Therefore, in the context of this study, one could postulate that a nurse’s verbal and non-verbal behaviours, constituting ‘gestures’, could signal to a patient either a neutral act, an act imbued with caring or an act of indifference depending on the context, the interpretation of the gesture and the meaning assigned. The response
of the nurse may lead the patient to maintain or change his/her own role behaviour. Thus, "... patterns of social interaction develop out of and beyond the initial expectations which the participants brought to them, being shaped by the emergent mutual responses of the interactants" (Worsley, 1977, p. 546).

4.4.3. Criticisms of symbolic interactionism

Meltzer et al. (1975) document a number of criticisms which have been made of the Blumer-Mead version of symbolic interactionism, including some by symbolic interactionists. The criticisms of Mead by symbolic interactionists are: that Mead's major concepts are not precisely defined, particularly the pivotal concept of 'self'; that Mead's theory almost totally ignores the emotional and unconscious elements of human conduct; and that Mead did not provide procedures or techniques for research. In addition to these, Mead has been criticised by others as being obsessed with meaning, and of treating too lightly, social structure and social change. Symbolic interactionism, according to critics, may result in an overemphasis on situation, and in over-concern with matters transient, episodic and fleeting (Meltzer et al., 1975).

Other critics assert that symbolic interactionism is a-historical and non-economic; that it has a limited view of social organisation and social structure; that it presents a naive picture of social reality which is inherently conservative; that it is ideologically biased, culturally limited, uncritical and apolitical (Denzin, 1992); that is, "... that it lacks a proper appreciation of social organisation and social structure" (Meltzer et al., 1975, p. 97).

Symbolic interaction has been criticised as relevant only for a particular time and place, as a product of "... a culture with an egalitarian ethos and mobile class structure - the United States of America of the nineteen twenties and thirties" (Shasholski, 1970, cited in Meltzer et al., 1975). The (idealised) American way
of life has been characterised by respect for the individual and a belief in gradual change as a way of meeting society’s fluctuating needs. In this perspective, there is an emphasis on flexible interpersonal relationships as a basis for understanding the workings of society. Its basic thesis is thus considered inappropriate for other societies (possibly, for culturally distinct societies such as are still found in Asia, Africa and the Middle East) where class structures and formalised, unchanging modes of behaviour prevail (Shasholski, 1970, cited in Meltzer et al., 1975).

4.4.4. Criticisms of symbolic interactionism addressed

To counter the third criticism documented by Meltzer et al. (1975) Blumer has suggested a broad procedure for theoretical inquiry, the stages of which he termed, ‘exploration’ and ‘inspection’ (Blumer, 1969). In addition, grounded theory research methodology developed by Glaser and Strauss has been effectively used in a number of disciplines. Both Mead’s and Blumer’s work, especially in relation to ‘self’, have led to “... productive debate by symbolic interactionists, too productive for premature closure” (Meltzer et al., 1975, p. 118). Essential criticisms of symbolic interactionism may be reduced to two presumed deficiencies concerning its limited treatment of human emotion and of social structure. In defence of symbolic interactionism, Manis and Meltzer state that from a distinctly sociological perspective, it

... directs attention to the social derivation of man’s unique attributes; it represents mind and self as society in microcosm; it describes how the members of any human group develop and form a common world; it illuminates the character of human interaction by showing that human beings share one another’s behaviour instead of merely responding to each other’s overt behaviour and, in numerous other ways, it implicates the individual with society and society with the individual (Manis & Meltzer, 1972, cited in Meltzer et al., 1975, p. 121).

Meltzer et al. (1975) strongly support the notion that symbolic interactionism in the hands of its protagonists, is intrinsically capable of dealing adequately with significant criticisms.
4.5. **Social Structure, Autonomy, Constraint**

This section of the chapter raises the issues of social structure and to the way in which individuals are conceptualised as acting and interacting in society. The relationship between individuals and social structure has been the subject of discussion between philosophers and other scholars for centuries. Social structure is defined as "any recurring pattern of social behaviour; an enduring orderly and patterned relationship between elements in society" (Abercrombie et al., 1988, pp. 228-229). In what has come to be known as the agency-structure debate, questions are asked about the limits on an individual to act independently of societal structures and about how we can understand individual and group behaviour apart from or distinct from social structure. The debate has relevance for the thesis since it provides background and insights into the apparent paradox of having personal freedom to choose and to act (as patient, as nurse) as well as having subtle or other constraints placed upon behaviour.

4.5.1. **Social structure - development of the concept**

When anatomy was developing as a science, structure was aligned with function, and was epitomised as buildings or as organic analogies by people such as the English mathematician and philosopher, Thomas Hobbes (1588-1679). In 'Leviathan', Hobbes' major work, written when his country was embroiled in civil war and the overthrow of one form of legitimate authority, Hobbes attempted to reason out a solution to the problems of law and government using principles of physics, mathematics and deductive logic. Hobbes advocated (but not without outrage being expressed by his contemporaries) a social contract which called for complete submission of individuals to the state in return for protection and peace. Without the state, there would be a war of every man against every man, the only hope of security being the delegation of power to person or group (Collinson, 1987). Much later, Marx saw the economic structure
of the state as the basis on which judicial and political structure are built. Marxists “assume that individual psychology is both shaped and constrained by social structures” (Charmaz, 1990, pp. 1161-1162).

4.4.5.1. The agency-structure debate

There is ongoing disagreement and controversy among social scientists as the Hobbesian question in a new form is revisited. Within the agency-structure debate, contemporary philosophers and sociologists argue about the extent to which social structure places limits on individual creativity and freedom. Abercrombie et al. (1988) outline three positions: independent (individuals create the world around them), deterministic (structures and roles determine life scripts) and mutual dependency of human agency and social structure, a position somewhere between these two.

Dawe (1981, cited in Marshall, 1986) believes there are two views of society. In the first, structural functionalists give priority to the social system over the individual. They see socialisation processes acting so efficiently as to constitute and not merely regulate, the self. In the second view, society is seen as the creation of its members, the product of their construction of meaning and of action and relationship, through which they attempt to impose that meaning on their historical situations (Dawe, 1981, cited in Marshall, 1986). Social structure has been reified, notably by Parsons (1951, 1971), who argued that societies have survival needs which institutions such as families, and law and order agencies are designed to meet. Society can ‘cause’ behaviour by prescribing and assigning roles. This form of functionalism (structural or normative functionalism) concentrates on society’s need for the efficient discharge of tasks. The central goal of any system is to sustain itself and to maintain equilibrium. Order and equilibrium are achieved through the existence of common norms and values.
One view of behaviour is that people act out of instinctual drives for need fulfilment. Yet another is a social anthropological view, which asserts that it is necessary to understand the social structure of a group and the way rituals and norms have evolved, before one can understand the behaviour of its members. Structure influences behaviour in strikingly different ways. Coulson and Riddell (1980) cite the primitive society, the small town with a single industry (or none) the city with limited apprenticeships, as limiting the life courses which one may fashion. Berger and Luckman (1967) argue that there is a dialectical process in which the meanings given by individuals to their world become institutionalised or turned into social structures. The structures, then, become part of the meaning-systems employed by individuals, and influence and limit their actions in a particular social, cultural and historical milieu.

4. 4. 5. 2. Social structure and health care institutions

One aspect of the social structure-agency debate relevant here may be framed in terms of the social structure of the hospital as institution, institutionalised routines and staff in ‘busy staff’, ‘expert staff’ and ‘caring’ roles. Other roles within this social structure are that of ‘adult patient’ and within that broad role, ‘patient-as-guest’, ‘patient-as-stranger’, ‘dependent patient’ and ‘self-caring patient’. The reflexive behaviour of an adult in acquiring an identity in a new situation, as for example, the temporary roles of patient as postulated above, can be thought of as similar to any socialisation process. We can partly explain the actions of individuals (patients, doctors, nurses) by the organisation of the groups to which people belong (for example, health care, hospitals), and the actions of groups partly by the organisation of the whole society, that is, the social structure.

The concept of structure is often subordinated to culture. What we learn derives from our culture - sets of established ways of doing things in a society (Coulson & Riddell, 1980). Individual and group identities grow out of interaction, in
which we learn a set of behaviours and a language to internalise their meaning. It is obvious that patients acquire a new set of roles and statuses, however transiently, while in hospital. The symbolic interactionist inquirer might ask, "Are there, then, sequential statuses of patienthood such as new patient, dependent patient, self-caring patient, transferred patient, whose meanings are constructed? Are there expectations of role behaviours to accompany these statuses? Are the meanings of these statuses constructed differently by staff and by patients? Further, do health care personnel act towards these patienthood statuses differentially? Are patient and staff actions constrained in any way by institutions? If so, how are they constrained and with what outcomes?"

The indirect effects of structure on the behaviour of health care personnel occur through socialisation and health care and hospital culture. They are mediated, for example, through the dominant biomedical and economic rationalist views of health and illness care in which health care is 'commodified' and costed. The economic worth of skilled nurse caring is carefully scrutinised in this culture (humanistic caring service being a commodity distinct from, and possibly traded off against, a lower level of technical service) in the interests of cost-cutting (Duffield & Lumby, 1994).

Thus, one could posit that the hospital is a societal health care institution which to some extent constrains behaviour. For example, there may be institutional constraints, through inadequate provision of staff and resources, on the behaviour of a nurse who seeks to comfort through purposeful 'being with' a patient and other constraints (not as obvious) on a patient who seeks and expects comfort care. Such situations and contexts invite further examination. Socialisation via hospital, medical and nursing culture may constrain a nurse to give higher priority to delegated medical tasks than to nursing comfort measures, particularly in post-acute contexts. The nurse who views illness/wellness from a biomedical perspective, or nursing as a series of tasks to be completed in the most expedient
way possible, has often been re-socialised to this view. Little is known or understood, however, about contextual constraints on patients.

Symbolic interactionism sits somewhere between the drive and instinctual behaviourist theories and the structural-functionalist, deterministic theories. In symbolic interactionism, society is understood in terms of the individuals who comprise it, and in terms of humans as ‘self-reflective beings’. Human behaviour is neither wholly caused by internal drives and instincts, nor wholly by external social forces. It is the product of “a reflective and socially derived interpretation of the internal and external stimuli that are present” (Meltzer et al., 1975, p. 2). From an interactionist perspective, doctors, nurses and patients hold highly generalised expectations about the probable behaviour of each other. Behaviour and meanings derive from what we learn via socialisation (also termed social learning) and via training. Socialisation is ongoing, never complete, and always limited by what we are willing or ready to accept (Coulson & Riddell, 1980). Thus symbolic interactionists, while accepting that social structures impact on individuals, would deny that the impact has automatic and invariable outcomes.

In the last twenty years it has become clear that there are a number of viable variants of symbolic interactionism. Denzin (1992) notes the continuing relevance of the interactionist tradition for informing and stimulating creativity in mainstream research and in newer social theories and perspectives such as dramaturgy, the sociology of the absurd, information technologisies and the study of communication, feminism, semiotics, postmodernism and critical ethnography. Denzin rejects what he terms Mead’s and Blumer’s socially conservative version of symbolic interaction, but finds that “earlier criticisms ... appear to have been addressed ... with social structure, power and politics no longer ignored” (Denzin, 1992). Symbolic interaction, in various forms, therefore remains a vigorous current in contemporary interpretive research., with its insights from critical
social theory and its ability to challenge dominant ideological and political meanings and biases.

4.4.6. Summary of the study's theoretical perspectives

Qualitative and quantitative research methods are often pitted against each other as being such diametrically opposed ideologies such that no accommodation between the two approaches is seen to be possible. This in part reflects "Kuhn's thesis on the incommensurability of paradigms" (Bednarz, 1985, p. 292) which means that the two paradigms, having alternative philosophical orientations, are unable to be compared at the level of their philosophical givens. Other, more moderate views allow for their being substantial merit in each approach, and suggest that the researcher's goals of discovery or of confirmation should guide the selection of method. Interpretive methodologies are now recognised as a legitimate and vital form of inquiry, with their own well-documented standards for rigour.

Symbolic interactionism, with which grounded theory is historically linked, is a theory of self, behaviour and society in interaction. Interaction and interpretation of symbols in the social environment are processes which lead to situations being defined and made meaningful through an internal dialogue involving cognition and affect. Meanings so generated create or alter subsequent behaviours as the individual responds uniquely to the meaning the situation has for him or her. Symbolic interaction theory contends that the individual, while socialised into the norms of society, can improvise and can act spontaneously as a result of their interpretation of the meaning of the actions of others, rather than habitually engaging in behaviours which are pre-determined by role, and by society's expectations. "The socialised individual is ... a 'self' capable of thought, invention and self-determination" (Strauss, 1964, in Worsley, 1977, p. 545).
The symbolic interactionist perspective focuses on social processes within and between individuals, rather than on social structure. Individuals improvise and construct responses based on the interpretation of a situation and its meanings in a dynamic way - meanings which may change over the course of the interaction. From a symbolic interactionist perspective structure is not denied, but it is also not given dominance as a determinant of behaviour. Symbolic interactionism acknowledges that social, cultural and historical contexts are among those things which may be taken into account by an individual when constructing meaning and interpreting events (Blumer, 1962, cited in Wells, 1978). However, there is a deliberative, reflexive element in the individual's interaction with the social environment which defines symbolic interactionism as a processual model of interaction in contrast to one based on a response to normative expectations.

Grounded theory is a qualitative research methodology recommended for the investigation of phenomena where not much is known, or in order to gain fresh insights on familiar phenomena, especially where there is change or incongruity in the phenomena. According to Denzin (1994) grounded theory is widely used and has broad appeal because it provides procedures to guide the researcher in developing middle-level or substantive theory which is grounded in the data. The grounded theory perspective "... continues to fit itself to feminist and other poststructural, postmodern interpretive styles" (Denzin, 1994, p. 508). When adequately developed, a grounded theory can offer plausible if tentative explanations of phenomena and processes which may be useful to practitioners.

This thesis reflects my view that the meaning of comfort and discomfort in the context of post-acute hospital care could best be explored using a grounded theory approach and that informant data would most usefully be interpreted in terms of my developing understanding of symbolic interaction (which locates meaning in context) assisted by my background knowledge of the sociocultural environment
of the acute care hospital. The following chapter presents grounded theory methodology and procedures as they were applied in this study.
CHAPTER FIVE
Using Grounded Theory to Investigate Comfort and Discomfort

This chapter outlines the methods of grounded theory used to investigate the experiences and perceptions of comfort and discomfort of adults who had been in hospital, for ultimately non-life-threatening conditions, for relatively short periods. The chapter is in three parts, reflecting the three phases of the study. The first explains the choice of grounded theory methodology and outlines the broad research plan, aspects of methodological rigour and ethical considerations. The study proposal is outlined, along with initial sampling decisions, development of an informant diary, description of informants and first interviews, early coding and analysis, and aspects of data management.

The second part of this chapter describes Phase Two of the study, which covers recruitment of additional informants, further analytical processes and reference to relevant literature. Again, informants are briefly described. Finally, in part three, theoretical sampling and strategies to achieve confirmability are described as a prelude to the next two chapters which present the study results.

Research is not only an exploration of a research topic, but also a process in which the researcher deals with the experience in a very personal and challenging way. Interviewing was on the whole a fascinating and delightful experience. Learning to keep track of memos, manage the data and eventually, to make sense of it, were more difficult and there were long periods when analytical processes seemed unproductive and circular rather than spiral in character. Experienced researchers who have used qualitative methodologies encourage greater candour by researchers in reporting methods and in writing up findings (Boyle, Morse, May & Hutchinson, 1991) That advice has been followed. Occasional technical problems with data collection occurred in this study and will be alluded to briefly as valuable lessons which were learned during the research process.
5.1. Phase One Of the Study

Phase One is concerned with early planning, choices, decisions, ethical and methodological considerations, the research proposal, recruiting strategies, first interviews and procedures for testing data collection techniques.

5.1.1. Choice of grounded theory

As previously pointed out in Chapter Two, the decision to investigate patient perspectives on comfort and discomfort stemmed from my experiences as a patient, then as a person interacting with nurses caring for members of my family at various times over the years, and later as a clinical teacher of undergraduate nursing students. Reflection on these participant experiences, some of which had seemed depersonalising, had influenced my own practice and teaching. They raised significant questions for me about the nature of the interactions between nurses and patients, about the context in which care was provided, and about the potential of interactions and context to exacerbate or to relieve patient and family discomfort.

A course in Advanced Qualitative Perspectives covering the history, development, epistemologies and methodologies of a number of research paradigms, led me to consider qualitative research approaches. I had also read nursing research studies utilising grounded theory methods, which were personally meaningful. In particular, when my aged parents were separately admitted to nursing homes, Bowers' (1988) investigation of family perceptions of care in a nursing home, using grounded theory, had helped me step back from and better understand the dynamics of interactions between myself, as family carer, and nursing home staff. I found that other grounded theory studies, for instance those of Fagerhaugh and Strauss (1977) and Wilson (1977), were intriguing in
their capacity to tease out, surface, and explain intricate relationships between patients, carers and context.

Grounded theory method requires the researcher to begin with a broad question, and few assumptions. It is designed to enable the development of concepts, hypotheses and propositions directly from the data, in order to generate theory that is grounded in the data. Some writers assert that grounded theory researchers and nurses both use processes in common: initial data collection, clustering of data, hypothesis formation, exploration of the problem, constant comparison of collected data, reference to the literature and collection of additional data to verify or reject hypotheses (Stern, Allen, & Moxley, 1984). This was encouraging for me, a novice researcher who as clinical nurse and educator, had experiences of working through difficulties encountered in applying the nursing process in clinical settings.

While there are similarities in the analytical stages of the nursing process and grounded theory, there are also significant differences. In using nursing process, one clusters subjective and objective data as well as impressions under a meaningful label, a process which while intrinsically linear and reductionist, is intended to facilitate communication. In a sense, this process in nursing reflects the pragmatism of the clinical world. The outcomes of interacting with clinical data in this way are somewhat removed from the standards demanded of research and scholarly theoretical work. A major problem with nursing process is that clustering and labelling may represent faulty data collection and reasoning by the nurse. Also, in day to day practice, assessment and evaluation findings may not be rigorously validated, that is, well grounded in evidence and able to withstand critical appraisal, in contrast to the validation required of the research process (Fehring, 1987).
Research 'subjects' in grounded theory methodology become 'informants' who provide a narrative account of their experiences. Narratives "... are understood as stories that include a temporal ordering of events and an effort to make something out of those events: to render, or to signify, the experiences of persons-in-flux in a personally and culturally coherent, plausible manner" (Sandelowski, 1991, p. 162).

For someone with an interest in developing a greater understanding of social processes and interaction between nurses and patients/families which might account for comfort and discomfort experiences, grounded theory and the underlying theoretical framework of symbolic interaction, outlined earlier, offered a way to begin.

Zaner asserts that "... most patients are not only willing but eager to talk about their illness experiences, to share them with other persons, while in hospital or afterward" (Zaner, 1985, p.103). I felt confident of being able to interact effectively with such informants, to collect and transcribe data and to carry out recommended procedures such as memoing, theoretical sampling and constant comparison. The idea of needing to develop categories, propositions and resultant theory was intimidating, at least initially. The final choice of grounded theory method was made on the basis of appropriateness of the methodology for the research question, and a reasonable level of confidence in being able to work with the methodology in exploring the research question.

5.1.2. The research plan

The research plan was conceived to have three phases. In Phase 1, an informant diary would be developed and its utility evaluated. Interview procedures would be trialed and audiotaping techniques mastered. Transcribing, coding and analytical procedures would then be reviewed and refined. In Phase 2, further
interviews and analysis would add to the data. In Phase 3, it was anticipated that a deeper level of analysis would uncover and confirm basic social/psychological processes, aiding the formulation of a theory grounded in the data.

In qualitative research, the researcher begins with a broad question. The researcher collects data from key informants using fieldwork methods such as observation, participant observation and open-ended interview. In grounded theory, as in other qualitative methods, informants are selected purposefully, in line with the needs of the research question. Key informants are those who have personal experience of the phenomenon under study, and who are willing to spend time reflecting on and articulating their perceptions of and responses to particular experiences (Morse, 1991).

In this study, the question was, "What are the in-hospital experiences of comfort and discomfort of adult medical-surgical patients?" Informants' stories would be elicited during open-ended, semi-structured interviews in which the stated goal was to explore perceptions and meanings of comfort and discomfort with adults who had recently been hospitalised for medical and surgical conditions. The study design did not call for observation or participant observation. Informants would be:

... free to interpret the researcher's questions in a number of ways ... to explain themselves and their thinking. ... What is important to note is that a narrative by an informant is not a simple description of perfectly remembered historical events. The reality ... is revealed or created in the interpretive efforts of the researcher who seeks it there (Steeves, 1992, pp. 534-536).

I had had many years of clinical experience as a bedside nurse and clinical teacher and in the recent past had worked in, or taught in, a number of hospitals in the areas from which informants would be initially recruited. The reflections and experiences referred to earlier in this chapter were consciously surfaced at the design stage of the study. Their potential for skewing my focus was recognised,
and acknowledged throughout the research process. The potential for bias at all stages of the research process and the safeguards proposed for qualitative methods, are now discussed in relation to methodological rigour.

5.1.3. Reliability and validity in qualitative methodologies

Analytical procedures in qualitative research are designed to comply with the developed ‘rules’ of each method within qualitative inquiry. However, even within qualitative research circles, some cautious questions have been raised concerning the inexact use of terms. It is the existence of rules, procedures and definitions, and the lack of precision with which they are sometimes applied which creates a confusion about whether qualitative methodologies are, on the one hand, sufficiently scientific, that is, worthy of respect in terms of systematic and rigourous inquiry, or on the other hand, have sufficient artistic integrity to communicate the “richness and diversity of human experience” (Eisner, 1981, cited in Sandelowski, 1986, p. 29).

Sandelowski (1986) refers to Guba and Lincoln’s (1981) four standards which should be applied in judging the validity and rigour of qualitative studies, especially in those dealing directly with human informants. These criteria are credibility, fittingness, auditability and confirmability. A qualitative study is credible when it faithfully describes or interprets human experiences so that it is recognisable to people who have had the experience, or to those who when confronted with it, recognise it from description. A test of fittingness is passed when findings are grounded in and reflect the phenomena being studied, and when readers of the descriptions, explanations or theory derived from the data find them meaningful in terms of their own or other familiar contexts (Sandelowski, 1986). Sandelowski appears later to argue against a too-rigourous testing as conceptually and epistemologically inconsistent with interpretive approaches (Sandelowski, 1993).
The qualitative researcher who is concerned with validity leaves a ‘decision trail’ which can be followed by an auditor, who would reach comparable or at least, not contradictory, findings if “… given the same data, perspectives and situation” (Sandelowski, 1986, p. 33). Finally, findings ought to be confirmable. Confirmability refers to the neutrality of the findings, rather than to any objective or subjective stance of the researcher. It is achieved when the other three criteria have been met, and some would argue (Denzin, 1970; Fielding & Fielding, 1986), that it is strengthened by triangulation.

Strauss and Corbin (1990) place considerable emphasis on internal validity for the grounded theorist through procedural rigour. They stress the need to verify statements of relationship, to support findings with the literature, or justify and explain differences from published works. Morse (1991) raises concerns about the rigour of qualitative research produced by those beginning researchers who blend, change or adapt a methodology’s procedures, and end up with confusion, or worse, failure to have the study’s findings viewed as valid. However, there are divergent views about the relative contributions of consistency and diversity of method in qualitative studies which are part of an ongoing debate and which may relate more to the selection of the most appropriate set of procedures for the question and the sample (Morse, 1991) and to solid justification of any changes, rather than to either consistency or diversity, per se.

The reader of a qualitative study looks for evidence that issues which pose a threat to validity within the study have been addressed. These are usually issues of investigator bias, the basis on which investigator decisions are made, and the process of analysis. In this regard, the type of sampling, data collection, and analytical methods suggested for grounded theorists, if followed and documented, should assist in minimising threats to validity (Brink, 1991).
In the following sections what could seem to be fine-grained and detailed explanations of each stage of the research are presented. The intention is to lay a clear reasoning and decision trail which can be followed by an interested and critical reader. In particular, these sections are intended to locate in early data some important ideas which survived the analytic refining process and appear finally in the theory and major themes of the thesis. There appears to be no other way to do this than by providing evidence of my theorising if the issues of rigour raised in qualitative research are to be addressed.

5.1.4. Informants: sampling decisions

The initial choice of informants was guided by the research question and by broad considerations of access. The initial sampling frame consisted of ambulant, relatively well, hospitalised adult male and female medical-surgical patients aged 30-55 years who would be recruited in hospital in the post-acute stage of illness or surgery, who freely consented to participate in the study and who were able to communicate in English with reasonable fluency. For the purposes of this study, an ambulant, relatively well patient in the post-acute stage was defined as one who:

- was not receiving strong opiate or other analgesics continuously or frequently
- did not require frequent or multiple invasive procedures and
- did not require assistance with showering or getting out of bed.

A number of categories of patients were excluded from the study on the grounds of seriousness of condition or a disabling level of stress. Excluded patients were those:
• with terminal, critical, mutilating or undiagnosed conditions where stress, grief, crisis or pain could be significant

• with significant cognitive, visual or hearing deficits

• who were having, for example, frequent blood glucose monitoring which may have clouded broader issues of comfort by focusing attention on painful fingers and labile biochemistry

• who were immuno-compromised, where there could be issues of patient access and of patient safety.

Post-acute patients with a range of ‘ordinary’ conditions were chosen because, in my experience, their varying discomforts were underestimated, with many comfort needs neither assessed nor met. In addition, little research has been documented about the comfort/discomfort experiences of this patient group.

Adults were selected because my clinical experience and education had been with adult patients and because of the need to contain the size and limit the duration of the study. I considered that adults would be likely to be resilient, sensible, mature, cooperative, easy to approach and talk to, capable of reflecting on and relating their experiences, and for these reasons would be good informants. Adulthood is often categorised as either young, mid-life or older adulthood. The age group 30-55 years was initially chosen as broadly representative of adults, but respondents within a few years either side of this age would not be excluded if judged suitable.

Biological, sociocultural and psychological factors are integrated into any individual’s experience and appraisal of stress (Lazarus & Folkman, 1984). There is known to be wide variation in tolerance to stress, in coping strategies and in overt expression of personal discomfort (Calderone, 1990). However, Walding
(1991) found gender was less relevant to stress coping style than other factors and so both men's and women's experiences of discomfort would be sampled.

While in hospital, respondents were to be asked to record their experiences of comfort and discomfort, in a diary provided by me (see Appendix 1 and section 5.1.5. below) and if uncomfortable, to comment on the circumstances, and if they obtained relief, how that was achieved.

5.1.5. Patient Comfort/Discomfort Diary

The use of respondent diaries either as data collection instruments or as memory triggers is well documented. Citing Verbrugge's (1980) review of a number of studies, Oleske, Heinz and Otte suggest that "diary data provide a broader and more accurate account of an individual's (health) perceptions and behaviours" (Oleske, Heinz and Otte, 1990, p. 159). Cavanhaugh and Hertzog (in West & Sinnot, 1991) identify the diary as most useful in the systematic, daily recording of and reflection on, personal experience. It is claimed that diary use leads to greater accuracy and higher reporting levels about major and minor events experienced (Oleske et al., 1990), the production of "spontaneous, freely-structured, personalised accounts" (Ersser, 1991, p. 48) and the obvious advantage of having a record of events soon after their occurrence, rather than having to rely on memory (Duffy, 1986; Mateo & Kirchoff, 1991).

I did not intend to access the diaries which were intended only as an aide-memoire to assist informants' recollection of in-hospital events and experiences during the subsequent interview. The decision to reserve comfort diaries for informant use only was based on the premise that privacy would enhance accuracy and spontaneity of reporting and reduce apprehension about possible researcher criticisms of writing style, spelling, frequency of entries and so on.
A semi-structured interview schedule would be used. After each interview had been transcribed and substantively coded, the next informant would be interviewed. Members of the supervisory panel would initially listen to the audio-recordings, read the transcripts for accuracy and independently code the transcripts. After five interviews, the procedures and findings would be reviewed.

5.1.6. Study proposal and ethical considerations

A proposal was developed for submission to the Research and Ethics Committee of a large hospital where informants would initially be recruited. Nurse researchers intending to access patients in this hospital were required to first submit an outline to the Director of Nursing and then to discuss details with the Assistant Director of Nursing (Research) before final submission of their research proposal. This was a collegial and facilitative process for me, with constructive advice about the practicalities of negotiating contact with potential informants being offered.

Two major ethical issues are raised in any study: protection of human rights, and security and confidentiality of data. In this study, no one was coerced to participate. Each potential informant was advised of their right to withdraw freely, and given an assurance of confidentiality. No physical or psychological harm was anticipated. Consent was obtained in writing following a full verbal and written explanation. The consent was photocopied for my file, and the original returned to the hospital at the completion of the interview, where this had been requested. All consenting informants were given a written statement of the purpose of the study to keep.

To protect confidentiality, no real names are linked to the data. No wards, hospitals or personnel are identified, and no individual’s name or location is revealed. Theoretical sampling, which led me to informants who had been in-
patients elsewhere, co-incidentally served the purposes of confidentiality, by allowing me to state truthfully, that patients experiences of comfort and discomfort in a number of hospitals in a number of health areas had been sampled, rather than simply in the hospitals which had initially supported the study.

5.1.7. Phase 1: piloting the procedures

In Phase 1 the Comfort Diary would be piloted and audio-taping and interview procedures would be trialed. A hospital in another metropolitan health area was selected for these purposes and a Pilot Project developed. The Director of Nursing arranged access to possible informants through Nurse Unit Managers (NUMs) or Team Leaders who identified patients meeting the inclusion criteria. A written and verbal explanation was provided to nursing staff facilitating the study (see Appendix 2). I had intended to meet each new informant armed with the assurance of the NUM that the individual would meet study criteria, and knowing only the patient’s medical diagnosis. This procedure was revised after the first instance of being referred to a potential informant. I found him sitting out of bed for the first time, appearing exhausted and very uncomfortable, distinctly physically and psychologically stressed and so obviously unwell that I immediately concluded our conversation and withdrew.

From then on, in order to decide which patients recommended by the NUM most closely met the sample inclusion criteria, I quickly scanned each patient’s hospital progress notes, medication orders, and where relevant, the operating theatre and recovery room notes, prior to meeting the potential informant. This allowed me to become more familiar with the patient’s background and current situation and thus to make my own judgment about the suitability of approaching an informant. I would find the patient, introduce myself, ask if I could talk with them. The information gleaned from the clinical record facilitated communication and
enhanced the empathy of my responses. I would explain my purpose, show and explain the diary, and if they were agreeable, obtain their verbal and written consent for interview (see Appendix 3). I would then go slowly through the diary with the informant, leave them with the diary and a pen in a folder and make arrangements to return for a follow-up visit.

Four informants were recruited in this manner, and interviewed two to four days later to allow time for diarising. Consent for audio-taping interviews was readily given and audio-taping did not seem to inhibit these or subsequent informants in any way. Audio-taping provided opportunities for practice with technical aspects of recording as well data transcription and beginning analysis. One complete interview was lost due to not checking that the collar microphone was turned on, but field notes made during and immediately afterwards captured the essence and some significant verbatim comments from this informant. As anticipated in a general way in the planning of this pilot phase, one of many valuable lessons had been learned.

5. 1. 7. 1. Pilot interviews, P1 - P5.

Interviews began with a re-statement of the purpose of the research as an effort to understand the experiences of comfort and discomfort from the patient's point of view, and an open-ended question about the meaning of comfort to each respondent. Probe questions were used as necessary. I began by asking, "What does 'comfort' mean to you?" When the informant understood this in the context of the stated purpose of the research, this was quite often enough to begin free-ranging accounts of informant experiences within the hospital. Informants who talked about comfort in more general terms, such as "being at peace", "sitting in a comfortable chair, watching the football with no interruptions" were encouraged to focus on the current meaning of comfort and discomfort for them as patients.
In these cases, questions and probes (see Appendix 4) such as the following were occasionally needed:

“Were there times (or situations) when you felt especially comfortable?”

“What kinds of things made you feel uncomfortable?”

“When you were uncomfortable, how did you become comfortable again?”

“Was it difficult to speak about any discomfort you were experiencing?”

As the interview progressed, other probes were used such as,

“Can you take that a little further?”,

“What was that like for you?”,

“Can you tell me a little more about that?”

“How important was comfort to you?”

At appropriate points in the interview, I would confirm if an event or incident had been comforting or uncomfortable for the respondents, and verbally review and summarise my understanding of what had been said. This invited clarification and supported the beginning on-site analysis. At all times I attempted to maintain an attitude of empathic neutrality while engaging in a “critical inner dialogue” (Minichiello, Aroni, Timewell, & Alexander, 1990, p. 139).

Four pilot interviews were conducted with convalescing patients, three of about an hour each, one slightly less. Two informants were women, two were men. A
fifth scheduled interview lasted only a few minutes with a woman in her late twenties, generating a small amount of positive feedback about the diary format, and the brief comment that the most uncomfortable aspect of her hospital care was not being trusted to administer her own medications. This interaction was not audio-taped nor included as data because the patient’s husband had come to visit at the time scheduled for this interview. However, a further pilot interview was recorded with an informant who, while not recruited during a hospital stay, and with no opportunity to use but only to look at the diary, met the study criteria.

It became evident during these pilot interviews that the narrative would unfold more readily if the informant was offered a place to begin. Because the particular focus was intended to be the post-acute phase of hospital care, this seemed a logical starting point. It became clear, however, that the perceptions and meaning of experiences within this post-acute phase were outcomes of meanings given to earlier phases of the hospital stay. This finding was consistent with my developing understanding of symbolic interaction in that new experience is interpreted and integrated into an existing schema of meaning for the individual. The opening question became, “Can you tell me how you came to be in hospital?”

5.1.7.2. The pilot study informants

Characteristics of informants are now described while maintaining necessary confidentiality. Informants are designated P1-P5, and by their initials.

P1. Informant SS, a woman aged 44, married homemaker and community worker, with school age children, was admitted for intravenous antibiotic treatment of cellulitis of one leg. At the time of interview she was receiving oral antibiotics, and oral analgesia on an ‘as needed’ basis, and was able to get up to the toilet.
SS was the sole occupant of a two-bed ward at the time of interview and enjoyed chatting with all staff who came into her room. She had a high level of satisfaction with the hospital and the care she was receiving.

P2. Informant BT, a woman of 49 years, now medically retired from skilled clerical work, married, with a supportive husband and adult children, who had been admitted through Accident and Emergency with an asthma attack. I discovered after the interview began that she had a co-existing condition which severely limited using her dominant right hand. This was being managed with co-analgesic medication. She had taught herself to write with her left hand. She was cheerful, assertive and optimistic.

BT had a documented sensitivity to the normal adult dose of bronchodilator, which manifested as tachycardia. She was prescribed a nebulised bronchodilator, and regular oral medication for chronic pain from reflex sympathetic dystrophy of her dominant right hand and arm. She was pain free and breathing normally at recruitment and interview, and was interviewed in a ward when other ambulant patients were out of the room. BT was aware that some staff had been deployed to the Emergency Department to assist with an influx of traffic accident victims, and that others were kept busy by an elderly confused patient on the ward. She experienced support from some staff as well as casual indifference from others.

P3. Informant, FP, male aged 43 years, single, a high school teacher of Mathematics and English, was electively admitted for Appendicectomy, and was found to have Crohn’s Disease. He was ambulant, awaiting discharge, seven days after appendicectomy, and was interviewed in an unoccupied room adjacent to the ward.

FP, with one exception, expressed admiration and respect for his hospital carers. The exception was an incident which occurred early post-operatively where his veracity was questioned, which caused him discomfort on a number of levels. He also described situations where he had felt comfortable with staff, and reflected on a number of hospital routines and their effect on him.
P4. Informant SK, a man aged 40 years, married with wife and young children, with his own business, was admitted electively for investigation of a small renal neoplasm, detected three weeks prior to admission. He had been advised that the tumour had been completely removed during surgery. He was interviewed in an unoccupied room adjacent to the ward, seven days after surgery, and awaiting discharge.

SK added some interesting insights into nurse-patient interaction and its affects on him during the admission procedure. He revealed that during the three weeks leading up to his admission to hospital, he had put his own thoughts and feelings ‘on hold’ while he made arrangements about his affairs, and spent as much time as possible with his family. On admission he had a strong need to talk about his situation to the nurses, but for one reason or another, was unable to. For two or three days post-operatively, he received an opiate infusion which limited communication. Later in his recovery, when he was perceived to be self-caring and independent, his interactions with staff were friendly but essentially superficial. He voiced a need to talk through the experiences, and saw my interview with him as a way of doing this.

P5. Informant, MD, a woman of 54 years, skilled clerical worker, married with a large family. She was admitted electively to a large private hospital for bone graft from her iliac crest to the unhealed spiral fracture of her left humerus, secondary to a motor vehicle accident which had occurred about twelve months previously.

Interviewed some time after discharge from a private hospital, to elicit possible contextual contrast with informants with public hospital experiences, she had clear recall of her surgical hospital experiences. She read the diary introduction and understood what I was interested in but did not make diary entries. MD’s own maternal nurturing behaviours strongly influenced her expectations of nurse caring and of physical comfort measures. She had once been a voluntary hospital carer and two of her sisters were nurses. She expected to be uncomfortable and in pain with surgery. She experienced a considerable range of physical discomforts and was disappointed to be afforded little relief from these through actions taken by nurses.
5. 1. 7. 3. Summary: Phase 1 interviews

The Pilot study demonstrated that the diary format was acceptable to all informants. While only brief entries were made, mostly as key words or phrases, the diary served both as a reminder to think about comfort and discomfort and a trigger for useful reminiscence. Field notes were recorded during and following interviews. Summaries and comments were compiled, typed up and printed usually within a couple of days. Transcription of early pilot interviews by others proved unsatisfactory. I found that by typing them myself I had greater opportunities to interact with the data, become more familiar with it and begin comparative analysis. Typed transcripts were entered into a computer software program, NUD•IST (Non-numerical Unstructured Data Indexing Searching and Theorising) for ease of data management. Pristine copies of interviews, with identifying information removed, were stored securely. Transcripts were substantively coded using an open coding method and entered into NUD•IST with relevant passages from the data. Codes were clustered on the basis of common themes (see Appendix 5). I found initial attempts at coding mechanical, slow and difficult, whereas inductive and deductive reasoning triggered by coding were challenging and absorbing.

5. 1. 8. Phase 1: the process of early analysis

In this section, the analytical processes of induction, constant comparison and theoretical sampling are illustrated with brief references to the data, in order to provide an audit trail for readers of the thesis, to substantiate the notion of findings being grounded in the data, and to indicate reference to appropriate literature. Some of the early findings became enduring themes as further interviews were recorded, transcribed, coded and analysed.
The first section will deal with the Pilot Project interviews, designated P1-P5. Transcripts were examined for meaningful dimensions of comfort and discomfort, utilising a mix of inductive and deductive approaches. The second section focuses on the first five interviews of the major research project, designated R1-R5. As before, inductive and deductive reasoning were used to identify meanings of comfort and discomfort, and to cluster and categorise them.

5. 1. 8. 1. Early findings - substantive and open coding

In the following section, in order to illustrate the processes of analysis and reasoning in interacting with the initial interview data in interviews P1 - P5, I indicate ideas which seemed important to me in bold, and underline some tentative themes. Informants' verbatim remarks of significance are in "italics"; the symbol "...//..." indicates an interrupted or edited flow of comment which has then been resumed "R": indicates a Researcher comment. Forays to the literature are indicated.

Other people.

From the first interview, I was beginning to note the significance of other people for informants' comfort. Visitors, other patients and friendly staff were important in decreasing a sense of psycho-emotional discomfort of loneliness and isolation. This corresponded to the notion of comfort as a sense of relief (Kolcaba & Kolcaba, 1991). Nurses were recognised as being "very professional", as having to work under pressure and being very busy, but still being friendly and concerned. A number of instances found in the data were substantively coded as ‘nurses- psycho-emotional comfort’, ‘busy nurses’, ‘nice nurses’.
Competent staff

Having staff who "knew what they were doing" was comforting. This was similar to the concept of comfort as a sense of ease (Kolcaba & Kolcaba, 1991). Comments by respondents P2 and P4 led to thinking about what happened when staff did not get to know patients or were not friendly, or did not appear to know what was wrong with patients, or what to do.

Getting to know you

Nurses were a potential source of comfort to informants, especially once they "got to know you". Having pleasant and helpful staff who had gotten to know you was important. It seemed that time was needed for staff to get to know patients. A sense of the importance of patient-staff bonding emerged. This finding was evident in the first four pilot interview transcripts. Informant P4 had been through an impersonal nursing admission procedure on the eve of surgery which may have had serious outcomes for him. He noted that "... there was no time to establish a relationship with the nurses - I needed to talk. Now ?" - (R: that is, four or five days post-operative, and out of danger) - "I have got to know some of the sisters and we have a joke".

Routinised care

Informant P2 had been upset by the failure of a nurse assigned to her care for three shifts to notice that she had impaired function of her dominant arm, or to be curious about the medications she was on for neurogenic pain, given that she had been admitted for asthma. The consequences, of such routine attitudes noted in pilot interviews P2-P5 and in nine of the twelve of the later research interviews, emerged as several kinds of uncomfortable emotions (disappointment, frustration,
anger, vulnerability) and in one instance, an increased need for patient vigilance against receiving an incorrect medication.

Did patients with serious admission diagnoses, with all that that implies for eliciting therapeutic nursing support, receive exactly the same routinised approaches to admission as those with less serious conditions? Was a routinised admission procedure a reassuring, possibly calming interaction? Alternatively, did it effectively block communication? Was it protective, and if so, of whom?

Informant P5 made a point of engaging the nurse (who had earlier expressed irritation at being overworked) in nurse-focused conversation as a way of attempting to form or improve the nurse-patient relationship. This suggested a kind of patient work undertaken as a way of increasing social comfort. I wondered, comparing this with P4’s experience, if informants might see it as their responsibility to initiate a relationship with nursing staff, in an effort to become comfortable in the hospital environment.

In thinking about meaning in context, I wondered if nurses made some sort of decision about how much time and/or emotional energy they would commit to any patient, given contemporary hospital culture, work demands and the real possibility of not being assigned to the care of that patient on the following day. Would any support offered by nurses be perceived by them as being somehow dissipated by the system, somehow rendered insubstantial and therefore, not worth the effort?

In a similar context, Ashworth (1984) notes that in the British system of nurse training, general instructions to nurses to reassure the patient and to tell the patient what is about to happen are an inadequate basis for the practice of therapeutic communication, especially since a nurse seen talking at any length to patients was likely to perceived as not working and to be given additional tasks.
Similar attitudes were, until recently, evident in the Australian system and may still persist in some hospitals. Turnock (1989) observed that as the hospital patient's condition improves and the patient becomes less dependent, there is even less interaction with nurses. He also noted that most nurse-patient communication is nurse-centred and task-oriented.

**Information management**

Informant P2 could not obtain information about her uncommon and painful arm condition. She found it extraordinary that I could talk about it with her, and shed a few tears of relief at finding someone who knew of it. She was also angry at a recent change in hospital policy which meant that she not receive telephone messages from her family or be called to the telephone. She felt supported by a senior nurse who expressed concern about the impact of this policy change on patient wellbeing, especially on those with few visitors.

Informant P3 **could not find out what Crohn's disease was or how it was treated.** He was advised to wait to speak with the specialist (but no one knew when this would be arranged) and was still waiting in hospital a week after he was told the diagnosis. However, sometime during that week a nurse had lent him one of her text-books so the could read up on it himself. He thought she was "**very nice to take the trouble**". Melia (1982) in her study of British student nurses reported a phenomenon she labelled "nursing in the dark", referring to the lack of information available to students about the patients they were nursing. I wondered if there were organisational barriers in that hospital to nurses obtaining and providing useful information on a range of matters which would diminish patients' psycho-emotional discomfort.
Self-talk, self-help

Informant P2, asthmatic from childhood and sensitive to salbutamol, experienced tachycardia with the usual adult dose. She noted the nurse putting what appeared to be too much in the nebuliser, and had to ask how much and then to have the dose halved, as prescribed.

_It makes you feel uncomfortable that you’ve got to watch them, especially when its wrote down in your notes...//...We’re not likely to give you the wrong dose, they said, but I just let it go, its not worth arguing. I just watch now. Every time the nebuliser’s filled I watch. I make sure I’m in view of it._

This passage was coded as ‘self-talk, self-help’, but also as ‘psycho-emotional discomfort: increased vigilance’, and ‘psycho-emotional discomfort: feeling vulnerable’.

Informant P3 related an instance within the first 24-hours of his operation:

_Some of the nursing staff, I mean they’re very busy, and...//...they don’t account for individual pain or discomfort levels...//...I don’t think people believe you are in as much pain as you are...//...so being doubted is very discomforting. Um, one nurse made a comment about, oh, come on, its not hurting that much, which I thought, well, have you ever had it done or have you got what I’ve got? But they’re very busy too, and I mean they’re under a lot of pressure, so well, you can’t hold that against them._

This passage revealed an inner dialogue, an acknowledgment of his upset feelings followed by an effort to comfort himself by finding some reason, some excuse for what might have been an atypical nurse attitude. It was open coded as follows: ‘busy nurses’; ‘psycho-emotional discomfort: being doubted’, ‘psycho-emotional discomfort: non-empathic staff’, ‘self-talk: making allowances’.

According to field notes, informant P4 remarked at interview, “I’m comfortable now, but a few days ago...!” with a look suggesting he had had much greater discomfort earlier on. Just as he said this, a doctor came in and asked him how he was. He responded, “It’s just this ear thing. I have ringing in the ears and
bloodstained mucous coming from my nose.” An ear nose and throat consultation was planned and the doctor left. I wondered what he would classify as current discomfort, if not ringing in the ears and nasal discharge. He seemed not to count these as discomfort - they were physical problems and there were experts around to sort them out.

For him, discomfort meant not having someone recognise and listen when he needed to express his feelings, not having someone acknowledge that he was going through a very stressful time. I recalled his description of the checklist admission by nursing staff and the feelings he expressed to me of needing to talk to an understanding listener at times when he was vulnerable. It seemed to me that he felt that some nurses could have offered that support, if only he had had time to establish a relationship with them.

Time had other meanings. Informant P5 remarked:

Once they know you’re recovering - after the immediate post-operative time - they’re not going to bother to make any extra effort to come in and check you, unless it was time to check your temperature or blood pressure or something...//...I accepted that that was the norm, because you know, over worked, understaffed, that’s sort of accepted by most of the public. You’re left to get on with it. I accepted it, I was disappointed in a sense, you know, briefly, then you know that this is the way it is. So, let’s get on with it, let’s get better and let’s get home.

This paragraph was coded, ‘routine observation’, ‘self-talk, accepting’, and ‘psycho-emotional discomfort: disappointment’.

Responses to an uncomfortable encounter with staff or with hospital routines were then looked for in past and subsequent interviews. I kept in mind these patient strategies of inner dialogue, accepting and making allowances for dealing with discomfort and if they were not mentioned, would ask neutral questions such as, “If you were uncomfortable, how did you go about becoming more comfortable?” and “At any time, if you needed help, what did you do?”
Similar statements to those above, noted in later interviews, led to the tentative hypothesis that when patients were physically or psycho-emotionally uncomfortable, **they did not always initially seek help from others**. They attempted to rectify the discomfort by some kind of inner dialogue about the situation which I labelled ‘**self-talk**’. This took the form of recognising their negative emotions, such as disappointment, then accepting, excusing, **making allowances and accommodating to the reality of the situation**. In some instances, acceptance of the situation led to accommodating through self-care activities, such as increasing their vigilance, or “**getting on with it**” or through accepting the reality of having “**to do it all**” (that is, **do all the work of recovering, and of managing discomfort and of finding comfort**) themselves. In other instances, **accommodating led to avoiding asking for help or waiting until a more helpful person or attitude presented**. This early finding about patient work is supported in some respects by Fagerhaugh and Strauss (1977) who explored the concept of patient work, and by Cameron (1988) who identified patients as actively seeking comfort.

Codes developed from the Pilot Interview transcripts are indicated on the following pages. Initial coding of the five pilot interview transcripts led to the following list of codes being developed and some rudimentary clusters being formed. There were also a large number of codes which were difficult to classify and awaited further clarification.
5.1.9. Pilot Interviews: codes developed from transcripts

Table 5.1 shows early substantive coding and clustering of data.

<table>
<thead>
<tr>
<th>CODE</th>
<th>CLUSTER</th>
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<tbody>
<tr>
<td>Post-operative pain</td>
<td>Physical Discomfort</td>
</tr>
<tr>
<td>Sleeplessness/fatigue</td>
<td></td>
</tr>
<tr>
<td>Aches and pains</td>
<td></td>
</tr>
<tr>
<td>Visitors</td>
<td>Social Comfort</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>Conversation</td>
<td></td>
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<tr>
<td>Staff getting to know you</td>
<td></td>
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<tr>
<td>Predictability</td>
<td>Psycho-emotional comfort</td>
</tr>
<tr>
<td>Reassurance</td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td></td>
</tr>
<tr>
<td>Empathetic, competent staff</td>
<td></td>
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<tr>
<td>Social isolation</td>
<td></td>
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<tr>
<td>Inadequate information</td>
<td></td>
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<tr>
<td>Uncertain diagnosis</td>
<td></td>
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<tr>
<td>Disbelieving staff</td>
<td>Psycho-emotional discomfort</td>
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<tr>
<td>Routinised care</td>
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<tr>
<td>Others’ distress</td>
<td></td>
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<tr>
<td>Vulnerability</td>
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<tr>
<td>Patient advocacy by staff</td>
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<tr>
<td>Friendliness</td>
<td>Nurse comforting</td>
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<tr>
<td>Joking, humour</td>
<td></td>
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<tr>
<td>Providing information</td>
<td></td>
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<tr>
<td>Unobtrusive surveillance</td>
<td></td>
</tr>
<tr>
<td>Prompt pain relief</td>
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</tr>
</tbody>
</table>
Table 5.1  continued

UNCLUSTERED CODES
Venting feelings
Busy nurses
Knowing the system
Expectations of care
Time for bonding
Checking on the staff
Staff-patient interaction
Settling in
Self-talk, self-help
Work done by patients

Tentative Findings: Pilot Interviews

Visitors, including nurses who ‘visit’ and are perceived as competent and caring, are an important potential source of patient comfort which is experienced as social, physical, psycho-emotional.

Discomfort is experienced as physical, social, psychoemotional, and is perceived uniquely by each informant.

Getting to know the staff and staff getting to know you takes time. Comfort needs may be unmet while rapport with staff is being built. Some patients consciously work at developing rapport with staff.

Predictability lessens psycho-emotional discomfort. Hospital routines are acceptable - routinised care is not. Information is sometime difficult to obtain.
Informants use a variety of self-comforting and protective strategies when uncomfortable, notably 'self-talk'.

Broader categories emerged from the data with further theorising. Substantive or Level I codes were subsumed into clusters, node trees or Level II codes (Hutchinson, 1986) which identified the basic problems facing informants seeking comfort, and the strategies they used to deal with the problems. Analysis remained at this level until later interviews were substantively coded, clustered, and eventually further reorganised to reduce the number of categories.

5. 2. Phase Two Of The Study

Phase Two took the study forward to further interviews, ongoing analysis using constant comparison and a search for pertinent literature.

5. 2. 1. Recruitment of informants

In this next phase of the study, five convalescing adult female patients would be recruited while in hospital, and interviewed after discharge at a time and place suitable to each. It was anticipated that interviews would be arranged and completed within three weeks of discharge from hospital. The decision to interview away from hospital was initially based on the expectation that informants would feel much freer to talk about their experiences in a venue of their choice. This had been stated in the research proposal and was followed in interviews R1-R5, although I found that informants would talk freely in the hospital as long as we were relatively private. No constraint was evident in interviews P1-P4 conducted in a hospital in another health area. Interview P5 was conducted in the informant’s home.
Informants R1-R5 were recruited with the assistance of nursing staff of a hospital in metropolitan Sydney. Wards in which possible informants would be located were identified through Nursing Administration. An information sheet was prepared for staff assisting with the identification of possible informants (see Appendix 2).

At mutually convenient times I met with NUMs who had agreed to facilitate the research, in order to explain the study. They then either identified patients who met the broad criteria of age and condition or delegated this task to registered nursing staff. I was then free to access the patient’s chart to check out their criteria for inclusion, approach patients and recruit into the study those who were both suitable and agreeable. I judged a suitable prospective informant to be one who, as well as meeting the stated criteria for inclusion,

- was in no obvious distress,

- was willing to listen to an explanation of the research,

- made appropriate verbal and non-verbal responses and

- appeared able and willing to converse with me.

I gave a verbal explanation of the project to each potential informant and showed and explained the diary. If the person agreed to participate, a written outline of the research was offered (included in Appendix 1) and the need to sign a consent form was explained. If still agreeable, the informant was invited to sign the consent (see Appendix 3) which I then witnessed. Depending on which hospital was involved, I either kept the original consent in my own files, or, as requested, left it with the ward clerk after the post-hospital interview had been completed, retaining a copy for myself. While staff were aware of the nature of the research,
and in some instances, facilitated access to patients in the absence of the NUM, I requested that staff not discuss the study with patients recruited as informants.

As the study progressed, sampling became more theoretical and this meant contacting potential informants who were located elsewhere than in hospitals by letter or telephone. With these informants, I explained the consent and, at interview invited, them to sign it, leaving them a copy and retaining the original.

5.2.2. Sampling decisions

The first informants had demonstrated that both men and women were able to be forthcoming about their physical, emotional and psychosocial comfort needs as well as having similar general perceptions of physical, emotional and psychosocial discomfort. This raised the possibility that gender differences in the experiences of comfort and discomfort may be minimal. On the other hand, the literature on gender differences in self disclosure (Doyle, 1985; Snell, Miller & Belk, 1988) found that men disclosed fewer negative feelings and that sex of the disclosure recipient influenced negative emotional disclosures, both women and men disclosing more to women. Values and beliefs may mediate the way emotions are felt, and gender role mediation of cognition and emotional openness may reflect male values (Snell et al., 1988). It may be that gender is a critical, socially-constructed difference which potentially sets the context for the experience of comfort. In consideration of this, the decision was made to structure the sequence of further interviews to maximise discovery of any gender difference in (disclosed) perceptions of comfort and discomfort.

This decision was carried out through a plan to interview successive women informants until theoretical saturation of each category (cluster of related concepts) was reached. This would be followed by interviews with men. In this way it was hoped to discover if the emerging theory was adequate for men as well
as for women. If some of the concepts remained unaccounted for, interviews with both men and women would continue until no new concepts emerged.

5.2.2.1. The next five interviews

Once this first phase of the major study was under way, at least one follow-up visit was made to each recruited informant in hospital, beginning the day after the diaries were distributed, and then on ‘as-needed’ basis. Informants usually talked at length during these contact visits, and field notes were recorded very soon after leaving the ward. It became important to telephone or visit the hospital each day to monitor transfer or discharge of informants since discharge from hospital could be unpredictable (that is, either precipitate or delayed).

The diary recording procedure was slightly modified to allow for informants who were discharged within a day or two of being given the diary. All informants in this group of interviews were telephoned within a few days of discharge in order to arrange meeting details. Four informants were interviewed following this procedure over a six-week period, each for about two hours, each in the home of the informant and within a couple of weeks of discharge from hospital. The fifth informant who had formally consented to take part in the study, and who freely discussed her perceptions and experiences during a contact visit, was abruptly discharged and was unable to be contacted by telephone or letter. The field notes were subsequently considered to be valid data.

5.2.2.2. Informants R1 - R5

The first informants in the post-pilot phase of the study were designated R1-R5. Following each descriptor is a brief summary of substantive findings for each interview. Comparative analysis and significant connections are detailed later in the chapter.
R1. Informant DB, aged 43 years, divorced and living harmoniously with her teenage son. She was recruited on the third post-operative day following abdominal hysterectomy, and interviewed at her home a week after discharge.

DB related numerous instances of comforting by nurses. This comforting offset most of the physical discomfort and anxiety associated with intravenous line, indwelling catheter, drain removal, dressings, removal of sutures and episodes of nausea and vomiting. She comforted herself with inner dialogue and by walking about, by chatting with other patients, on occasions by pulling the curtains around her bed “to have a little cry”. She noted that patients helped each other, gave each other helpful advice, and made the best they could of catheters and drainage bags.

R2. Informant JB, aged 40 years, divorced, with teenage children at home. She developed an infected wound haematoma on day four following pelvic surgery. JB was recruited on Day 7, was discharged the next day and was not able to be contacted for follow-up by either telephone or mail.

Field notes of the interaction lasting about thirty minutes, were recorded during and after the recruiting visit with JB. Her early post-operative care had been satisfactory. Her perception was that nursing staff attitudes towards her changed markedly when she became slightly more dependent on them because of a wound complication.

R3. Informant SH, a woman of 40 years, was employed by a large company as a middle level manager, responsible for a staff of forty. Happily married with two teenage daughters, she was recruited on the third post-operative day following vaginal hysterectomy. She was discharged the following day and was interviewed at her home one week after discharge.

SH was described to me by the NUM as someone who met the criteria and was very happy with her care. She was full of admiration and praise for her nurses and for nurses generally, especially for the nurses in intensive care where a
relative had been nursed some time before. SH found great comfort in knowing that 'expert nurses' were caring for her. She praised the efficiency, patience and compassion with which nurses cared for other patients in her room. She was critical of her doctor for not preparing her better for discharge and did not regard information-giving and discharge preparation as the nurse's responsibility.

R4. Informant IH, aged 52 years, divorced, living with her married sister. She was initially recruited as a medical patient after admission to a medical ward through Accident & Emergency, with angina pectoris. She remained in hospital for investigations and cardiac surgery, transferring to the thoracic surgical ward pre-operatively, then to a high dependency ward, then a step-down ward and on day four following operation, back to the thoracic surgical ward. IH was interviewed at her home two weeks after discharge.

IH had been in the medical ward for some days when I first spoke with her. She mentioned several instances where nurses had been supportive, very helpful, friendly and understanding. Interviewed at home, she expressed high praise for "expert nurses", including one who gave her timely procedural and sensory information during twenty-four hours in intensive care, post-operatively. After transfer to the surgical step-down ward, she felt the nursing care was markedly different, less friendly, less helpful, at a time when she seemed to be most in need of those aspects of care. She initially stated that nurses were probably not responsible for patient comfort, but later made it clear that she felt they ought to be.

R5. Informant CS was a woman aged 45 years, divorced, with a dependent teenage son at home. Over the years, she had had admissions for day only procedures, as well as cholecystectomy, hysterectomy, and major surgery to her oesophagus two years previously. Her current admission was for further corrective surgery to the nerve supply to muscles of her oesophagus. She had been admitted to one ward, then after surgery went to a high dependency ward and finally to a third ward for step-down care. Recruited on her sixth post-operative day, she was discharged the following day. She was interviewed at home three weeks after discharge.
CS was more than happy with the care she received in both the admission and the high-dependency wards, with nurses being pro-active in her comfort care and pain relief, joking with her and taking time to check on her, even though they were very busy. On all previous occasions in hospital, she had been satisfied with her care. After transfer to a step-down ward, her perception was that the nurses there were uncaring, and probably did not know how to look after her or her fellow patients. This informant was still able to say,

*I reckon nurses should be paid a thousand dollars a week for what they do. That is, the good ones, you know, that really look after you - they give you showers, change the bandages, take out the drips and the drainage. They've got to have a nice attitude. Like, the doctor who operates, he does that, but then the nurses have got to do the healing part - besides yourself, you know.*

5.2.2.3. A note on informant selection

According to Miles and Huberman (1984), one criterion for validity where interview is the main method of data collection is that the researcher takes into account and guards against the possibility of ‘elite bias’. This would exert a subtle influence on the researcher’s choice of what to include as data, and possibly of whom to choose to interview. It should be understood that sampling in qualitative research is selective, that is, informants are chosen purposefully for their likelihood of being able to tell their story effectively.

Morse and Johnson (1991) note that the researcher would consider whether informants referred by other caregivers would be retained, based on the outcome of initial interviews. However, from a practical point of view, it is difficult to predict from a brief preliminary conversation how well an interview will proceed, in the sense of an informants’ willingness or ability to describe what happened and how and what they felt. I did not have a strategy for early termination of an interview nor for dis-engaging, once a patient had agreed to become an informant if the informant proved unsuitable, other than those tactful, ‘social closure’ tactics
one has learned to use. In this study I found that some informants were more articulate and reflective than others, and there was an occasional sense of disappointment during an interview and on first reading of a transcript. Despite this, none were discarded. Later in the study, while re-reading the transcripts and engaging in constant comparison, it became clear to me that all informants had added to my global understanding of the comfort experience in some way. Each had contributed what was personally valid about the experience. Some informants provided negative cases which added complexity and depth to the final analysis.

Meaningful insights could emerge unexpectedly, towards the end of an interview, sometimes after the tape recorder had been turned off, or as both informant and interviewer were becoming tired. I was conscious of the need to exercise careful judgment about what constituted valid data, and indeed, what constituted valid research methods, and to have in place some corrective processes should they be needed, as will be seen in the following passages.

5.2.3. **Supervisory checks on the novice researcher**

After each of the first two interviews, the audio-tapes and transcripts were listened to and read by the chairperson of the thesis panel. One of the panel, a nurse academic and qualitative researcher, substantively coded the second and third interviews of this phase and confirmed high inter-rater agreement with my own coding. He also noted that researcher bias was evident in one of the post-pilot interview transcripts, and that this required attention. Rather than having an ‘elite bias’, my bias in this instance was towards ‘good’ nursing practice. The interview had provided glimpses of ‘nice’ nurses but also - in my view - a rather inexpert and casual level of care. It was evident to the panel member and to myself that I had pursued in my questions issues of what constituted ‘good’ nursing, even in the face of the informant’s stated satisfaction with care received.
I had become aware of this undue emphasis immediately after completing the interview and when writing up field notes later in the day. It concerned me greatly and I described the interview skew in a lengthy *mea culpa* personal memo, and later discussed these and the issue with members of the thesis panel. The drift in my focus to nursing practice and away from patient perceptions and experiences, was also noted and corrected. From then on I took special pains to regain and maintain empathic neutrality.

5. 2. 4. The search for meaning continues

Analysis of interview R1 - R5 provided further opportunities for constant comparison and deductive and inductive analysis. The literature was selectively searched for relevant material. In this section theorising is explained in palin type, with informant verbatim comments in italics.

5. 2. 4. 1. Ongoing analysis and document review

The grounded theory researcher cannot avoid (and according to some, ought not to avoid) using one's own ideas and experiences in understanding and analysing the data, while remaining alert to his or her own possible biases. Inadequate nursing assessment of patients and inadequate management of pain are persisting problems in clinical practice, despite widely published nursing and medical research over the last fifteen years highlighting the need for improvement in this area. These problems and the problem of unresolved discomfort were evident in several interviews. There is also an apparent expectation that everyone will follow exactly the same path through early convalescence, and that those who do not cease to want attention and analgesia as soon as staff expect, for example, are labelled 'difficult'. These problems were typified by informants in this group of interviews who expressed considerable dissatisfaction with some aspects of their care.
In the light of a couple of informants’ strong negative perceptions, and alert to the possibility of my own bias, it seemed appropriate to attempt to confirm or disconfirm particular statements. I requested permission from the hospital’s nursing research co-ordinator to access medical records of three informants, as this had not been part of the study design. I was able to compare the written records with much of what informants had said in relation to their experiences of discomfort, and I summarise these below.

Informant R2 had developed a groin wound infection necessitating an ultrasound, intravenous antibiotics, stronger analgesia and a temporary return to bed rest. On requesting a bed-pan, she was upset and then angry at the nurse’s reluctance to help and the attitude that a “day five” patient should not be requesting help. She described the nurse as looking at her “in a hard way” and as “pulling a face”. She felt that some nurses simply did not believe that she was in pain or that she needed help with toileting. While able to acknowledge that some nurses had been very understanding and helpful, on balance, she felt that nurses had treated her in a callous and unsympathetic manner.

Another informant, R5, had stated that she was unhappy with the way repeated requests for analgesia after transfer to a surgical step-down ward were ignored by nursing staff. Her progress notes indicated lengthy dosage intervals and a long delay in changing the route and type of medication, on transfer, ‘medically well’, from a high-dependency ward. This informant had had painful surgery to her oesophagus, had a wound drain in situ and was walking about as much as possible, having been encouraged to do. She had a sore neck and headache and had made several requests to staff to call the doctor to order oral analgesia, each time being told that nothing was written up. She finally stopped asking. Her progress notes recorded that she was “Ambulant and self-caring. No complaints voiced.”
Other possible explanations for her experiences were hypothesised. Informant R5 had had over twenty admissions to hospital for short and longer procedures. This circumstance alone may be enough to create a stereotypical impression and expectations by staff that such a patient could have become ‘institutionalised’ and would ‘play on the staff’ and possibly have drug dependent or manipulative behaviours. Negative labelling processes may be triggered at nursing shift handovers by verbal and non-verbal language of staff (Lane & Rae, 1983). A careful review of this informant’s progress notes and medication sheets of the previous ten admissions there was no evidence of or reference to drug dependence or more than usual drug use. Seeking an explanation of her nursing management, I began to wonder whether patients who are transferred between wards during their hospitalisation, might be viewed in some intangible way as somehow not belonging to the staff of the receiving ward. Personal knowledge of similar instances came to mind, and prompted a search of the literature.

5. 2. 4. 2. Returning to the literature

For people with what I considered to be ‘ordinary’ (that is, non-problematic and relatively uncomplicated) medical-surgical conditions, I found very little of relevance with respect to inter-ward transfer or transition. One study of in-patient transfers found that “most patients knew the reason for transfer and were neutral in reaction about it” (Smith, 1976, p. 192). A small Australian study examining the process of transfer from a Coronary Care Unit and the potential for transfer anxiety to complicate the cardiovascular status of patient, reported 78% unconcerned or happy but recommended adequate patient preparation for transfer (Carr, 1989).

Literature on in-hospital transfer more often relates either to assisting with physically moving patients from beds to chairs or trolleys, or to the stresses of cardiac or intensive care patients transferring out of critical care units, who are
leaving the security of monitoring and intensive surveillance by staff (Saarman,
1993). In hospital-related literature an ‘outlier’ often refers to a statistical
abberation in the patient census, that is, to a patient whose diagnosis is different
from the usual patients nursed on a ward. In my own experience, for example, I
have cared for male orthopaedic patients in a gynaecological ward and for a
patient with a respiratory problem admitted to a renal ward because of shortage of
appropriate beds. References to such events in the literature are minimal and offer
no insights into any aspect of the experience from the point of view of staff or
patients, with the exception of the notions of ‘salience’ and ‘trajectory’
(Fagerhaugh & Strauss, 1977) noted earlier in Chapter Two.

‘Transition’ in the nursing literature focuses for the most part on care of the
premature infant, or in the social science literature, on major life transitions
(Cobb, 1976). At this point in the study I could find nothing about the transition
from acute care to convalescence. There was nothing concerning the breaking of
professional-social bonds with ‘ordinary’ patients by transfer to another ward, or
the re-forming or otherwise of these bonds, with implications for patient
assessment and physical, social and psychological well-being. The phenomena of
exclusion and confirmation (Anderson, 1981; Drew, 1986) while not specific to
social / professional bonding or failing to bond after inter-ward transfer, was
conceptually relevant here, as was the literature on stereotyping, and on
conformity and deviance (Kelly & May, 1982; Larson, 1987; Lorber, 1985).

5. 2. 4. 3. Constant comparison technique

I returned to earlier transcripts, in keeping with the constant comparison
technique advocated in grounded theory. Informant P3 had been transferred, and
there were glimpses of less personalised care after transfer. Informant P5 had not
been transferred physically, but attentive care and concern were, in her
perception, less available after her second post-operative injection. Was she, in the nurses’ minds, effectively transferred to a self-care status?

Informant R4 had moved several times between high and lower dependency wards. As an ambulant, non-monitored cardiac patient, who had spent several days in a medical ward, she had felt was impersonal on the occasion of her transfer to a surgical ward on the afternoon before by-pass surgery. This was a time of considerable anxiety and loneliness for her, but her needs for this to be acknowledged and to receive support were met with routine observations and minimal contact with nurses (similar to the admission experience of informant P4 for renal surgery and the post-operative experiences of P5, R1 and R5, and reflecting some similarity of approach to sub-acute or post-acute patients in different hospitals). The interpreted, constructed meaning of these experiences for informants was of not being adequately cared for, or about, when they had expected to be.

Informant R4 expressed the thought that surgical nurses may be busier than nurses on medical wards. On being transferred to the cardiac surgical step-down ward, and then back to the general surgical ward, she missed any sense of being cared for as an individual. This informant (and other patients on her ward who had been transferred for surgery) had been delighted by friendly visits of nurses who had cared for them in the medical ward, who made a point of following up their patients who had gone on to have surgery and who demonstrated ‘caring about’. In contrast to nurses on the surgical ward, these nurses were seen as being interested in what happened to their patients and were regarded as unusually caring. The experience of informant P4 was different in that he had apparently not formulated clear expectations of the kind of nursing care appropriate for an anxious pre-operative patient, and later had considered the onus of forming a relationship with staff to be his.
To sum up, the data from interviews R1-R5 was coded in a similar way to the pilot interviews, and categories were added or expanded. Level I coding was done as each interview was transcribed, entered into the computer, printed and examined. Level II coding and analysis was interrupted by my return to full academic duties after a period of study leave. By the final interview in this section, I began to wonder whether the categories had been saturated. However, this was premature. A summary of preliminary findings was made. In broad terms the data seemed to indicate that:

- nurses were perceived as being very busy;
- nursing surveillance at all stages of care was comforting;
- high dependency nurses used a variety of physical and psychosocial comfort measures;
- informants called nurses ‘expert’ when they were efficient and caring;
- informants engaged in self-comforting self-talk, and self-care;
- attention, assessment and comfort measures fell rapidly away once a person was deemed to be out of danger, that is, stable and judged by the doctor to be ‘well’;
- assessment is perfunctory and rarely involves the patient in any meaningful way; discomforts are not assessed;
- there is accelerated transition from high dependency to low-dependency care which continues to discharge. Commonly, discharge from hospital for this group of patients is a casual process, many simply leaving hospital after being told by a doctor
they can go home, in distinct contrast with the formal procedures of admission;

- informants accepted physical discomfort and were always in self-help mode, only expecting help from nurses when discomfort was intense, and when care needs exceeded self-help resources;

- psycho-emotional discomfort encompassed a wide range of negative emotions;

- hospital routines took precedence over comfort measures in some instances;

- nurse-staff interactions were either formal, social or superficial, rarely patient-focused, that is, designed to identify and address a need or deficit;

- transferred patients may not be ‘owned’ by the receiving ward, with implications for adequate assessment and comfort care;

- there is little expectation that nurses will provide comfort other than analgesic medication.

5.3. Phase Three Of The Study: Theoretical Sampling

Grounded theory methodology calls for a strategy of theoretical sampling and suggests a deliberate seeking out of informants with different, atypical or even negative experiences in order to describe the study’s phenomena as richly and accurately as possible (Morse, 1991; Glaser and Strauss, 1967). The original plan had been to interview men after the women’s interviews. As the study progressed, and after ten interviews (P1-P5, R1-R5), I sought male informants with a range of experiences, contexts, situations and ages. Each informant
sampled theoretically in the latter part of the study was sent a diary with an explanatory letter and consent form through the mail, prior to interview.

Four male informants were recruited and interviewed (R6-R9). Analysis of data from these and earlier male informants convinced me that there were no comfort and discomfort. Two further informants, a male and a female (R10-R11) were then interviewed. At this stage I had intended to stop interviewing and continue with the writeup. When a colleague referred another informant (R12), the interview was undertaken more as a courtesy than to collect additional data. Fortunately, this informant proved to be among the most articulate and his experiences, perceptions and insights repeatedly confirmed and strengthened my analysis. A brief summary of these informants is provided below and later in the chapter, their experiences are amplified.

Informant R6 spent twelve days in a major public hospital following chest trauma sustained in a motor vehicle accident. Informant R7 was a slightly older man who had had surgery in a small public hospital in a different health area. Informants R8 and R9 had been short-stay patients, one in a public, the other in a private hospital. Informant R10, a woman who had had a Caesarean Section, was able to describe her obstetric surgical experience. She had been a community-based midwife but this was not clear until the interview began, as she had been referred by a casual acquaintance and had seemed to meet inclusion criteria. Informant R11 had been hospitalised in another Australian state. Informant R 12 was delayed in hospital with complications of what had been described to him as 'minor' surgery.

5.3.1 Informants R6 - R12.

R6. Informant BH, a fit man of 45, father of four adult sons, an author and educator, was referred by a casual acquaintance as someone recently out of hospital. BH met the major criteria of the study. He had been admitted to a large public hospital in a different health area, with chest
injuries and possible cervical spine injury, following a motor vehicle accident. He was interviewed at his home seven weeks after discharge.

BH had had no previous hospital experience, but had suffered from severe migraines as a child, and recalled the immense comfort of his father being with him and helping him through his pain. He had been transferred from Accident & Emergency, to a neurosciences ward to rule out cervical injury, thence to a respiratory ward for further management of chest drainage for haemopneumothorax, then to a step-down ward. On his twelfth day in hospital, to his considerable surprise, he was told by a doctor that he was well and could go home. "I didn't know I was well", he said. This informant, a school principal, was impressed by the efficiency of the hospital's trauma team, but puzzled by its failure to involve him in any care-planning or decision-making. On the whole he was grateful for the care which emphasised his safety, but he felt dehumanised by the system. He had periods of great vulnerability while in hospital. No-one had prepared him for discharge, nor given him a certificate for absence from work, and being a first-time patient, he had not known to ask for one. He was uncharacteristically weepy in the several weeks after discharge and was embarrassed when he weep at one point in the interview.

R7. Informant MH, was admitted electively to a 300-bed suburban public hospital for prostatectomy. He was admitted to a surgical ward, transferred unexpectedly to four days in intensive care post-operatively, then transferred to a ward which had been opened for the weekend for a small number of patients, overflowing from the Monday-to-Friday surgical ward, and finally back to 'his' ward on the following Monday.

Informant R7 was a recently retired plumber. He is the main carer of his wife who has a chronic illness. The basis for his inclusion in the study was to assess the salience of age, in relation to perception and experience of comfort and discomfort. In addition, this informant had been cared for in a smaller district hospital in a different health care area from any previous informant. MH was interviewed three months after discharge. He valued nurses, male and female,
who were caring and efficient, whom he termed “expert”. Both of these informant narratives added thick descriptions of comfort and discomfort experiences to the accumulating data. They had been exposed to in-hospital transfers, providing further interesting insights about social and professional bonding.

The process of constant comparison and theoretical sampling continued. On the basis of Level I and Level II coding, decisions were made to recruit and interview short-stay patients. Two men having had similar surgical operations in different hospitals in different health areas were referred separately by colleagues and agreed to be interviewed.

R 8. Informant SJ, aged 45 years, employed as a printer, married with young teenage children. He was interviewed following a short stay for carpal tunnel surgery in a local private hospital. His doctor had warned him that the operation would be very painful. He had previous minor surgery at age 16.

SJ had felt very uncomfortable on admission to the hospital because he did not quite know what to expect or what was expected of him. His uncertainty was intense for some hours. A patient in the next bed eased the situation with a friendly and informative chat about how ‘the system’ worked. This became an outstanding memory of comforting. Post-operatively, SJ recalled being given oral medication only and found that severe pain returned about an hour after the tablets. He was accepting of this “... out of necessity” (qualifying his comment with a significant expression and emphasis) because he had been led to expect it by his surgeon. A sympathetic nurse was “... ten out of ten excellent” because she had inquired frequently about his pain, but from what I could discern had not otherwise intervened to lessen his discomfort.

This view of nurses as being excellent if they were caring, is supported by an American hospital survey which stated that most patients have no frame of
reference for evaluating professional knowledge and skill. Nurses are judged by their human qualities and interaction skills (Doll, 1979).

R9. Informant RF, aged 60 years, a business consultant, married with children and grandchildren, was interviewed after discharge from a public hospital following surgery for correction of Dupuytren’s Contracture.

Comfort for RF was to be in the patient role for the barest minimum time. Comfort was having complete confidence in his surgeon, who gave him the amount and type of information he needed beforehand, and who (he believed) had organised a pain-free post-operative period and his very early discharge from hospital. He reported few discomforts, all regarded as minor.

R10. Informant PF, 35 years, married with young children, was referred by a colleague simply as someone who had very clear memories of hospitalisation. Since a meeting was impossible due to her commitments, she agreed to be interviewed by telephone.

PF had been admitted to district hospital for an elective Caesarean section. This could be regarded as a surgical procedure for the purposes of the study, but it was also an attempt to theoretically sample further the experiences of people with other acute, elective, short-term hospitalisations. PF, a migraine sufferer, had wanted information about the likely effects of epidural anaesthetic on her type of headache. Her perceptions were that pre-operatively, her questions about this to the anaesthetist were brushed aside, and that further questions were dealt with defensively by him, as though they were perceived as threatening. After surgery, she felt obliged to go to extraordinary lengths to obtain analgesia from the nurses. When a first, then a second request for analgesia did not get a response, she felt she would only obtain relief of her pain by intentionally groaning loudly enough to disturb other patients, who then called the nurse.

In the post-acute period she received ‘expert’ assessment and nursing care from two nurses who were observed to be similarly interested in all their patients. By
contrast, other nurses in the post-partum ward were perceived as "distant, authoritarian, unresponsive and interested only in the technology of care" where she had expected them to be concerned about the emotional needs of women as mothers. "It was as though we were not there." She felt alienated and disempowered by the insistence on routines which facilitated staff more than patients and their partners.

This informant's narrative described routinised and disinterested caregiving, albeit with notable exceptions, and strengthened the notion of the salience of unpleasant hospital experiences for later recollection. In relation to the persistence of negative memories, Rieman (1986) documented patients' perceptions and feelings about un-caring nursing behaviours. Non-caring nurses were remembered for many years after the event by patients in her study, as coldly efficient, not human, with no time to talk, always in a rush, who just did what had to be done, rough in speech and action, belittling patients, not responding to questions, treating people as objects and sounding indifferent.

R11. Informant JG, 67 years, married with children and grandchildren. He was an acquaintance of long standing living in a neighbouring state and meeting broad criteria for informants of the study. He was recruited prior to discharge following Cure of Hydrocele and exploration of testicular lump, found to be benign. He recorded briefly in the diary and posted it back to me. Two weeks after discharge, the interview, conducted by telephone, was electronically amplified, audio-taped with permission, transcribed and entered into the computer program.

This interview had three purposes. The first was to continue to explore issues of comfort and discomfort as perceived by older adult males, with the benefit of possible comparisons of care in different states. The second was to test the theory that was beginning to emerge by September, almost a year after the pilot interviews had taken place. The third purpose was to evaluate whether data saturation had been achieved.
JG had anticipated pain and discomfort connected with surgery and anaesthesia. He was confident that nursing and any other need care would be available. He expected that his recovery would be assisted by the staff but would mostly involve his own efforts. He had emotional tension and apprehension pre-operatively related to possible outcomes of surgery, which he managed by self-talk (maintaining perspective). It was unexpectedly painful having a lumbar puncture, but this was somewhat offset during the procedure by the physical and psychological support of the assisting nurse. He was unable to move his legs for many hours after surgery, a major unrelieved discomfort. This and his concern about genital/sexual functioning were managed by self-talk (accepting).

'A final informant, referred by a colleague, was interviewed at his home four days after discharge from a district hospital.

R.12. Informant MW was aged 32 years, with no adult experience of hospitalisation. He worked as a paramedic and had never been a nurse. Admitted to a district hospital for acute abdominal pain, he proceeded to laparoscopic appendicectomy, eventually staying seven days because of peritonitis, instead of the predicted two.

MW provided insightful comments on comfort and discomfort, the nurse-patient relationship, the expert nurse, his reluctance to initiate requests for help, vulnerability, embarrassment, and the fear of being considered a demanding patient. By contrast with the previous older informant MW was articulate and not at all reticent about expressing his fears and anxieties.

At one point in the interview, MW, admitted through Casualty with severe and worsening abdominal pain, had had a succession of different staff coming to him and asking him to repeat his story. "It was embarrassing. I was in agony and in tears. As each new nurse came in I had to explain to them what was wrong with me, why I was vomiting." He was finally transferred to a surgical ward:
This is where I noticed that I had the one nurse all the time - it wasn’t like Casualty where you had a few coming in and out - there was one nurse and that was it. “(R: And that seemed good to you?) “That was good, yeah, I liked that. It wasn’t until I got to the ward that I really knew what was happening, ‘cos I remember saying, what happens now? I felt I could find out what was happening. I thought, I’m here, but no one’s actually said what I’m doing here. There was a sense that I could stop now and get my thoughts back together. I was oriented to the ward. This was done very quickly, and very - um, tick the boxes as we went through it...//...That was a little bit disheartening in the sense that this was just a routine - couldn’t we do this later? The actual location of the shower and toilet meant nothing to me. I was in too much pain and I couldn’t get out of bed anyway. In one sense it was good, it made me feel welcome. But in my opinion it was done at the wrong time. (Informant R12.)

Throughout the interview, there was a sense of the informant’s active participation as a patient - anticipating, interpreting, defining situations as ambiguous or upsetting or comforting, or as uncertain and needing to be sorted out; accepting that some things are routine, making allowances for this and if it was well-intentioned (however inappropriate in his particular circumstances) and maintaining some perspective -

... but in another sense, just the process of going through that made me feel I like I belonged. In Casualty, you don’t feel you belong because you know you’re only going to be there a short time. Once I was told I was going to the ward, and the ward would be Unit X,” I then sort of knew my fate had been determined, do y’know what I mean? I felt, right, I’m going to be there for the night.”

I noted the sense of wanting to belong somewhere, of needing to have a definite place, having someone to relate to, of being someone’s responsibility, of needing to feel less vulnerable and more ‘anchored’ and safe, of having an identity, a role with a name on it (‘Patient of Unit X’) - perhaps a script or some direction to guide the new occupant of the role. I followed this up with MW during the interview, to confirm or disconfirm some ‘bonding’ and ‘role’ ideas. I now sensed that saturation had been reached.

The constant comparison of subjects along several dimensions is recommended in grounded theory methodology (Bowers, 1988). One of the dimensions in this
study was the range of hospital settings, public, private, large teaching hospital and smaller district hospitals, where comfort and discomfort could be experienced by in-patients. MW's experiences added to the number of hospitals, a final total of nine, in which informants in this study had been nursed, in four different health areas of a large Australian city.

The dimensions in this study of patient comfort and discomfort were as follows:

- **Age range** - 32-67 years
- **Gender** - 9 female and 8 male informants
- **Type of admission** - 12 planned and 5 emergency admissions
- **Type of condition** - medical, surgical, trauma
- **Length of stay** - 2 to 17 days
- **Hospital type** - 4 private and 5 public hospitals
- **Hospital size** - large, medium and small hospitals
Informants in the study were admitted for the following conditions, as shown in Table 5.2:

**Table 5.2  Reason for Informant Hospitalisation**

<table>
<thead>
<tr>
<th>Condition</th>
<th>No. Cases</th>
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</thead>
<tbody>
<tr>
<td>Surgery</td>
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</tr>
<tr>
<td>cardiothoracic*</td>
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</tr>
<tr>
<td>abdominal*</td>
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</tr>
<tr>
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<tr>
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<tr>
<td>orthopaedic</td>
<td>3</td>
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<td>inflammatory process*</td>
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*Denotes informant had distinctive medical and surgical hospital experiences.

5.3.2. Experiences of comfort

There was no appreciable difference in the discomforts identified by informants who had been in different hospitals, not between male and female informants. The data revealed numerous instances of comfort and comforting. These were analysed by asking a number of questions of the data, such as:
What is the patient’s definition of comfort?

Most informants found a definition difficult to produce, but gave examples of comfort. These included nurses with positive attitudes and supportive non-verbal behaviours, nurses communicating effectively, seeking and giving information, being social and friendly and nurses acting as comforters in general and in specific instances of vulnerability.

Who provided comfort/comforting?

Nurses - busy nurses, specialist nurses, expert nurses, nice, friendly nurses; other staff - doctors, a physiotherapist, an X-Ray technician, tea-ladies; visitors; other patients; patients themselves.

Where and in what situations was comfort provided?

Mostly in high dependency areas, or in situations where patients were treated, however briefly, as highly dependent. Comfort measures were physical and psycho-emotional: attention, humour, vigilance, support, information, analgesia, re-positioning, pillow-fixing, shampoos, massage. Comfort was offered sometimes spontaneously, sometimes routinely, sometimes provided in response to patient request.
How did nurses provide comfort?

Nurse comforting was physical, psycho-emotional and social: nurses giving gentle and thorough physical care; nurses coming in and out, nurses getting to know you, nurses’ attitudes, nurses letting you cry, distracting you, supporting you, telling you a little bit about themselves, giving procedural, sensory and orienting information; nurses keeping on eye on things, noticing you, nurses being protective, patient and kind to informants and observed to be so towards other patients.

How was discomfort experienced?

In analysing the data, I isolated individuals and situations that aggravated or caused discomfort. Some nurses, doctors, physiotherapists, other staff, other patients and numerous or inappropriate visitors were sources of discomfort. Discomfort could occur in any situation, and could co-exist with some kind of comfort.

What situations aggravated or caused discomfort?

Discomfort was described in terms of routines being given priority over care needs, impersonal care and lack of needed support, disappointed expectations of care, not enough help or attention when needed, unexplained and accelerated transition to self-care, lack of useful information, sudden transfers, too many visitors, not being believed or listened to, analgesia withheld, delayed or denied, rudeness of staff to other patients and having to be vigilant on one’s own behalf. Situations of discomfort resulted in a number of negative feelings including anger, disgust, anxiety, isolation, boredom, disappointment, surprise, loneliness,
shock, hurt, frustration, embarrassment, vulnerability, depression, feeling let down, sensing rejection.

5.3.3. Further analysis

At this stage in the analysis process, I felt unable to move beyond the substantive data to a level of understanding deeper than description, to search for meaning and metaphor, as recommended by Miles and Huberman (1984). Strauss and Corbin (1990) suggest that writing a story is helpful at a particular point in the analysis and assists the researcher to focus on important categories. A collective narrative was written which was intended to capture essential, common features of the hospital experience gleaned from seventeen narratives. The story, structured in numbered paragraph-length statements, was sent to all informants who were able to be contacted, with a covering letter and response sheet (see Appendix 7). This was a simple form of ‘member checking’, described as

a procedure that can be used to determine if data and findings reflect the respondents' realities; ... analytic hypotheses, interpretations and conclusions are tested with respondents from whom data were generated (Hoffart, 1991, p. 523).

Over a year had passed since early informants had been interviewed, and not all could be contacted. The twelve informants who responded indicated full agreement. This was reassuring, particularly since some informants had returned their response sheets with scribbled confirmatory messages. I felt sure I had developed a substantial, empathic understanding of their experience of hospitalisation, and this feedback from informants increased my determination to uncover deeper meanings which I knew were there but which were presently eluding me.

Burns and Grove (1993) suggest that asking probing questions of the data assists the process of moving from concrete to abstract thinking. It was, in fact, a constant questioning of the data and an inductive reasoning process which
facilitated the rounding out of concepts and the firming up and refining of relationships between them which allowed the substantive theory finally to emerge.

5.3.4. Process of interaction with the data

Theorising cannot be delegated to a computer program, no matter how helpful. It requires deep immersion in the data to achieve familiarity with it as well as an ability to stand back from particulars and search for process themes (basic social and human processes) or key categories. During immersion I am simultaneously participant and observer in every scene of every narrative. I am there: I hear, smell, touch, think, act and respond in and to the context. I feel and think and construct the meaning of encounters as busy but committed nurse, or as patient grateful for good nursing or affronted by its untimely absence. I 'live in the data'. Out of this immersion come fresh ways of articulating the experience of finding comfort and of managing discomfort. But if fresh connections with the past and present work of nursing scholars are to be made, and if the richness of the data is to be further explored and understood, the qualitative researcher in grounded theory method must interact with the data at a higher level of abstraction.

Abstraction calls for distancing one's self from data details and moving beyond substantive coding. Distancing, which is a stepping back combined with reflective appraisal, incorporates continuous processes of constant comparison and of data reduction through summarising and sorting, simplifying or paraphrasing the data (Miles & Huberman, 1984). However, it is important to keep returning to interview tapes and transcripts to ensure that summaries, simplifications and paraphrasings closely reflect what informants have told you, in order to minimise any distorting effects of distancing. A constant comparative technique was used in thinking about and questioning the data in search of some kind of process. After identifying the types of comfort and discomfort and the
circumstances which produced them, I found that questions such as, "When did patients ask for help from others?" and "Few actually asked - why?" and, "Do patients go through stages of achieving comfort? If so, can I identify any of the stages in my data?" were extremely useful in coming to a deeper understanding of processes embedded in the data.

The growing list of codes was updated, amended, added to or reduced as I worked further with the data, formulating hypotheses, testing them, discarding and reformulating as seemed necessary. Data from initial interviews was compared with later interviews along a number of dimensions. Processes and categories were listed and diagrammed many times. A colleague’s unenthusiastic feedback about a preliminary theoretical schema was ultimately helpful. Theoretical memos and various analytic schema decorated my study walls during attempts to relate major categories and identify the most significant symbolic and interactional processes. A conceptual map was drawn, and this served to underscore the interactive character of the physical, social and psychological ‘events’ revealed by the data.

Qualitative analysis is integrated, spiral, molecular, even “visceral” (J. Lawler, September 20, 1993, personal communication). It is difficult to describe and report for this reason, but also because of the proliferation of confusing terminology regarding stages and levels of coding. The “intellectual and emotional struggle” (Swanson-Kauffman, 1986, p. 65) to go beyond description to achieve valid interpretation and to generate elegant metaphor, was at times, nightmarish. Stern, Allen and Moxley (1984) refer to the emotional state of the novice grounded theorist as likely to touch on bedevilment, horror, panic, and an oscillation between creativity and insanity.

The poet-philosopher Leunig has graphically captured the anxieties of the research experience:
God be with those who explore in the cause of understanding; whose search takes them far from what is familiar and comfortable and leads them into danger or terrifying loneliness. Let us try to understand their sometimes strange and difficult ways; their confronting and unusual language; the uncommon life of their emotions, for they have been affected and shaped and changed by their struggle at the frontiers of a wild darkness, just as we may be affected, shaped and changed by the insights they bring back to us. Bless them with strength and peace (Leunig, 1991, unpaginated).

I had a draft of the emerging theory, and the seventeenth interview confirmed many of the themes and ideas I had gleaned about the meaning of hospitalisation and illness. In qualitative research data adequacy is evaluated in relation to sampling of events, incidents and experiences perceived as relevant for the study question and purposes, rather than people per se (Sandelowski, 1995). At each interview I was able to sample a minimum of between three and five experiences of comfort and/or discomfort, and thus I considered this a suitable sample size in terms of both grounded theory methodology, which necessitates theoretical sampling, as well as in terms of data adequacy (Morse, cited in Guba & Lincoln, 1994).

In working with the data, it seemed that for a number of informants there were often two senses of meaning of events. Often there was an up-side - “they emphasised safety”, as well as a down side - “but comfort wasn’t in it”. It was good that they did ‘X’ but the timing was sometimes wrong, or the patient being given information was in too much pain to take it in, or “… they told me to ask if I wanted to know anything, but how do you know what to ask?”; or, the nurse’s special tea didn’t take the pain away, but somehow it was comforting. There seemed to be a sense of dialectic in all this, an oscillation between discomfort and comfort, leaving the person both comforted yet still uncomfortable, as well as a disposition to accept and make allowances, because “… they meant well”.

After further refining, I explained and diagrammed the theory to an interested colleague, who had had many hospitalisations for exacerbations of a chronic
condition. Her response was mixed, but when she related my findings to her partner and family care giver, he was instantly able to confirm them: "That’s exactly what you do!" he said. I contacted six of the most articulate study informants and asked them to comment on the theory diagram and explanation, which I posted to them with a covering letter and response sheet (see Appendix 8). I was able to get further confirmation of the findings from others who fitted the inclusion criteria and were keen to discuss their recent hospital experiences with me. Their responses indicated that there was an excellent fit between their experiences of comfort and discomfort and the findings of this study.

Not surprisingly, two core variables - comfort and discomfort - were confirmed. Two core categories, basic social interactional processes and their sub-processes gradually emerged and successive drafts of the substantive theory finally appeared to account plausibly for the data. These activities are referred to as delimiting the theory and writing the theory (Nusbaum & Chenitz, 1990; Strauss & Corbin, 1990).

### 5.3.5. Summary of Investigative Procedures

This chapter has amplified the choice of grounded theory for this study, and has outlined the methods used to collect, record and interpret narrative data from seventeen informants about their experiences and perceptions of comfort and discomfort in hospital. Informants in this study were adults aged between 32-67 years, who had varied lengths of stay in nine different hospitals in urban settings. All were interviewed when the prospect of full recovery from a range of conditions, was good, or had been achieved. The broad research question - "What are the experiences of comfort and discomfort of this group of hospital patients?" - remained the same throughout the study, but interview questions were broadened from an initial focus on post-acute experiences, to include experiences
of comfort and discomfort during the whole of the hospital stay, for reasons which have been outlined.

The original research design was modified for theoretical sampling purposes, in relation to diary entries by informants. The time between discharge from hospital and interview varied from days to many months, and in one case, well over two years, without appearing seriously to impair recall of people and incidents which had significantly influenced their perceptions of comfort and discomfort. A patient note audit was initiated in the interests of procedural rigour (Burns and Grove, 1993) where there was some initial doubt concerning informant credibility. Requirements for diarising were modified as circumstances changed and as theoretical sampling progressed. The diary was an important orienting and triggering device, which had been the intention, but had limited value as a recording tool. No other design features were changed.

Background information on informants as well as small slices of data have been presented here as a way of explaining and validating the developing hypotheses and ongoing analysis. The value of memoing in providing an audit trail for myself and others was noted and issues of ethics and rigour in qualitative research were addressed. The next chapter explains the theoretical findings in greater detail by focusing on the core categories, specific problems and basic interactional processes which emerged from the data.
CHAPTER SIX
Analytical Findings: The Theory Explained

The chapter provides an overview of the theoretical findings of the study beginning with a statement of the core categories and processes which were uncovered. A simple diagram of the analytical findings is provided, with a discussion of critical elements of the substantive theory of finding comfort and managing discomfort which was eventually developed.

I set out to ask people about their experiences and perceptions, and in the section following this introduction, describe general characteristics of the study’s informants. The chapter continues with informants’ expectations of care and with selected examples of their experiences linked to and in support of elements of the theory. Critical constituent elements of core processes are explained and supported from the data. A brief summary of general findings of the study concludes the chapter.

Chapter Six is intended to prepare the reader for the one which follows which further elaborates core categories, core processes and the hospital convalescent experience, and with the concluding chapter, in which the theory and other findings are discussed.

6.1. Overview Of Study Findings

I began with the hope of being able to better understand the experiences of comfort and discomfort of post-acute hospital patients, and to be able to generate a substantive theory grounded in the data which could be of use to nurses. The major findings of the study are summarised in the following pages.
6.1.1. Finding comfort - managing discomfort

From the data two core categories were identified. These were comfort and discomfort. Comfort was experienced by informants in this study as physical comfort through interventions to reduce discomfort; as psycho-emotional comforting by self and others; and as social comfort obtained through the company and support of others. Only one informant mentioned environmental comfort which was experienced as a sense of feeling soothed, rested and at peace which came to her as she focused on a framed wall print, soon after transfer to a single room from a noisy admission area in the hospital. Another informant noted the spiritual comfort he experienced when his parish priest visited and gave him the Eucharist. This informant was additionally comforted when a senior nurse manager took the time to visit his wife, admitted for respite care in a different part of the hospital, and to come back, sit briefly with him and tell him how she was, and how she had been reassured about his condition. He saw this level of care and sensitivity as ‘expert’ nursing.

Study informants experienced physical discomfort as a variety of discomforts some of which were predictable and some, unexpected. Psycho-emotional and social discomfort resulted from negative emotions, some of which were predictable and others, surprising and unexpected. Most informants reported environmental discomfort due to noise, light and disturbances involving staff and other patients which impaired sleep, rest, mood and general well-being. No informant directly identified an experience of spiritual discomfort, as such.

The core processes which emerged from the study were those of finding comfort and managing discomfort. These were basic social and interactional patterns of thought and behaviours which accounted for process, change and movement over time (Glaser, 1978) in relation to comfort and discomfort. Finding comfort and
managing discomfort were achieved through sub-processes of self-talk and self-care. In simple form the finding are as shown in Figure 6.1.

**Figure 6.1  Overview of Study Findings**

Adult Patient Experiences and Perceptions in Hospital

Experiences and Perceptions in Hospital

Comfort / Discomfort ⇔ Self-Talk / Self Care ⇔ Finding Comfort Managing Discomfort

Finding comfort and managing discomfort are global strategies which subsume a number of processes collectively labelled 'self-talk' and 'self-care'. These were uncovered through repeated scrutiny of the data and use of the constant comparison technique. These sub-processes of self-talk and self-care are characterised as an integrated set of cognitive, affective and psychomotor responses to people and situations in hospital, mediated through interaction and interpretation, from which meaning was derived. Through these interpretive responses, informants both managed discomfort and found a measure of comfort.
6.2. General Characteristics Of Informants

In order to provide the reader with a background for understanding the subprocesses of self-talk and self-care, the general characteristics of study informants and an outline of their expectations are set out in the following sections. There is a fine distinction between expectation and anticipation which will be elaborated further on in the chapter.

6.2.1. The study's informants

The research was conducted over a period of eighteen months. Seventeen English-speaking adult respondents between the ages of thirty-two and sixty-seven years were interviewed. Informants had been hospitalised for acute and subacute medical and surgical conditions in nine hospitals which included two tertiary referral and teaching hospitals, four district hospitals and three private hospitals in metropolitan areas of cities on Australia's eastern seaboard. Informants' length of hospital stay ranged between two and seventeen days.

Five informants provided data for a pilot study to trial data collection techniques. Four of these were interviewed while in hospital, that is, within a few days of admission, and almost at the point of discharge. A further twelve informants were interviewed. The length of time which had elapsed between discharge from hospital and these interviews varied from several days to almost three years. Interviews and field notes were transcribed immediately and analysed in a number of stages, as outlined in the previous methods chapter.

The seventeen informants, nine women and eight men, interviewed for this study were adults mostly of British or European background. All but one were native born or naturalised Australians, the exception being an English woman who had lived and worked in Australia for some years. Apart from two women who were
homemakers, informants were actively engaged in, or recently retired from, skilled or professional employment.

Four had been admitted with acute conditions: asthma, angina, trauma, acute appendicitis; one for antibiotic therapy and rest for a leg infection; the remainder for elective abdominal, gynaecological, orthopaedic, cardio-thoracic, or renal-urogenital surgery. All were recovering from medical-surgical conditions which were ultimately non-life threatening. They had had varied experience of the health care system. Most had nurse or doctor relatives or friends. Some had visited relatives in hospital, or had known people with similar conditions, or people who had undergone similar procedures to their own. All but three had been patients at some time or other - some within the last few years, some as children, some for child-bearing. One was an ambulance officer with no recent personal in-patient experience. One had been a community-based midwife with minimal experience as a patient. One informant had never been in hospital, and based his expectations of care on one-to-one interactions with his doctor in a medical centre. One informant had had more than twenty admissions to hospital over a period of years, mostly for relatively short periods, but two years previously had undergone major surgery.

6.2.2. Informant expectations and assumptions

For the informants in this study there was a measure of cultural, social, language and experiential homogeneity from which could come common, elementary understandings of the Australian health care system, and some expectations of it. Because perceptions are related to assumptions and expectations (Inguanzo, 1992) the reader is provided with an overview of the things study informants assumed and the expectations they had, about the kind of care they would receive in
hospital. Their initial interpretation of events and encounters within the hospital, were based on these expectations and assumptions.¹

6.2.2.1. Expectations about care in hospital

At some point in the course of every interview, it emerged that each informant had had some general expectation about the care they would receive in hospital. Their expectations had surfaced prior to, on, or soon after admission, and were initially engendered by previous experiences, both personal and vicarious. "They've always been marvellous," said one informant who had had numerous admissions. Another noted that she had visited close relatives, one who had been very ill, and one who had had major surgery. This informant said, "I've seen them working, and just marvel at their expertise"; another, that "... there is always noise, of course, in a hospital, with people coming and going".

Nurses were expected to be caring and kind and good at what they do, as one informant put it, "... technically able to do things, but they need that extra bit, not just being able to take out drips, but to be able to do it in a nice way." One informant had expected that nurses would have "... a concerned attitude, not a frosted-over personality". These expectations were later either confirmed or somewhat revised as a consequence of events in hospital and of personal encounters with staff.

¹ There is a fine distinction between, on the one hand, broad expectations and assumptions about hospitals and care and on the other, the informed anticipation which comes from actual encounters with systems and individuals. Context-specific information provides some basis for prediction about what might happen next. I have drawn that fine distinction in formulating the 'anticipation' component of the theory (see Figure 6.2.) while acknowledging that both expectation and anticipation were probably closely linked in the informants' perceptions and emotions.
6.2.2.2. Expectations about hospital routines

There was a general expectation that hospital care would be efficient and organised, with someone in charge: "I do know that the doctor had to order medication." It was also expected that the work of caring for patients would get done, mostly by nurses. There was a general understanding that nurses were there all the time, and that doctors visited briefly. "The doctor's visits of course, only last about a minute - you probably know: yes, well, how are you, and so on and then out he goes." It was expected that if needed, the nurses would contact the doctor: "I was in constant pain. They wouldn't give me anything for it - but I couldn't see what the problem was. Why couldn't they just go and ring a doctor to come up?" Informants understood, or soon came to understand and to accept, that care would be organised around routines "... checking your chart, taking your temperature" and that "... the night nurse would give you something to sleep."

These routines came to have meaning as admission and discharge procedures; doctors' rounds, nursing shift changes, necessary activities such as delivery of meal trays, bedmaking, taking of temperatures and blood pressures, giving out medication, checking on drips, and as specific procedures related to doctors' orders.

_The visits you got was because there was a purpose. You used to get so that you could count the day by the visits you got. It was either to do your obs, administer medication or pain relief, or at the change and start of each shift - the nurses would come in and sort of ask you briefly how you were, sort of like a greeting for the day." (R: Anything in between?) No, other than - unless you called them - like, if you specifically asked them. (Informant R12.)_

There was a general trust in this routine system and an expectation of being cared for by competent staff. An exception to this was an informant who had only a vague idea of what to expect, or of what would be expected of him, when he went in for short-stay surgery, other than that his doctor had told him he would have a
lot of pain afterwards. He identified that not knowing what to expect of his hospitalisation was psychologically very uncomfortable for him.

6. 2. 2. 3. Expectations that nurses would be busy

There was a perception by each informant that nurses are very busy, that they are "... over-worked and understaffed - that's sort of accepted by most of the public"; "... they're very busy, under a lot of pressure". "You hear about it on the media, you know they're flat out"; "I knew the buzzer was only there for when you really needed somebody ... I've always known how busy nurses are - I know that in a necessity they'll be there". Because nurses were busy, "... on the go all of the time", there was an expectation that they would not be able to spend a great deal of time with any one patient, nor "... be there every minute, because they have a whole ward of people to work with, and they have other jobs behind the desk."

6. 2. 2. 4. Expectations that nurses would not be too busy

It was always expected that despite being busy, nurses would not be too busy to provide adequate care. One informant recalled in the first few hours after surgery,

"Every time a nurse came in I was vaguely aware of them coming and checking things. They went too soon, soon as they had checked things, and they didn't - I couldn't make myself heard loud enough to ask for help." (Informant P5.)

Informants expected nurses to be interested in their work, to be casually interested in them as individuals, and to be concerned with their well-being. "I didn't expect them to be falling over me, fussing over me, but I did expect that they would help me. They're there to help you." One informant recalling a childhood experience of a 'cranky old nurse' was glad to find nurses so changed. Others wished for the old-fashioned type of nurse who "knew how to make you comfortable", and knew how to assess a situation:
The older sister came in - the evening shift were just going off and they'd just come in for their afternoon goodbye talk - and she said you don't look real well, and I said, I don't feel too good either. I thought that showed that she had some experience, and it also meant that she'd actually been keeping an eye on me, even though I hadn't known that. I felt, this is someone who knows what she's talking about. Like, if she says I don't look well, then I mustn't be well. You know? (Informant R12.)

6.2.2.5. Nurses' routines

Nurses' routines were recognised as important but were not expected to take precedence over patient care, nor to make the patient feel objectified. One informant sensed that his pain and fever were treated in this way.

To her, it was cassette number four, we play that one, we know what to do now. There was a sense of relief that somebody was looking after me, but there was a feeling that, Gee, I wish somebody had told me they had been taking care of me - it was just routine to them, just routine. (Informant R12.)

One informant was extremely hungry but met with a routine response.

None of us felt like the food, it was so unpalatable, we couldn't eat what they brought up, it had no flavour. We were starving, really hungry. We mentioned the food, lots of times. The nurses said, don't complain to us, you'll have to write a letter to the - whoever they said - in the kitchen. They didn't want to know about it. Well, it's not their responsibility. They have a system, and that's what has to be adhered to, I would think. (Informant R4.)

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1 The interview with informant R12 who had had minimal experience as a patient, yielded a number of "quotable quotes" which epitomised many of the experiences of other informants.
Another informant felt that he didn’t have any say in his treatment, because of routines:

*I felt that she wouldn’t let me explain that I was in a great deal of pain. It was, you will walk up and down the corridor, you will not lay in bed all day. All done under the auspices of, we’re looking after you, but you do as you’re told. The book says you’ll get out today, so you’ll get out today. It was a race to see who was got out of bed first. Whoever got their patients up first, won. That’s how I felt. I felt I was getting out of bed to satisfy them not to help me.* (Informant R12.)

6.2.2.6. Patients’ expectations of comfort and discomfort

Few had given much thought to the matter of comfort prior to admission to hospital, except to assume that they would have painful or uncomfortable procedures, which would then be offset by adequate relief measures. Those admitted electively expected to be uncomfortable for some time after surgery. As one informant said, “My doctor told me to expect a lot of pain after the operation”. Informants were surprised and shocked when the intensity and duration of their pain and discomfort were more than had been expected. Another said, following laparoscopy, during which his appendix had ruptured, “The thing was, I had a lot of pain. Everyone kept saying to me, this is a new, you-beaut minor operation. I thought, if it’s so you-beaut, why’ve I got all this pain?”

There was a general expectation of some level of nursing assistance in dealing with their discomfort. Informants expected to have adequate pain relief and that nurse’s attitudes would be generally helpful, caring and supportive: “You expect a little bit of support and a little bit of understanding”. A typical nurse was one who “... would always be concerned about the people they were caring for, and do anything for you without making you feel it was a bother.” Informants expected that nurses would interact with patients in a friendly way and would give nursing care that was different “... not just following the book at the end of the bed, but treating the person, not the numbers.”
While one respondent thought nurses were responsible for "pain relief, monitoring blood pressure and statistics" many expected, as well as pain relief, something more:

You expect a little bit of support. It goes a long way to getting you back on the normal road, but if you're not treated very tenderly in that first couple of days, it could probably put you back a bit. ...//...The nurse is there all the time and it's a big responsibility to make sure that you are comfortable. (Informant R4.)

One informant recalled just such an episode. The night shift sister had recommended a "wind cocktail" and promptly returned with some hot peppermint water. She had made a nursing decision, he said, and he held her in higher esteem than some others. He could distinguish between nursing care and medical orders. He said that he expected more nursing care to be given, "I expected them to say, I can fix that for you - that sort of thing. Let me just do this for you, or, I'll put this cloth on your head. Yeah, that sort of comfort care." He said he experienced this level of nursing care on two occasions during his seven days in hospital.

6. 2. 2. 7. Expectations about asking for help

Most informants expected that adequate care would be provided without having to ask. Informants wanted to be as independent as possible, as soon as possible, and to cooperate with the staff, by following their advice to ambulate and to do as much as they could for themselves. Several informants asserted, "You've got to help yourself. You've got to get up and walk, you've got to get yourself better."

One informant expected the nurses to use -

common sense, just common sense, you know, the first day after operation, to come in and ask are you comfortable, have you got your lunch, are you OK? (Informant P5.)
They expected the nurses to know what to do. While some informants assumed that if something was *not* done then it was not part of the usual care, others asked for help when necessary. This informant had had a bone graft from left hip to left humerus:

> *I had to ask for a grip above the bed to help me pull myself up. They put everything on my left side, my food tray, the telephone, my locker, but I could only move my right arm. Everything else hurt.* (Informant P5.)

6. 2. 2. 8. Expectations about information

Few respondents expected the nurse to provide information. This was seen as the doctors' role. The doctor was expectantly perceived as the authoritative professional, possessing information, directing staff and generally above criticism. A male informant noted:

> *I'm taking up a bed waiting to see one doctor, days now, when I want to be home. He's the guy I have to talk to about my disease. He's the specialist, and so I can't really expect him to come and see me when it suits me.* (Informant P3.)

There were exceptions to this view of the doctor as the ultimate authority, and beyond reproach. One informant felt that she should have been prepared for bright vaginal bleeding a day or so after she went home after hysterectomy, and felt that she would raise this with her surgeon at the next visit.

Reflecting on his time in intensive care, one informant noted, "*I think the nurses know a lot more, a lot of the time, than what the doctor does.*" Nurses were sometimes expected by informants to know more about their individual needs than the doctors did. One informant related how the nurse, concerned about his condition, had called the doctor to see him.
I'd never met that doctor before, and I didn't know whether he was good or bad. I didn't sort of trust what he was saying. He was a stranger, he had no part in the whole thing beforehand. But the sister stayed with me, which was good, because he would say something, and I remember looking at her to say, is that right, is that wrong, sort of waiting for her to confirm what the doctor had said. She's here, she's the stable person in the situation, he's just lobbed in. (Informant R12.)

6. 2. 2. 9. Expectations about the patient role

Informants had common expectations about their role as patients in hospital, which was basically, to cooperate with staff: "The way I look at it, they're the experts, they know what they're doing, that's their job." Seeing the patient role as a transient but unavoidable necessity, they each attempted to fit into the system with as little fuss as possible, by co-operating with doctors and nurses -

I wanted something to drink more than anything else. He said, don't drink. I said, you're the boss, I don't want to go through any of this again. (Informant R7)

- and by making as few demands as possible on busy staff, for example, by not ringing the bell for help unless in real necessity.

In summary, then, individuals coming from an Australian social and work culture into a sub-culture of hospital, medical and nursing activities, had broad expectations of being able to trust the health care system to provide adequate care and comfort. They made a transition to the patient role and began to interact with hospital staff and to gain first-hand experience of the hospital, medical and nursing way of getting things done. In doing so, they retained many of their expectations but on a moment to moment level, these were fine-tuned by experience so that the label 'anticipation' more truly reflects the cognitive process they described.
Informants perceived and interpreted aspects of care and treatment as either comforting, or as uncomfortable. Global processes of managing discomfort and of finding comfort began on admission and continued until discharge, reflecting a complex interplay of self-talk and self-care. Through this interplay, in the context of becoming, being, and ceasing to be a hospital patient, the meaning of events and interactions was constructed, understood and acted upon.

6. 3. Global Processes Explained

The core processes of finding comfort and of managing discomfort were mediated through sub-processes of self-talk and self-care, and are diagrammed on the following page to indicate the dynamic, recursive nature of their interplay. Each sub-process and its constituent element, through which informants both managed discomfort and found a measure of comfort, is then separately described.
Self-talk was the collective label I gave to numerous recounted instances of interactions with the (Meadian) Self, characterised as an internal dialogue or commentary about perceptions and experience. Dialogue with self was evident when informants explained their thought processes in terms of “I thought ... // ... I expected” or as more definite statements of opinion. The basic social interactional process of self-talk has a number of sub-processes which are generated in response to perceived attitudes or situations. Sub-processes of self-talk were tagged as anticipating, interpreting, accepting, making allowances, and maintaining perspective.
6.3.1.1. SELF-TALK - Anticipating

For the purposes of this study, anticipating was characterised as a set of ideas about what a future experience will be like, formed through personal or vicarious experience. In the context of this study, informants anticipated, for example, what the next encounter with a particular nurse might be like, or anticipated that they would have to rely on themselves more. They then anticipated, in a sense, what options they might have in achieving self-reliance. This took the form of an internal dialogue, self-talk. As already outlined, informants in this study went into hospital expecting a variety of discomforts, but also expecting that they would be looked after by hospital staff, especially by doctors and nurses, in a competent and caring way. They had a set of common sense understandings about what hospitalisation would be like, how to behave, what to expect: "Oh, yeah. As I said, I've been in there quite a few times", and "You see it on the telly." Informants took for granted that nurses would be busy, but never too busy to meet important needs.

With each event or encounter with staff a new set of anticipations, or predictions of others' behaviours or of possible strategies would be formulated, depending on three possible outcomes of expectations (that is, unmet, partially met or met to the informant's satisfaction). As illustrated in the following passages, informants had some of their expectations for comfort met, but not others.

Informants expected and got good, sometimes extraordinarily good, attention in the immediate post-operative period, "I was sick a few times and someone was there to help me." The nurses were in and out frequently to check on patients, "... going out of their way to see you were OK...", providing pain relief and comfort measures, often promptly, and sometimes without having to be asked.
Sometimes, being asked if one had pain was both comforting and uncomfortable. As one informant remarked, “They just said, are you in pain? If I said, yes, I got a needle. If I said, not really, the attitude was, well call us when you have pain.” The only choices offered were to get a needle or to have the nurses go away. This informant had expected comforting nursing care which included pain relief. He quickly recognized that this would not occur, and anticipated that subsequent request for pain relief would be dealt with in a similar fashion.

Another informant commented that patients needed someone to recognise that the pain was awful, “I think the pain’s a lot easier to bear when there’s someone actually there, handling it with you.” The needles were “... great, they took the pain away,” but informants wanted nurses to recognise that other care was needed. “I didn’t just want the relief, I wanted someone to recognise that I had the pain, too.” They wanted to be re-positioned, or for the nurse to use other physical and non-physical comfort measures:

... like, the doctor operates, but the nurses have got to do the healing part, besides yourself, you know, rubbing your back and making you feel comfortable. (Informant R5.)

For this informant, as for others on occasion, nursing comfort measures and a comforting presence contributed to healing. With respect to having their discomfort eased, their expectations had been met.

When expected comforting from nursing staff did not eventuate, informants anticipated that this would be the pattern of care in future. For example, they began to anticipate that nurses might disbelieve them (Informant P3) or would feel more comfortable joking with him than getting close to his existential concerns (Informant P4), or would not use common sense or make other than routine visits unless she were having an arrest (Informant P5).
After asking that something be done to improve the food, Informant R4 anticipated that the nurses would probably brush off expressions of dissatisfactions about it. From her own and a neighbouring patient’s experiences, she anticipated that nurses would not provide comfort and not understand her need for support in the first few days post-operatively. Informant R5’s experience after transfer to a less acute ward, of not being able to get a couple of painkillers, led her to anticipate that the situation would continue, and to be surprised, and to re-formulate anticipations, when her request was granted. Informant R6 anticipated that when some nurses were on duty, he could relax; but with others he would feel tense and not quite comfortable.

Anticipating is closely linked with ‘interpreting’.

6. 3. 1. 2. SELF-TALK - Interpreting

In the context of this study, interpreting was the outcome of observing, experiencing and assigning meaning to the language and behaviours of self and others - of discerning the meaning of interactions and situations. Interpreting is the way a person takes in, analyses and makes sense of what is going on. It may involve ‘taking the role of the other’. It allows the person to consider in an anticipatory way, options for action by self and others, to weigh up possible consequences and to decide how best to respond in a given interaction or situation. Informants experienced or observed the actions and interactions of others within the hospital setting, interpreted their meanings and constructed responses in the light of prior experience and present understanding, all through commentary and and continuous dialogue with the self, or ‘self-talk’.

Each event or interaction which constituted hospital experiences was both common and unique. It was common in the sense of being ordinary in the hospital context and likely to have occurred with other patients, but unique (in the
way that all personal experience is unique) in that each situation/interaction can never have happened before, in just that way, with those participants. Therefore, each situation/interaction required a fresh interpretation and definition. To the adult, the benchmark for interpreting and defining situations and interactions was reasonableness: reasonableness, and a set of expectations which had been revised in the light of actual experience to function as ‘anticipation’.

Continuing to explore the data in relation to the post-acute period of hospitalisation, I found that informants perceived that nursing attention soon fell away.

_Once they know you’re recovering, that you’re not screaming in pain, you realise they’re not going to make any extra effort to come in and check you, unless it was time to check your temperature or blood pressure ... // ... that stuck in my mind, that first couple of days, I suppose because they’re crucial ... its sort of like a chain reaction._ (Informant P5.)

Informants were encouraged to care for themselves with minimal assistance and were left to their own devices -

_... once they knew you had been got up a couple of times. I went through a couple of days when I thought, how am I going to last out, because I was just so uncomfortable. I needed a little bit more assistance to be comfortable. Any movement hurt, nothing was quite right._ (Informant R4.)

After trauma or surgery informants experienced headache, neckache, intense muscular chest and back pains, but sometimes "... you couldn’t get assistance to put the back of your bed up.” In this same vein, another informant noted that in the first couple of days after what had been called minor abdominal surgery, he was unable to bend or to move himself up in the bed, or change position. His feet were constantly touching the footboard and cramping. He felt there was never anyone around,
... to give you any help to get yourself up in the bed ... unless you called them, or specifically asked them. They didn’t just pop in just to say how are you. There was none of that contact, for the opportunity to say, well, whilst you’re here, could you just help me up the bed a little bit. The whole week I was there, no one ever asked me if I was uncomfortable or needed any help. They only asked about pain or bowels ... there was the end of the shift and the start of the shift - how do you feel today? Nobody ever asked me how I felt, on my own. (Informant R12.)

Informants interpreted friendly, attentive nurses as being caring and ‘good’. Friendly nurses popped in and out, asked how you were, talked with you while they worked, joked, were relaxed, shared a little bit of information about themselves. Informants interpreted nurse behaviours by watching their interactions with other patients and anticipating how that nurse might behave towards themselves, via self-talk. Instances where a nurse had commented on an informant’s progress meant that someone had actually noticed, seen the informants as an individual, had taken an interest: “That meant a lot.”

6. 3. 1. 3. SELF-TALK - Accepting

Accepting, in the context of this study, is the term given to the cognitive and emotional stance achieved in recognising, acknowledging the meaning and conceding to the reality of a situation. After each interaction or event, they reformulated a fresh ‘definition of the situation’. Adult informants in this study had a general expectation that discomfort and inconvenience were the inevitable lot of the patient. The multiplicity of conditions which informants additionally managed or were obliged to accept are noted in the following paragraphs.

   Hello and goodbye

Informants recalled that doctors visited briefly, interacted in a business-like way and moved on. While this had been a general expectation, having timely and authoritative information was reassuring and helped locate informants on some
sort of treatment and recovery continuum. Brevity of encounters with caregivers was a source of dissatisfaction only when informants felt they had been dismissed with little explanation, information or review of their situation. Brief encounters could also be friendly, cheerful, ‘popping-in-to-see-how-you-were’ assessment visits which had both clinical and social functions.

Several informants noted the difference between the formality of admission procedures and the almost casual nature of their discharge. Some informants, advised that they could go home, packed up and left without satisfactory social closure, practical information or assistance. In the words of one informant,

... this doctor whom I had never seen before said I was well enough to go home. I didn’t know I was well. I felt dreadful. I could barely stand for five minutes without feeling giddy, and I was aching all over. (Informant R6.)

Informant R6 asked a nurse to telephone his family to come and collect him. “She said, oh, you’re going. She phoned, and that was it. I packed up and left.” Informants accepted, but did not like, being visited or discharged by doctors in peremptory or casual fashion. Informants who were told they could go home did not always seek, or did not know to seek, discharge information. They simply vacated their wards. ‘Self-talk - accepting’ was reflected in comments such as, “I guess this is the way it is!”

Routine care

While it was recognised that some nurses were attentive and were considered “excellent”, the reality was that other nurses did not visit very often, or they expected patients to ring for help only when necessary. One informant summed up a general feeling of several informants about nurses. He said that every time he went for a walk, the nurses were clustered around the nurses’ station. In his opinion, patients needed to see nurses more frequently, that nurses need to be
more visible and that it would be a good idea if they did more of their routine
tasks where patients could see them. He did not want to bother them but would
feel reassured to know that they were close by. Informant R4, on transfer to a
surgical ward prior to chest surgery, had written in her diary,

*I don’t feel very happy. I have been moved into a single room and it’s
quite lonely. The nurses are so busy and no one comes near, only to
take temps and blood pressure and hand out pills.*

She later wrote,

*Nurses are so busy, they never seem to have the time of day for you
other than to do the necessary requirements. You feel so ill, a day or
so after operation, but there is no one other than the other patients to
give comfort or a cheery word.* (Informant R4.)

While informants recognised that nurses were very busy, some perceived nurses
as clustering around the nurses’ desk, and appeared (to informants) to believe that
patients would require little nursing help beyond the first hours or days of
hospitalisation. Informants responded to these experiences by accepting and
anticipating routinised care as a fact of life in hospital. However, when nurses
acted only according to routines, it was difficult to perceive them as caring.
Routines were acceptable, routinised care was not. Nurses came in either to
record observations, give medications, check on infusions, or at change of shift.
Informants anticipated, interpreted and accepted that nurses would be in to do
essential tasks, every few hours, and it meant accepting that if you needed
anything in particular, it was up to you to ask - but don’t ask at change of shift.

*I noticed that at change of shift times in hospital, the level of care
drops off - like, if you’re going to spike a temperature, don’t do it at
half past ten, do it at midnight, you’ll get more care. Don’t ask for
pain relief at half-past ten - you won’t get it until much later.*
(Informant R3.)

Similarly, another informant in a different hospital, who was otherwise very
supportive of the nurses and pleased with her care, was surprised at the abrupt
response of the nurse from whom she had requested a sedative and disappointed by having to wait an hour and a half before it was provided. She later recognised that this had been just prior to the evening change of shift. Informants learned to accept that ten-thirty at night was a bad time to request anything - sleeping, pills, analgesia, re-positioning, assistance to get to the toilet urgently - or even to try to get to sleep, because of the noise of the nursing shift changeover.

Hospital routines sometimes meant that if you asked for analgesia and it was not written up, the nurses would have to ring for a doctor, or wait for one to come to the ward and prescribe it. If this occurred at night, the doctor might not be contacted. Informants in this study accepted through their self-talk the need to be as independent as possible, as soon as possible. Some found that not only was this desirable but also necessary, if they were to become comfortable at all.

_You have got to get yourself comfortable. But lots of the other patients wouldn't do that. I don't think they realise that when they go into hospital, it's their responsibility. They would call the nurse and say, 'I'm uncomfortable, can you help me?' But how does the nurse know how to make you comfortable?_ (Informant R4.)

Not only did informants accept the need for independence as a reasonable development in their recovery, but also that they had to get better as quickly as possible - "I knew I had to get well myself. I knew I had to rehabilitate, and that's why I was walking several times a day, because I was determined to get better." Most informants used walking as a way to distract from and alleviate pain. But walking apparently signalled patient independence and could have been interpreted as a low level of need for nursing care. Informants accepted that there would be pain and discomfort and sometimes felt irritated by superfluous comments such as, "Yes, well, you've got to expect pain from an operation and what you've had done" as one informant recalled when requesting analgesia. Individual differences in staff and staff attitudes were recognised and accepted.

"Sometimes you get a good one ... // ... this nurse used to come and offer back
rubs ... // ... others are too busy to take more than a couple of seconds to make
you comfortable.” That there were ‘different nurses, different temperaments’ was
also accepted:

_There was one particular nurse who didn’t talk much. She was good
at her work, she was a nice person, but when she didn’t talk to you,
you didn’t relax, you didn’t have the opening to say anything to her
about how you felt._ (Informant R4.)

**The ‘expert’ nurse**

Differences not only in temperament but in in expertise were recognised and
accepted. An informant, referring to his high-dependency experience said:

_You could notice the difference in her shift every time she walked in
that door. I said to her, no messing about when you’re on. Several
others looked after me, they got their work done, but her particular
shift, you were confident that she was right on the ball, and that was
comforting._ (Informant R7.)

Asking questions of nurses brought standard responses of “that’s normal” or
“you’d better ask the doctor”, but some nurses were good at giving information
and this would spread by word of mouth among patients.

6. 3. 1. 4. SELF-TALK - Making allowances

Informants came to recognise and accept shortcomings in a given situation
through taking the role of the other, seeing things from the perspective of the
other, findings reasons, excuses or justification for the actions of the other or of
the workings of the system, explaining to the self why such and such may have
happened. I identified this as a self-comforting self-talk strategy, ‘making
allowances’, which assisted the individual to better tolerate uncomfortable or
aggravating circumstances.
Informants made allowances when the food was unpalatable, or unsuitable for throats swollen and sore after endotracheal intubation. Examples of self talk: "Perhaps the nurses have tried to get it improved, and haven’t been able to." When food service personnel put food trays at a distance from early post-operative patients and refused to move them closer or lift up the bed-table, "Well, it kind of shocked me a little, but I suppose that’s not their job." When nurses did not visit often, "I suppose this is the week-end and there’s a skeleton staff on; they might have had an emergency." When nurses delayed analgesia or discounted informants’ pain, "I suppose they thought, oh well, she’s walking around, she’s alright”. When there was insufficient information, "Maybe they assumed that I knew a lot. You don’t know what questions to ask, but they did say, anything you want to know, just ask.”

Informants made allowances for environmental disturbances, although it was difficult, as one informant put it, to see why drainage bags had to be emptied every night just after one had gotten to sleep. They tried to make allowances for the noise of new admissions, wandering and confused and noisy patients, and shift change-overs. They sympathised with distressed other patients who kept them awake. They made allowances for inconveniences such as delays in obtaining care, or staff or other patients who were noisy or disturbing.

6.3.1.5. SELF-TALK - Maintaining perspective

Maintaining perspective was the label I applied to a self-comforting self-talk strategy for regaining equilibrium of upset feelings of either intrinsic or extrinsic cause, by moving from a focus on particulars to a more global view of things, as a way of keeping a sense of proportion.

Informants comforted themselves with the knowledge that even if they visited infrequently, nurses would always be there in an emergency, by making
comparisons with the plight of others, "... which makes you realise your own condition isn't that bad", by being philosophical about hospital routines: "Well, sometimes things work in your favour, sometimes they don't, there are always pros and cons", and "... you realise that you have to be there, so you just put up with it as best you can", as well as by trying to understand a nurse's refusal to help a patient get more comfortable three days after open heart surgery,

... but I could see this nurse's point, up to a point. She said, if we do everything for you, you won't want to do anything for yourself. I think that she was inferring that we had to move, had to help ourselves - but it just didn't come across right. (Informant R4.)

Informants used humour and seeing the funny side of things to maintain or regain perspective. An informant who had been kept awake for hours one night by a nurse coaching another for a midwifery examination, vowed he would be now quite expert at delivering babies. When he was kept waiting for hours, he was amused when he found out that it was because staff who did not know him, arranged for an interpreter, because his Australian name had been inferred to be Asian.

There were many instances of comfort and comforting by informants themselves, by other patients, and by various categories of staff, which will be described further in the next chapter. Pleasant attitudes and helpfulness of staff, interpreted by informants as caring behaviour, assisted in restoring and maintaining perspective.

6.3.2. Self-care

To restate an earlier definition, self-care is a collective term describing the activities engaged in by informants in meeting the various situational demands of their patient role. Self-care had several aspects which are outlined below.
6. 3. 2. 1. SELF-CARE - Self-help

Self-help, in the context of this study, summarises the ability and intention to attend to one’s own physical and other needs to the greatest extent possible in the situation, before relying on others. All informants engaged in self-help at some time during their hospital stay. Informants in this study were mature, independent adults who accepted that nurses were busy. Self-care was their preferred mode of functioning. They were reluctant, even embarrassed, to ask for help unless it was really necessary. For various reasons related to responsibilities of other life roles, getting better as quickly as possible was imperative. Informants took responsibility for their own care as early as possible in the recovery period. They initiated or attempted self-help usually before requesting assistance and complied with staff instructions intended to speed their recovery wherever possible, through getting out of bed and walking as often as they could, by resting when tired, by reading or talking to others, “... and basically following the advice that you were given.” One informant noted that as a self-comforting strategy, she drew the curtain when things got too much for her, and

... got the tears out, ‘cos your curtain was drawn and so you felt you had privacy ... I used to fight it by getting up, once I felt better. You’re not going to sit there and cry for long, you’re going to walk around and get yourself better. (Informant R2.)

Another informant said,

I think you’ve got to help yourself, in a way, after a few days, if you can walk, you’ve got to get up and walk, and not have people running around like slaves after you. (Informant P3.)

A third informant used deep breathing and “thinking about different things, trying to shut my mind off.” Another informant, when transferred from a high dependency unit said “… I looked after myself, cos nobody ever offered anything. I mean, I could have asked them to do it, but I didn’t. I did it myself. You’ve got to do it yourself.” Elsewhere, other informants were self-helping out of necessity.
We were basically, you know, watching out for each other. A couple of the nurses had been sent to Casualty, and the ones left were busy with a dementia patient. A lot of the time we were seeing to ourselves, because the nurses were busy. (Informant P2.)

6.3.2.2. SELF-CARE - Asking for help

Asking for help in this analysis is a deliberate choice to seek assistance from others when it is considered appropriate to do so in the context of physical needs, and of staff or others (visitors, other patients) physically available and interpersonally suitable to help. Self-help is maintained but assistance from others supplements informants’ own efforts.

'Asking for help was easy when the nurse convinced informants that they were available to help them. Nurses did this by introducing themselves, moving closer, looking at you and seeing you as a person, coming and going in such a way that meant they were "... keeping an eye on you ... having a nice attitude, having a joke with you, mucking around, saying, 'it's no bother'."' Nurses who conveyed clearly that helping patients was no trouble were reassuring and confirmed the genuine interest of the nurse in the patients. Feeling "grotty" not long after her emergency admission and transfer to a ward, a woman informant mentioned to a nurse about not being able to shave her legs. The nurse immediately attended to this while conveying that it was no trouble at all.

Few informants actually asked for help by ringing the buzzer, and only when bedfast and acutely physically dependent, or when they simply couldn’t manage to untangle tubes or move about in the bed. Informants did not want to bother busy nurses. They found that buzzers were a general irritant for nurses and avoided using them. They used less direct methods such as waiting for the nurse to come in on a routine visit, or getting out of bed and looking for a nurse, or not asking at all.
Not asking for help

Apart from this, informants were reluctant to ring for help because they did not want to bother the nurses, or because they were apprehensive about the nurse’s possible reaction:

You don’t like to worry the nurses - you know they’re short staffed and that other people are really ill - and then there’s that thing where you don’t like to make a fuss, or ask other people to ‘do’ for you. (Informant R3.)

For one reason or another, informants were reluctant to use the nurse call-bell. Fear of actually ringing for help was expressed. One informant in his I-Me interaction, imaginatively took the ‘role of the other’ as he reflected on this feeling.

I felt like I’d get in trouble: if I press this buzzer, they’re going to yell at me. I didn’t want to be treated like, ‘O God, he’s buzzed again!’ And I think to myself, if I push this buzzer, someone’s going to think I’m a whinger. (Informant R12.)

Another informant revealed that because of her early post-operative experience of not being helped she -

... would rather have sat there in pain than to actually push the button and say, Sister, am I due for pain relief now, or can you come and fix this or that for me. If someone had walked in and said, gee you look like you’re in a bit of pain, then I would ask for something for pain. (Informant P5.)

When asked how they felt about ringing the buzzer, other informants said they had felt reluctant to call a nurse either based on their experience or from remembering old movies depicting bossy, no-nonsense nurses.

Patients helped each other in numerous small ways, such as suggesting to another patient to guard abdominal muscles while coughing, and getting the nurse for someone who didn’t want to ring the buzzer. It was clear to me as an experienced
nurse that one informant's advice to a fellow patient had forestalled worsening
digoxin toxicity. This informant noted over a couple of days that her fellow post-
cardiac surgery patient had vomited each time she had been given a tablet, then
was given an injection, and felt better until the next tablet. Both were "starving",
finding hospital food unpalatable (and were probably hypokalaemic) from the
effects of taste alteration and sore throats post-operatively.

* I'd mentioned to the lady opposite that she should tell the nurses that
  she was being sick so they could monitor her a bit better, so she told
  them and they sort of asked her questions. She told them how she'd
  been sick, and they finally said, we'll take you off the digoxin.
  (Informant R4.)

Asking for help from nurses was sometimes problematic. "You sized up the nurse
and decided whether you could ask." (R: How did you decide?) This informant
said she thought it was "something in the tone of voice, the eye contact, body
language" which said, 'too busy' or 'not interested'. She said, "There were some
nurses you just knew you wouldn't ask to do anything for you." Sometimes, this
informant -

...got the feeling that you shouldn't be asking, shouldn't be a bother—
that it's not the job for the nurses to do. They haven't got the time for
trivial - what they seem to think is trivial, so you don't bother asking
... / ... something to do with the nurse's attitude when she comes in,
and you think, oh, perhaps I shouldn't have asked for that - but it isn't
trivial, is it? (Informant R4.)

Referring to her diary during the interview, she noted that there seemed to be a
code, a "Hi, everybody!" code. If the nurse greeted patients from the door with
"Hi, everybody!", did not introduce herself or speak with patients individually,
this was understood by some informants to mean, "Don't bother me; this is just a
job."

Another said,

* There was distance maintained, like a royal visit. They came in a
team, nurses and doctors, stood at the bottom of the bed, looked at
the notes, moved on. (Informant R6.)
No informants mentioned requesting help or information directly from doctors. There was an expectation that doctors would provide any necessary explanation or information. Some informants did not know what to ask about their condition, or when it was appropriate to ask.

6. 3. 2. 3. SELF-CARE - Accommodating

Accommodating in this study refers to the cognitive, affective and psychomotor behaviours involved in adapting to a situation, to persons or their behaviours (verbal and non-verbal) as they are encountered, interpreted and defined. It is a way of harmonising expectations with reality, a way of resolving cognitive dissonance, of re-defining a situation, of accepting one’s perceptions of the status quo, both positive and negative, and of moving on to selecting appropriate strategies. Those options, or modes of accommodating, included deferring, avoiding, persisting and desisting.

**SELF-CARE - Accommodating - deferring**

In this option, one’s needs for assistance could sometimes be deferred by waiting until the staff were less busy. Informants waited, continuing their own self-care, considering the nurses, understanding how busy they were, not calling by buzzing, but waiting until they popped their heads in the door or walked by; working out that a change of shift was due, or that the nurse would be coming in soon; taking the role of the other in imagination and making a plan of deferred action.

*A couple of times if was near the end of that person’s shift, I'd wait until the shift was finished and then saw the next person who was on.*

(Informant P3.)
SELF-CARE - Accommodating - avoiding

Avoiding was a decision not to ask for help, because of a strong need to be independent, or because of an impression that staff would be either unable or unwilling to help, or disinterested in helping.

It was uncomfortable asking for help from someone you have had a negative experience with, someone who has scolded you for ringing the bell, or has shown exasperation at being asked for a bed-pan, or who has said, "... you can't have that much pain, you're day four." Informants chose where possible to avoid asking for help from such individuals. They chose not to ask for help from caregivers who had shown indifference, such as when two nurses made the beds of patients in a six-bed ward without speaking to or looking at any of them; or when a nurse had laughed and said, "... don't worry about it!" when an informant reported his hallucinations while having a nebulised bronchodilator. They waited, sometimes, until a new shift of nurses came on, with the possibility of friendlier faces, to ask for pain killers or for other help.

SELF-CARE - Accommodating - persisting

Informants persisted in seeking help (from staff or others) when physical needs such as pain, nausea, or difficulties with equipment or drugs became overwhelming. The selected mode of accommodating was often the outcome of a learning process. Persisting with a request in the face of perceived busy nurses, for help which might be regarded by them as trivial, and risking being chastised for asking, called for considerable effort from informants. Some did persist. One informant, after transfer to a ward where she felt that the nurses did not understand her condition, found it difficult to obtain any analgesia. In this informant's medical records, her doctor had written, "Patient well" and had discharged her from a high-dependency ward. No-one had changed the
medication order from parenteral to oral, and repeated requests for this to be done seemed to fall on deaf ears. Because the pain and discomfort did not abate, she persisted in asking for tablets from any new nurse she met. She said -

This nurse came back from her days off, and she was lovely. She used to talk to me. I said, maybe I can get a Panadol out of you. She seemed quite surprised that they hadn't given me anything, and she went and called the doctor. (Informant R5.)

SELF-CARE - Accommodating - desisting

Informants ceased to request assistance when they no longer needed it, when they had been requested not to seek further assistance, or when they considered that the quality of help needed would not be available.

One informant recalled that early post-operatively, she experienced pain with even slight movement and was unable to reach meal trays, tissues, water jug.

This happened for almost two days, and I'd say, please can you - but they'd be gone, and I'd have to buzz. Sometimes when you buzzed, they wouldn't come for ages. Some were annoyed - it was, what do you want, I'm busy, what's wrong, why did you buzz twice, I thought you were having a heart attack. Other nurses were great, you know, but I didn't ever buzz for anything after that - I would get up and go and find someone and ask if I needed anything. (Informant P5.)

Some informants ceased to ask nurses for assistance with their care, and simply wished for the day they could go home. Two other informants reported being rebuked, and others witnessed fellow-patients being rebuked, for ringing the bell or buzzer for assistance, and subsequently refrained from doing so.

6. 4. Summary Of Analytical Findings.

Expectations and anticipation played a significant part in shaping informant interpretation of the in-patient experience of comfort and discomfort. In this study, informants actively managed their discomfort and found a measure of
comfort, through processes of self-talk and self-care, mediated through an interpretive inner dialogue. They engaged in a process of monitoring their own comfort and of working to reduce discomfort, directing their sometimes limited energies to self-help and self-comforting. They were always in self-care mode.

Social and psycho-emotional comfort and discomfort held a dominant place in the recollections of all informants. Comfort was in part, social: nurses making you feel that you were somehow part of the ward, that you belonged. Informants talked about “my ward ... // ... my nurses.” Informants labelled nurses as as ‘expert’ when their attitudes and behaviours were perceived as both caring and competent.

A major finding of this study was that comfort and discomfort often co-existed, that is, were not mutually exclusive. A person could have intense, distressing physical discomfort, but be comforted by caring staff attitudes, or by nurses or others lightening the atmosphere with friendly humour or support. “For every discomfort, there was a nurse there to comfort you.” In the words of one informant, who had endured intense pain and whose discomfort persisted for some time after discharge, “... I remember the joking and the friendliness long after any injections for pain.” Informants gratefully accepted any type of comfort being offered:

She said I wasn’t due for painkillers. She came back with a cup of her own special tea. It didn’t help with the pain, but it was comforting. (Informant R6.)

Similarly, a ‘dialectic of discomfort’ was identified. Coincident with being relatively physically comfortable, individuals could feel miserable because of the nature and implications of their condition. Informants described abrupt, disinterested, non-comforting interactions with staff which left with a sense of searing disappointment or frustration, even if physically comfortable.
Several distinct themes which surfaced and persisted in the data included vulnerability, nurse-patient interaction and bonding, routine assessment, transition and the imposition of self-care without negotiation. Informants in this study, keen to participate in their own rehabilitation and to regain their autonomy experienced an accelerated transition from dependence to independence, from a high level of care to non-negotiated, unexplained minimal care, which often culminated in abrupt discharge from hospital. These themes will be taken up in the following chapter.

This chapter has provided an overview of analytical findings from the study including the grounded theory of finding comfort and managing discomfort, has outlined the expectations and described some of the interactions which shaped the meanings of perceptions and experiences. It presented slices of interview data from which the substantive theory was derived. It is followed in the next chapter by a further exploration of the management of discomfort by informants and of the ways in which they found comfort.
CHAPTER SEVEN
Making Connections: Experiences of Finding Comfort and Managing Discomfort

This chapter describes and further explains the way respondents in this study managed their discomfort and found comfort using basic psychological and social processes of self-talk and self-care. It expands on several themes which are significant in the in-hospital convalescent experience of patients with medical-surgical conditions.

It became clear that discomfort and comfort often co-existed in a dialectic, in the Hegelian sense (Collinson, 1987; Osborne, 1992) of contradiction and reconciliation of contradiction; of thesis, antithesis and synthesis. The dialectic was worked through by informants using integrated processes of self-talk and self-care. These processes were non-linear in the sense that any meaning derived from interactions with staff could be de-constructed and re-constructed with each fresh experience, thereby demonstrating the dynamic, integrative and recursive characteristics of the processes.

During hospitalisation informants experienced physical discomfort as well as some alleviation of this through physical comfort measures. However, in the main, comfort was experienced as psycho-emotional and social comfort. This was associated with a sense of being adequately looked after by friendly, caring and expert staff, and with the support and companionship of family, friends, and sometimes, of other patients. Of particular importance in finding comfort and in managing discomfort were perceptions of staff as both caring and expert, and the degree to which expectations of care and the experience of care were congruent.

No informant was free of discomfort and only one informant, a short-stay patient with excellent pain management, reported minimal discomfort. All other
informants experienced multiple discomforts with a wide range of intensity and duration, and some degree of concomitant personal distress. Discomfort was experienced as both anticipated and unanticipated physical, psycho-emotional, social and environmental stimuli which were unpleasant. Discomfort was associated with vulnerability and with the unexpected. It was found in impersonal routines and routinised communication, and was managed in the main through self-talk and self-care.

This chapter begins with a description of the verification of core processes in relation to analytical criteria developed by Strauss (1987) and Strauss and Corbin (1990). Following on from this, a number of respondents' experiences of managing discomfort and finding comfort are presented to illustrate the range and variation in perceptions of comfort and discomfort. In the final section of the chapter, I present a synthesis of persisting themes in the data, which provide insight into sources of comfort and discomfort in this patient care context. The reader will note a change of presentation style, with less reliance placed on the actual words of informants.

7. 1. Making Connections: Procedures For Examining Core Categories And Processes

In order to make - and demonstrate - connections between categories, Strauss and Corbin (1990) suggest a coding paradigm, referred to as axial coding, whose parameters include events or conditions (causal) which lead to the occurrence or development of phenomena, the context in which phenomena occur, constraining or facilitating conditions in the context, as well as strategies developed to manage or respond to phenomena.

Axial coding is a matrix of inductive and deductive manoeuvres within, around and between segments of data which can be employed in addition to, or instead
of, logical diagrams and analytical memoing. While I found all of these recommended approaches useful in attempting to clarify connections between a sometimes overwhelming amount of data, they were understood as guidelines only. I used axial coding more as a verification procedure for meanings I had already constructed, through theoretical memoing and diagramming of the processes I had detected in the data.

As part of procedural rigour and somewhat retrospectively therefore, the core categories of comfort and discomfort were examined using a mini-framework of phases suggested by Strauss and Corbin (1990) as part of an axial coding paradigm. Phase 1 encompasses the phenomenon being analysed, its specific properties and any strategy/ies for management. Phase 2 focuses on recurrences of the phenomenon, again with strategy/ies for management. Both phenomena are dealt with in this way in the sections below. However, because discomfort has not been well described in the literature, more descriptive data are presented to better illustrate the phenomenon.

7. 2. Comfort: A Core Category

Comfort is one of two core categories central to this study.

7. 2. 1. Phase 1: phenomenon, specific properties, strategy/ies for management

Comfort is a comprehensive term denoting a sense of well-being in a number of dimensions of experience: psychological, emotional, physical, social, environmental, spiritual.

Comfort is a high order category, subsuming a number of substantive codes found in the data, such as attention, humour, vigilance, support, information, expert
nurses, nurses getting to know you, busy nurses (but not too busy), and different kinds of physical comfort, which later clustered into broad dimensions of experiences of comfort.

7. 2. 1. 1. Comfort as experienced by informants

Comfort was psycho-emotional, characterised by an underlying sense of safety (even in pain, worry, illness or trauma), enhanced by adequate information which supported coping and which took account not only of how much information was wanted and needed, but when it was most needed.

Comfort was interactional and relational. Informants found comfort in interactions with friendly and competent staff whom they could trust, in the knowledge that many of their expectations about the skilled, compassionate care they would receive were being met. They found comfort with visitors and in sharing experiences, diversions and humour with other patients. Comfort was a sense of belonging somewhere, getting to know and be known, feeling accepted by staff, even for a shift, but sometimes for a little as a single but authentic and meaningful encounter.

Comfort was occasionally environmental, with informants sharing glimpses of the respite which came from peaceful and aesthetic surroundings, such as a room with an elegant print on the wall, a window with a view, or having access to a solarium filled with plants.

Comfort was physical: analgesia, back rubs, pillow-fixing, re-positioning; mouth care, showers, shaves and shampoos; being able to move about and to walk and rest to your own tolerance. Physical comfort came through skilled nursing care and, importantly, through informants’ own efforts.
Spiritual comforting was experienced through pastoral care visitation by priests and chaplains, and in the sense of an uplifting of the spirit when staff were extraordinarily and memorably considerate. There were instances when nurses used sensitivity and tact to minimise moments of acute embarrassment for patients. These and other instances of comforting were perceived by informants as somehow having an ‘extra’ dimension and as transcending ordinary expectations.

Comfort was ultimately, self-comforting, as informants interpreted the language (verbal and behavioural) of caregivers, constructed comforting meanings and chose responses appropriate to those meanings.

7. 2. 1. 2. Dimensions and ranges of comfort

Comfort as a sense of well-being may be experienced in one or more dimensions simultaneously such as having a feeling of physical, environmental, spiritual, psycho-emotional and social well-being. Comfort in one dimension of experience may co-exist with discomfort in a different dimension, for instance, a person may experience the social comfort of family, friends, supportive staff, but still experience physical pain or discomfort, or be physically comfortable but lonely or dispirited.

Comfort has a range of occurrence from expected to unexpected, a range of duration from brief to relatively enduring, a range of stability from gradual change to acute fluctuation, a range of availability from spontaneously through routinely - to on request - to unavailable, and a range of intensity from mild to something transcending expectations. Due to a common-sense understanding of the nature of their condition, at least for part of their hospital stay, informants did not expect to be physically comfortable. A degree of physical comfort was achieved by some informants prior to discharge. However, some level of psycho-
emotional comfort had been expected and this related to prior positive perceptions of nurses and other health care personnel.

7.2.2. Phase 2: Recurrence of phenomenon, with strategy for management

The phenomenon of comfort was experienced in one or other dimension to a greater or less degree throughout the hospital experience. The management strategy of finding comfort was an active process achieved through sub-processes of self-talk and self-care. Examples of these will be found in the latter part of this chapter. Strategies for management could not be separated into discrete phases of intial and recurring instances of this comfort, and therefore are most appropriately discussed below.

7.2.2.1. Finding comfort - a core process

A basic psychological and social process in which participants in this study engaged was finding comfort. Finding comfort is an active process facilitated by three circumstances. These are first, several self-talk strategies, a recursive internal dialogue through which adults come to define and accept a situation, make allowances and maintain perspective; secondly, finding comfort by chance or unexpectedly, but actively responding to comforting circumstances; and thirdly, self-help strategies, involving exploration and effort. In terms of the axial coding paradigm, the 'modifying conditions' (that is, structural or contextual conditions which intervene to constrain comfort) were a number of different forms of discomfort which had to be managed.
7. 3. Discomfort: A Core Category

The second core category, discomfort, was retained after carefully considering the advice of Strauss and Corbin (1990) to the contrary. I believe the two phenomena are integrated in an intrinsic manner in the grounded theory which has evolved in this study. They are closely related, yet distinct and of equal importance.

7. 3. 1. Phase 1: phenomenon, specific properties, strategy /ies for management

Discomfort was a core problem for the informants in this study. Discomfort is a term which denotes that one or more unpleasant conditions, either ‘causal’ or ‘modifying’, is present which arouse/s negative emotions. Discomfort and the resultant negative emotions are broadly due to unfavourable physical, psycho-emotional, social, environmental or spiritual conditions.

Discomfort is a higher order category which describes several clusters of codes which were evident in the data. These clusters included negative feelings (psycho-emotional discomfort), hospital routines, physical discomfort, environmental discomfort, spiritual discomfort, visitor discomfort, nurses who were too busy and staff who seemed to lack empathy.

When any form of discomfort is expected, no matter how severe it turns out to be, it may not arouse strong negative feelings. When it is not expected, or is present to an unexpected degree, it will arouse surprise, and in extreme cases, if discomfort is unremitting, feelings of intense distress, of desperation, even of despair.
7.3.1.1. Discomfort as experienced by informants

Discomfort was psycho-emotional, feeling vulnerable in a number of ways, feeling insecure, feeling isolated when transferred to other wards; feeling that no-one was responsible for you, that staff did not know what was wrong with you nor care about what you were going through.

Discomfort was interactional and relational, characterised as feeling hurt, disappointed; feeling rebuffed, excluded, trivialised, dismissed by others; being treated as an object, as a nuisance, or being perceived as overly dependent. Discomfort was feeling unwilling or unable to ask for help from particular individuals. Discomfort was often an outcome of inadequate or impaired communication.

Discomfort was environmental and related to noise, smells, lights, crises - your own or that of other patients, transfers to different wards, having to re-orient to staff and surroundings. It was sleep interrupted by preventable disturbances.

Discomfort was physical pain as well as a variety of transient, persisting or recurrent aches and pains: from wounds and dressings, backache, headache, stiff neck, sweatiness, dry, furry mouth, nausea; blood-clotted or greasy hair; unshaven face or legs; discomforts from several different kinds of invasive devices - nasogastric, intravenous, epidural, wound, urethral, vaginal, rectal - tubes, drains, lines and packs, and of plaster casts, skin electrodes, oxygen masks, sweaty pillows, thin mattresses and high or difficult to adjust beds.

Discomfort was spiritual, in the sense of a deliberate, self-protective distancing from others too ill or likely to die, being unable to help and feeling unwilling to get involved and expend emotional energy, albeit with some feelings of regret.
Discomfort was systemic: bureaucracy, routines, and routinised care, which were at best mildly annoying and unintelligent, at worst, demeaning and depersonalising.

Discomfort was surprise at the unexpected discomforts such as side effects of drugs, uncomfortable treatments and the reality of persisting discomfort. Discomfort was not being able to get or stay comfortable or to feel rested in bed or to reach your possessions or the call bell through decreased mobility. Discomfort was feeling hungry but not being able to face the food, feeling dizzy when you stood up, feeling fatigued, bruised, battered, weak and weepy, sometimes for long periods after discharge.

It is worth noting that managing multiple discomforts, often without support, while physically and psychologically and emotionally vulnerable, was itself uncomfortable.

7. 3. 1. 2. Dimensions and ranges of discomfort

Discomfort may be physical, psycho-emotional, spiritual, social or environmental. It has a range of severity from mild and manageable by the sufferer, to severe and unmanageable. It has a range of expected occurrence from expected to unexpected. It has a range of duration from relatively transient to relatively enduring. Discomforts may persist for days to weeks beyond the acute stage of illness or surgery. It has a range of evanescence from diminishing to persisting.

7. 3. 2. Phase 2: recurrence of phenomenon, with strategy for management

The phenomenon of discomfort was experienced in one or other dimension to a greater or less degree throughout the hospital experience. Importantly, physical discomforts abated much more gradually than was recognised by staff. While
what they would describe as definite ‘pain’ eased away, for the most part, over a few days, many informants continued to experience intense discomforts associated with fatigue, soreness, aching muscles, head and neck ache and dizziness, which were exacerbated by psycho-social and emotional discomfort. One informant summed up the common discomfort (taken for granted and frequently overlooked) of having to be in bed for a greater part of the day and night, even with periods of ambulation:

You’re sitting up in bed for days on end, and you get sort of stiff, and the bed’s so hard. After you’ve had your operation, you don’t know how to get the top half of you comfortable, or the bottom half. You don’t know whether you can lie down, sit up, half sit up. Just getting comfortable is a terrible dilemma. You don’t know where to put yourself. You can’t seem to change your position by yourself. You can’t relieve the pressure of the bed against your toes. You’re very conscious after a few hours of aching back, unsupported shoulders and neck. Your hips and heels burn, they go sort of numb, but they ache. Your elbows hurt from trying to drag yourself up in the bed. You are sore, head to toe. You are exhausted. You feel awful. You can’t sleep, you can’t get into your normal sleeping position. You can’t rest. You can’t get comfortable. (Informant R4.)

Unexpected physical discomforts included the application, presence or removal of uncomfortable tubes and pieces of equipment. They were unexpected because the anticipated experience of hospital provided an image that was global rather than detailed. Painful procedures, investigations and surgery were interpreted as necessary, accepted as inevitable, but anticipated to be transient. Self-talk here was a comforting management strategy. Occasionally, nothing and no-one was able to relieve intense physical discomfort, even with strong medication. An informant who experienced several days of persisting head and neck pain commented:

I didn’t particularly want to live, at that time, because I was hurting like hell. It was awful. I’d had enough, and I didn’t care if I lived or I died. (Informant R6.)

One informant, a retired plumber, objectified the source of his difficulty and embarrassment with a catheter, and was able to joke about it:
Me plumbing kept coming apart. I was always getting soaked, and I'd dive in and put it together again. (Informant R7.)

Noise was an expected environmental discomfort. At night, unavoidable and avoidable noise from activities of staff and other patients kept informants awake. This was in addition to inability to sleep because of physical discomfort, and to lights shining directly on some informants, despite curtains being pulled. Informants managed these discomforts with inner dialogue, and were able to recall incidents of hospital noise, light and interruptions to rest and sleep, in narratives tinged with wry humour.

Discomfort other than physical was a recurring phenomenon for most informants in this study. A spectrum of uncomfortable emotions was identified. Those emotions which were more or less expected were apprehension, worry, concern and homesickness. Other negative feelings associated with hospitalisation were reported as annoyance, anger, disappointment, loneliness, isolation, vulnerability, embarrassment, hurt surprise, sadness, depression, frustration and aggravation.

Again, respondents were generally taken unawares and a little thrown off balance by the unexpected. One informant was told by his surgeon that he would probably go straight back to his ward but woke up in Intensive Care. Even though he had been there pre-operatively for placement of a central line, he was shocked:

_I thought, what am I doing here, and then, after a while, I just got used to it. I thought, something must have gone wrong somewhere. They never did tell me what went wrong._ (Informant R7.)

He tried to offset this lack of information by accepting it, making allowances and maintaining perspective:

_I suppose it wasn't important. The way I look at it, they're the experts, they know what they're doing._
But later he commented:

*I found out that they never seem to tell you anything that was going on - they treat you like a vegetable.* (Informant R7.)

If lack of information made this informant feel vulnerable, it was increased by having his epidural catheter and monitor leads removed without warning. The doctor in the intensive care unit had been trying to find beds for other patients.

*She went around trying to find out who she could get rid of. She looked at me and said, you don’t need that. She saw I had a couple of sticking plasters - pulled them off without any warning, and I’m hairy - and that hurt a lot.* (Informant R7.)

As he recalled, a prolonged argument then ensued about how many new patients could be admitted to Intensive Care. In the informant’s perception, cardiac monitors were alarming, including his own,

*... and that interfered with the argument, so she came over, reached under the bedclothes and disconnected me. I felt uncomfortable. I thought, if anything was to go wrong, no one would know about it.* (Informant R7.)

Informants reported feelings of vulnerability in a number of other instances. One sense of this related to being exposed to embarrassment. In one instance,

*Visitors came who were your superiors in your work hierarchy, to find you with a tube up your nose, barely able to straighten up, physically weak, unable to concentrate - and this was in stark contrast to the way you usually presented.* (Informant R6.)

He did not have the energy to deal with this, but he remembered feeling acutely uncomfortable and resentful of the exposure of his vulnerability to uninvited work associates.

In another instance, an informant admitted urgently for investigation of abdominal pain felt he had to guard against the embarrassment of showing fear, or reporting distress, or asking for additional help. He said he would not have
minded having a caring nurse recognise and accept that he had these feelings and needs, and take the initiative by offering him support. He interpreted the absence of this explicit recognition and support as an expectation that patients would be ‘brave’, and as he put it, that ‘non-macho’ behaviour would run counter to expectations of staff about how an adult patient would act: “There was no opportunity for me to show that I was a bit scared. I felt like that wouldn’t have been tolerated.” In addition to experiencing a mix of feelings, he felt he needed to protect himself from the embarrassment of obvious vulnerability. He did this by telling himself how bad the pain was, how afraid he was of what would be found at surgery, accepting that he felt like a small child, chiding himself, reassuring and reasoning with himself, and generally managing his psychoemotional discomfort by processes of self-talk.

Similarly, vulnerability was a source of discomfort for another informant admitted for excision of a renal neoplasm and expressed as a need to talk to the nurses when he was admitted. In his understanding, getting to know the nurses was an important first step in being able to turn to them for support when he thought he would need it during his hospital stay. On admission, which was a routine checklist procedure,

* I didn’t have a chance to talk to the nurses. There was no time to establish a relationship with the nurses. I needed to talk.

In his recollection, nurses made no reference to his condition, his surgery and its possible impact on him, on admission or subsequently. He interpreted this to mean that it would be his responsibility to reach out and bond with staff. When told by the surgeon that the neoplasm has been completely excised, he had an emotional let down. “I was relieved - I felt like a million bucks.” He said that the next day when this was further confirmed by the Registrar,
I fell apart - what I wanted was to be able to talk to the nurse. My wife wasn’t there. I needed someone to support me. I had tears. I am a strong man, but I was overcome with emotion. [Instead, it was several days later that he] got to know the sisters, and we have a little joke. (Informant P4.)

One informant felt vulnerable when she noted that nurses dispensed the usual adult dose of bronchodilator instead of the half-dose prescribed for her. She knew that she became tachycardic when the normal dose was given and felt alarmed that this would be repeated. This led to her developing a self-help strategy of managing the discomfort of her anxiety by increased vigilance and by monitoring each nurse who came to give her medication. As well as feeling exasperated at having to do this, she then had to deal with the defensive behaviour of some nurses who saw that she was checking up on them. She did this with self-talk, justifying her own behaviours to herself. This same informant felt vulnerable as well as disappointed when she realised that the nurse who had been looking after her for two days did not know that she had a co-existing, quite visible impairment of her dominant hand. She thought this should have been evident from even a cursory assessment and from noting the other medication prescribed for her. The nurse’s perceived lack of knowledge about her was interpreted by the informant as both uncaring and dangerous.

There were discomforts associated with the vulnerability of the patient role such as irritation at having to rely on others, not being given enough analgesia and frustration with hospital routines. The distress of fellow-patients was a source of significant discomfort. One informant shared the anguish of staff trying to understand a patient beside him who could not speak English. By the time they had brought a bedpan the patient had collapsed. He retained a graphic memory of the failed resuscitation he unavoidably witnessed when the curtains were not drawn. Another described her feelings of mounting anxiety as a cardiac patient in a Casualty ward during the admission of people with overdose, heart attacks and trauma, and of having her own angina worsened. Other informants experienced
distress when fellow patients were seriously ill or did die. In each case, discomfort was managed and a measure of comfort was achieved through protective self-talk and in the case of one informant, through avoiding or distancing himself from very ill fellow-patients.

7. 3. 2. 1. Managing discomfort - a core process

A basic social and psychological process in which participants in this study engaged was that of managing discomfort. Managing means to be in charge; to succeed in being able to do something, in spite of obstacles; to contrive to carry on despite difficulties (Wilkes & Krebs, 1991). Managing requires a definition of the current situation, recognition of a problem and its probable cause, identification and mustering of resources to cope, and choosing strategies.

Managing discomfort was achieved through processes of self-talk (with sub-processes of anticipating, interpreting, defining, accepting, making allowances and maintaining perspective) and self-care (with self-comforting processes of self-help, seeking help from others and accommodating to the kind of help available). The ‘modifying condition’ in discomfort, that is, “any broad or general condition bearing upon action / interactional strategies” (Strauss & Corbin, 1990, p. 103) which intervenes in and offsets discomfort is the active seeking of comfort by informants, and their ability to recognise and find relief in various forms of comfort which are described below and further on in this chapter, and which I have called ‘finding comfort’.

Informant R6 was admitted with trauma, x-rayed and diagnosed as having cracked ribs, one of which which had punctured his lung. He had a chest drain put in, probably the most painful thing he had done. When they pushed the tube in and out, he was able to find some comfort, in that “… they were good about that - they told me it would hurt.”
Three circumstances (or, in axial coding terminology, structural or intervening conditions) may make physical discomfort more tolerable. These are firstly, physical measures to reduce discomfort, by self or others; secondly, any attempt on the part of others to show concern, or to offer psychosocial help in a variety of forms (even if the help did not reduce the physical discomfort, there was a sense of being comforted) and thirdly, by individual 'self-talk', an internal dialogue in which in symbolic interactionist terms, the 'I' and the 'Me' engage in conversation, the ultimate goal of which is to manage present discomfort.

As with finding comfort, strategies for managing discomfort could not be separated into discrete phases of intial and recurring instances, since varied instances of discomfort were experienced from admission to discharge.

7.3.2.2. Self-help - the dominant self-care strategy

There were periods of intense physical discomfort for all informants associated with attempting to become comfortable in bed. Informants always tried self-help first. They re-positioned themselves and their pillows, even attended their own pressure areas care - "I just sort of worked it out for myself. Get out, sit in the chair where it was softer, rub cream on myself, then hop back into bed" - and felt uncomfortable when on occasions, when no help was offered, they had to ask the nurse for help. As one informant put it, she knew that if she asked for help, the nurses would come, but was worried that they might have other things to do.

A general request by an informant for help to become more comfortable could be met with an exasperated, "Well, what do you want me to do?" and the informant would then have to ask for the pillows to be moved, the bed to be straightened, and so on. All informants in similar situations felt conscious of not wanting to delay the obviously busy nurses, but also were slightly resentful at having to
explain to the nurse how to be made more comfortable. They avoided having to
do so:

*I had this discomfort in my back. It persisted, and I’d only kind of
mentioned it. They said I could have tablets if I wanted. I kept
moving the pillows around. It persisted and I coped with it, but I
asked the doctor if I could go home early.* (Informant R3.)

Pain, discomfort, stiffness and immobility were intensified by thin, hard
mattresses, sweaty plastic covers, tight top sheets and pillows which did not
support enough. All informants were encouraged to get up, walk around, take hot
showers. All informants attempted to manage their discomfort via self-help by
walking, reading, resting, standing or sitting under hot showers, sometimes three
times a day, and attempting somehow to divert their attention from the whole
experience. They distracted themselves by talking with other patients, even
assisting *them* on occasions to relieve their discomfort with small but important
services. Patients were mutually supportive, and sometimes passed on hints about
becoming more comfortable, such as holding and guarding the wound when
coughing or changing position, or explaining hospital routines. To informants,
self-help was a matter of having a positive attitude, working out how to help
yourself, and “*just getting on with trying to get comfortable.*”

Physical care to relieve discomfort was given, or offered. However, this was
usually only at times when, and for as long as, informants were judged by staff to
be in need of assistance. Analgesia, while not always adequate, was available to
relieve pain but even this could become a matter of routine in that it was offered
for the first two or three days only. Six days after being admitted, and the day
after a firm neck brace had been removed, one informant experienced a
distressing level of physical discomfort.
I was having really bad headaches. - they were just about lifting my head off. And I wanted something strong, and they said no. Then I said, well, can I have something else? They said, I'll go and get you something, and they never came back. So you're laying there with your head just about ripping off your shoulders, and being quiet, lying there and not making a fuss, because she said she was coming back - and then didn't. I'd say it was well and truly an hour. (Informant R6.)

In desperation, when anticipated and promised help was not forthcoming, he developed a plan of self-care.

I planned to get up and go to the phone and ring friends, and ask them to bring me in some. (Informant R6.)

7. 4. Finding Comfort And Managing Discomfort

Informants found comfort in a number of ways and from a number of sources outside themselves. They managed discomfort themselves, as well as with help from others. Enduring was a self-management strategy for discomfort. Intense fatigue, persisting aches and pains, pressure on back and limbs, involuntary immobility producing stiffness, sweatiness from plastic pillowcases and mattress covers, wound drains which pulled and hurt, drug side-effects including taste and appetite alterations, intense itchiness and hallucinations, all were endured, sometimes without staff recognising or assisting.

Unexpected physical or psycho-emotional discomfort was experienced and remembered as more distressing than those which had been expected. Similarly, informants recalled in some detail their experiences of caring and comforting, aspects of which had not been expected or which exceeded their expectations. It seems that both negative and positive experiences, rather than simply the negative ones, remain salient for long periods and that both the unexpected element of the experience and the emotions associated with those experiences (Ingwanzo, 1992) played some part in determining what and how an experience was remembered.
Global strategies of self-talk and self-care were commonly utilised. These discomforts were mostly interpreted, accepted and tolerated as normal and "only to be expected" and this self-talk assisted in maintaining perspective by providing some inner reassurance. Because of this acceptance, informants did not initially seek help from nurses. The following passages describe some of the outcomes of help-seeking.

7.4.1. **Help from the ‘expert’ nurse**

The notion of the ‘expert’ nurse was introduced by informants many times (see Chapter Six, Section 6.3.1.3.). The expert nurse made a decided difference to experiences and perceptions of comfort and discomfort.

Throughout the hospital experiences, nurses who were perceived as ‘going out of their way’ to see that patients were comfortable were regarded by informants as ‘excellent’ and as ‘good nurses’. Informants described a number of instances where care was considered ‘expert’. One informant recalled his significant discomfort and the manner in which it was lessened. After prostatectomy and with a tender and swollen scrotum, as he recorded in his Comfort Diary, the nurses packed pillows between his legs and at his back so he could sleep at night, and turned him so that he could be comfortable. Despite the intense discomfort felt during repositioning, it was the first instance of comforting among many that he related: "They took care. They were experts. That was very comforting."

This perception of expertise, characterised as staff working in particular ways to achieve particular patient care goals, was echoed by most respondents.

‘Expert’ staff were an important source of comfort. Staff who “knew what they were doing”, in Casualty, in X-ray, in Intensive care, in high dependency wards, in medical and surgical, post-natal wards and short stay wards, were reassuring. They gave informants confidence that all was as it should be. Staff who did this
included nurses, doctors, physiotherapists, and in one case an X-ray technician, who gently re-positioned and carefully explained everything he had to do. Information and explanation were important to informants, and staff who provided this helpfully and patiently were regarded as

\textit{excellent, the very best in terms of making you feel comfortable and letting you know what the situation was.} (Informant R6.)

Comfort providers were predominantly nursing staff. Nurses came in often to see how informants were, allowed them to cry when they needed to, encouraged and supported them and otherwise made their caring evident. Nurses as comfort providers were attentive, they were different, and this difference was interpreted by informants as a caring attitude combined with professional skill and knowledge.

\textit{Well, J--- used to come around and ask how you were going all the time. She was a bit of an exception because she was very good. A good leader.} (Informant R7.)

‘Expert’ staff gave timely and useful information, explained things, or made it easier for informants to access information. They distracted them during painful procedures, getting them to talk about anything at all, to take their minds off the ordeal. They guided, as one informant who had been mechanically ventilated for a few hours after cardiac surgery recalled,

\textit{I can still hear that voice in the background. That voice was there all the time. It was super. Nice young lad, telling me what I’m going to feel - you know, I might feel a bit of discomfort - and everything that he was going to do. I knew that I was either not going to feel anything, or that I was going to feel a bit of discomfort, so that was fine. I was OK.} (Informant R4.)

One said, in relation to a procedure which she thought would be painful, "... they gave me confidence, they told me exactly what they were going to do.” The ‘expert’ nurse noticed, paid attention, knowledgeably assessed the informant’s condition, tried to help, instilled confidence that informants were in capable
hands. Another informant noted the 'expert' care given by nurses to other patients who were at the time more in need of help than herself.

Informants were sometimes given a choice of strong or milder analgesia and this provided a comforting sense of control. Other physical measures experienced as comforting were back rubs (but one informant with angina found this actually worsened her discomfort, although she thought of it as a caring nursing action) and re-positioning (which, while this could be lengthy and distressing, was ultimately comforting). Informants recalled with appreciation and sometimes, surprise, instances when busy nurses offered or provided comfort measures promptly or pro-actively.

_This nurse in the high dependency ward, she'd come and say, are you in any pain, and I'd say, just a bit, and she'd come and do something with the morphine. The nurses used to come in and rub my shoulders and back with some special stuff ... and fluff the pillows and fix them in a way so that there wouldn't be too much strain on the neck._ (Informant R5)

There were many instances where expert comforting by staff, during informants' ordeals was both physical and psycho-emotional. The memory of intense physical discomfort of a spinal anaesthetic or catheterisation or other invasive procedure persisted, but the hands-on physical support and verbal comforting of the assisting nurses were also remembered. One informant recalled the nurses "fooling around, trying to add a bit of lightness to the situation" while he was being sutured in Casualty. "It was tremendous, especially when you were - quite down. It was quite important. It seemed to do a lot for you."

7.4.2. **Discerning discomfort - a matter of empathy?**

However, not all staff were either 'expert' or caring. It was annoying and frustrating not to be able to get attention and medication when it was needed. Ringing for help could be problematic: if the nurse came, there was no guarantee
of help. Interactions with non-empathic of staff led to feelings of disappointment, frustration, even anger. Informants interpreted staff as either having or lacking empathy from observing body language, eye contact, physical distance, time and circumstances of staff visits, what they said, their tone of voice and general manner. Sometimes, informants observed behaviours towards other patients which were interpreted as non-empathic, anticipating the possibility that they would receive similar treatment. A judgement would be made about the likelihood of finding some comfort or of managing a particular discomfort with such an individual. On these occasions, accommodating to the level of help likely to result from seeking help became a choice between deferring, avoiding, persisting or desisting. Behaviours judged as lacking in interest or care might effectively deter a patient from asking for help at all, or led to avoiding those staff if possible, waiting until others appeared, or risking that staff might respond with irritation.

Impaired communication, inadequate information and lack of empathy on the part of some staff were other sources of discomfort.

One shift I wasn't too comfortable. They never did anything wrong, but they just didn't seem to have the same caring”. (R: Can you talk about that a little bit more?) They wouldn't come near you unless you yelled out to them, which I didn't. They just left you on your own. You're on the monitors and they just walked around and looked at the monitors. (Informant R7.)

Another informant was impressed with the efficiency and technical expertise of staff throughout his stay in hospital. He felt able to trust the staff, had confidence in them, and was able to relax, with no need for hypervigilance. He accepted any discomfort associated with procedures and equipment: "You just thought it was important, so therefore you didn't particularly worry about it.” He went through several stages of care from high dependency to medium dependency “... and finally to the on-your-own ward”. Being in the 'on your own' ward was a frustrating and curiously lonely time. After the most acute phase of hospital
care had passed, contact with nurses was mostly superficial. Several doctors visited him - it seemed they were different each time, which was disconcerting. He did not know how much they knew about him, or whether they were junior or senior doctors. Nurses and doctors, he said

... didn't approach you - they were always at the end of the bed, speaking with that distance maintained - unless they were coming in to actually do something, like check your tube. They'd say, how are you today. I'd say, I'm fine. They kept a group space. You talked to a group of them. (Informant R6.)

Their 'how are you' was interpreted as a social greeting, where he would be inclined to say no more than, "I'm OK." Finally, a doctor, someone he had never met before, said he was well and could go home. "I didn't know I was well", he said, because no one had ever discussed his condition, or the expected course of his recovery with him. He wanted to identify with a member of the staff for discussion and information instead of having, as other informants noted, to repeat his story to five different individuals, most of whom he never saw again. This was a major source of dissatisfaction to him. He had expected to know what going on and what his part in it all was to be. Instead, he felt that he had only been given a passive role to play. He was unaware of the plan for his care and he felt marginalised by attitudes of medical and nursing staff which excluded him from participation in it.

7.5. Contextual Themes In The Data

In the process of coding, identifying themes and abstracting and reducing the data, a number of interesting facets of the patient hospital experience were uncovered, and decisions had to be made about what to pursue and what to leave aside, both during interviews and in the analysis and write-up. In the following pages are several contextual themes which are worth noting for their implications for practice and future research. They include patient vulnerability, nurse-patient
interaction, social-professional bonding, routine and ritual in assessment, adequacy of information provided by nurses, the ‘transit lounge’ phenomenon and further perceptions of the ‘expert’ nurse.

7. 5. 1. Vulnerable patients

Vulnerability is an important element of psycho-emotional discomfort. It is a sense of being defenceless, insecure, at risk, unprotected, unsupported and psychologically uncomfortable. Informants experienced vulnerability when they felt exposed, unsafe, embarrassed, scared, uncertain, powerless to change staff behaviour or to protest at it, and when they felt alone in crisis. For obvious legal and ethical reasons, the clinical/physical safety of the patients is given high priority in nursing. Adults, concerned to maintain their privacy and some semblance of normalcy in hospital, hesitate to raise their concerns, and may not self-disclose to busy nurses, or in the absence of empathy. In this study, nurse behaviours which signalled ‘too busy’ or which lack emotional warmth not only increased the sense of vulnerability but stifled any inclination to self-disclose.

Informants managed these feelings internally via self-talk strategies of accepting, making allowances and maintaining perspective about experiences in hospital, both during and after. Most patients are “submissive, obedient and cooperative ... and remarkably resilient and forgiving. Though vulnerable, compromised, weakened and subservient, [they are] uncommonly prepared and able to understand, and forgive” (Zaner, 1985, pp 85-86).

Copp’s (1986) continuum of vulnerability includes the presence of the unwanted, including pain and the numerous discomforts which may be experienced without relief during hospitalisation. Patients rendered temporarily vulnerable by acute illness, surgery or hospitalisation are made even more vulnerable in a depersonalised environment, where there is absence of expected pro-active care,
anticipatory support and a choice to be involved in discussions and decision-making concerning their care.

Vulnerable patients need help to meet comfort needs without loss of dignity associated with constantly having to ask for it. The nurse is well-positioned to anticipate and intervene to prevent or minimise problems in vulnerable persons, but may not do so if lacking a phenomenological understanding of the client's situation or if distanced from it by defining the situation in terms of a system or functionalist perspective.

7. 5. 2. Nurse-patient interaction

There was both comfort and discomfort in the nurse-patient interaction. The nurse - being friendly and approachable, interested, believing the patient, anticipating help required, providing useful, timely and individually appropriate information - created a sense of partnership in care. When the nurse used independent nursing judgement, even on a very simple level, this was valued. Many of these interactions, while important, seem very ordinary, and many would take for granted that they are integral to all nursing care. However, in this study, these 'ordinary' interactions were sometimes the exception. When present in the nurse-patient interaction, these nurse behaviours and attitudes were sustaining and comforting, and contributed to a feeling of psychological safety. When expected but found to be absent, there was a sense of disappointment. This finding is consistent with the nursing literature on the significance of such interactions (Benner & Wrubel, 1989; Brown, 1986; Christensen, 1990; Drew, 1986; Gaut, 1984; Taylor, 1992; Watson, 1979).
7.5.3. Social-professional bonds

Social / professional bonds developed between patients and staff occasionally within a single encounter, sometimes during an eight-hour shift, but often over a couple of days (see Steeves et al., 1990). These connections or bonds were reassuring to informants because they did not have to explain themselves to each new face. Bonding can be articulated as a social and cognitive ‘connecting’ process which occurred more readily when nurses spoke in a friendly, human way and took an interest in patients as individuals. Patients were then able to feel more secure, could begin to trust their nurses and were more likely to talk to them about their concerns. An important aspect of social and psychological comfort during early convalescence was to be able to recognise a familiar face and to be recognised, to be on first-name terms and to be able to share a joke with nursing staff. Often there was a sense of ‘family’ or at least of being part of a friendly community, as evidenced when informants spoke of “our ward, my nurse, our nurses, we.” Warmth and the mutual empathy felt with caring nurses was characterised by some informants as part of the healing process which was facilitated by social-professional bonding.

7.5.4. Routine and ritual in assessment

Perhaps because such patients who were the subject of this study are often ‘ordinary’ and non-problematic, familiarity has bred, if not contempt, then indifference for their post-acute discomfort, in the sense of a generalised failure of health care professionals to approach this group in any but a routine manner. Their hospital trajectories are often relatively well mapped out and their care path ‘cut and dried’: high to moderate dependency for hours to days; analgesic cover for moderate to severe pain, usually for forty-eight hours; attention to the wound until drains are removed; early ambulation and self-care; home when pressure on beds builds up. This is a practical plan from a medical, administrative and
functionalist view point. It is one which could be transformed, professionalised and humanised through a perspective that is person-centred, informed by interactionism with a view of nursing as having some autonomous role in patient care. Assessment in this post-acute stage of care, even pain assessment, was ritualised and impersonal. Informants experienced numerous, sometimes intense discomforts amenable to relief by nurses, which were neither assessed nor relieved.

Uncomplicated convalescence was assumed, patients being 'rubber-stamped' as 'ambulant and self-caring, no complaints voiced'. This assumption was more often than not based on indirect nursing assessment, through noting vital signs, independence in self-care activities such as showering and ambulation and from information received at handover, rather than directly talking with the patient and eliciting the patient's perspective, their 'definition of the situation'. There was a stereotyped perception of these patients as requiring minimal nursing care.

Having earlier said that the literature on chronic illness was initially less relevant for this study, I later found a number of similarities between my study and a section of the work of Strauss, Fagerhaugh, Szczek and Weiner (1985) in relation to the taken for granted comfort work of patients, the routinising and technologising of comfort care in acute care institutions and the emphasis on clinical safety in acute-care hospitals much that was relevant to comfort work.

Nurses who are too busy may not make adequate assessments. Nursing assessment requires a focus, which is the person's current physiological psychoemotional and spiritual state of well-being (here understood to include comfort and discomfort) and the condition of the environment and technological equipment which may impinge on it. It also requires a perspective which is informed not only by the clinical nature of the condition of the patient and its usual trajectory, but by a phenomenological understanding of the possible
subjective meanings of that condition and status for the patient. Assessment takes careful, thoughtful and efficient use of time and requires sensitivity in communication. It is thus a complex skill which must constantly be practiced and developed. Assessment is no less important in the post-acute stage of hospital care, although it has shifted its focus from survival to rehabilitation. It should never be routinised. When nursing assessment is absent or deficient, there can be no opportunity for sharing definitions of the situation, for re-shaping expectations or for mutual goal setting.

7.5.5. How much information do patients want or need?

It is always difficult to judge how much information a patient needs and how much is appropriate to convey at particular times. What and how much to tell patients about what is happening has to be carefully weighed up in each situation. Informants in this study exhibited a range of information desires and needs, from wanting little or no information other than general explanations, to expecting and being able to deal with a reasonably detailed accounts of what was and would be happening to them. One informant commented that the video shown to intending cardiac surgery patients was considered not to be sufficiently informative, since it in no way prepared her or any of her fellow patients for the extraordinary amount of discomfort (as distinct from pain, which was generally well-managed) they would face after surgery.

My impression is that many nurses, unwilling to risk upsetting a patient (or perhaps lacking the confidence to deal with other than routine passing of information) would err on the side of providing less rather than more information. Certainly, informants would have benefitted from information about changed expectations concerning their self-care behaviours, in that it would have added to their psychological comfort. In symbolic interaction terms, in an organisational context, this would be an educational process of changing the patient’s ‘definition
of the situation' by design (Lauer & Handel, 1977) through a restructuring of expectations, in order to facilitate the work of the hospital as well as to reassure the patient and family that a plan of care (in this case, of increasing self-care) was in place.

Apart from those labelled by informants as 'expert', nurses were generally perceived as not knowing enough to give adequate information, or as insensitive to the patient's need for information appropriate for the circumstances. In the view of these informants, carefully timed and structured information made a significant positive contribution to psychological safety and comfort in early convalescence, and thus to the patients' transition back to wellness.

7. 5. 6. The ‘transit lounge’ phenomenon

An important finding was that informants experienced transition from high dependency to self-care before they felt ready to fully-self-care. Physical discomforts fluctuated in intensity and persisted well into convalescence, and psycho-emotional discomforts emerged.

In my view, it can be reasonably inferred from the data that at least some nurses unilaterally withdrew instrumental and expressive nursing care when the decision to taper medical care was made, and thereafter provided care at a simple technical level. This 'care' was, effectively, medical monitoring rather than person-focused care based on nursing assessment. There seemed to be little appreciation that recovering from illness or surgery was a time-bound process, nor that healing and rehabilitation could sometimes meet with set-backs requiring nursing care that was protective, supportive and restorative. There were to be no 'half-way houses' or refuges in convalescence, only 'transit lounges', a kind of no-man's land between acute care and discharge from hospital.
Informants missed a reassuring, protective and concerned nursing presence. They were left to make that transition to self-care virtually alone while they still felt weak, tired and uncomfortable. When the only option offered in backache is 'tablets, if you want them', as some informants of this study experienced, we need to put in place a more therapeutic nursing approach, a nursing model of care which focuses on rehabilitation rather than on survival. For this group of patients, the literature suggests that nurse-patient interactions are likely to be curtailed and superficial (Clark, 1989; Ramos, 1992), and this was certainly the case for many of this study's informants in the post-acute period. Superficial, task-focused communication created a sense of no-one 'owning' the patient and of the patient not seeming to be the responsibility of anyone in particular. Inter-ward transfers merely intensified the sense of isolation and vulnerability, of being excluded from important discussion and decision-making concerning their progress and condition by the absence of any ongoing health teaching or preparation for discharge. The opportunity to clarify aspects of earlier care and to reinforce or remediate earlier perceptions was lost through this pattern of superficial interaction. Informants were visited briefly by a bewildering succession of often unidentified groups and individuals with, as time passed, the visits becoming fewer. They were comforted by what they termed the 'nursing' visit, the occasional, brief but meaningful reassurance of nursing interest, expertise and support.

7.5.7. The 'expert' nurse comforter

While no one could question the complexity of the demands made on nurses' time, it is evident that nurses whom patients regarded as 'expert' did find the necessary time to communicate their interest in the patient, even to share briefly some information about themselves or their families. Clinician self-disclosure, or giving something of one's self, a spontaneous, sociable, friendly practice characteristic of many nurses, is also confirmed by theorists as decreasing social
distance and contributing to a genuine and empathic helping relationship (Chipman, 1991; Young, 1988).

As indicated in Chapters Six and Seven, in one way or another, ‘expert’ nurses were able, in a few moments - and convincingly - to convey a sense of knowing what they were about. From glimpses of the ‘expert’ nurse which came through informants’ narratives, it was possible to make inferences about what being an ‘expert’ meant. It meant stepping aside from the pressure and chaos of the rest of the ward, and approaching patients pleasantly so that each one was aware of being treated as an individual and was not inhibited from asking for assistance by the nurse’s obvious busyness. It meant being capable, and instantly, effectively communicating that capability through verbal and non-verbal language. It meant limiting threat and vulnerability through a range of protective strategies, including planning and intervening appropriately, sensitively, and with patience, sometimes overtly, sometimes covertly and discreetly.

Informants provided brief vignettes of ‘expert’ nurses which possibly only other skilled nurses would appreciate as depicting deliberate casualness and ordinariness when the patient’s well-being was under threat in some way - in Morse’s (1992) terms, a kind of ‘keeping it cool’. Such was evident in the narrative of the informant admitted with trauma, when nurses kept the atmosphere light with witticisms while extracting glass from numerous small lacerations. That informant understood that they were ‘keeping it cool’ for him. He thought they were ‘expert’.

The data suggested that being an ‘expert’ nurse meant sometimes using humour, and light-heartedness, sometimes voice, sometimes touch or presence, deliberatively or possibly, intuitively, when a patient might be anxious. Nurses can also assume a casual, almost off-hand demeanour to forestall likely expressions of gratitude from emotionally vulnerable patients which might
embarrass and make more vulnerable both patient and nurse. This capacity of the expert nurse for rapidly assimilating, interpreting and responding to global impressions or particular cues given out by patients, and for selecting what might be an appropriate strategy, has been noted elsewhere by Benner (1984) and by others:

Experienced nurses use nursing gestalt to arrive at a diagnosis on which they base their care. Nursing gestalt is a matrix of basic knowledge, past experience, sensory impressions and recognition of cues presented by patients. A nurse’s sensory impression of the patient is as important as theoretical knowledge ... in deriving sound judgments (Pyles & Stern, 1983, p. 52).

In summary, the meaning of ‘expert nurse’ was constructed by informants in this study to signify nurses who were interested, friendly, available and knowledgeable who signalled, however briefly, an authentic and distinctive caring nursing presence.

In contrast to implicit comforting, a casual or cool manner may also be assumed in a fast-moving, technocentric environment to limit the intrusion of heightened emotion and intimacy which would then oblige the nurse to spend time in managing. This is a distancing strategy which while occasionally necessary, should not become habitual. As professional nurses, we need to reflect on our interactions with patients, who have a right to expect that we are technically competent, interested, socially appropriate and above all, helpful. We also need to learn to value and foster the actual and potential ‘expert’ in each of us.

7. 6. Summary Of Finding Comfort And Managing Discomfort

In this chapter, using axial coding and support from the data, comfort and discomfort have been identified, described and verified as core categories and finding comfort and managing discomfort as core processes. Discomfort was ultimately managed by informants themselves, with assistance from others,
utilising strategies of self-talk and self-care. Self-comforting came through ongoing inner dialogue between the 'I' and 'me' selves and through self-help, help-seeking and accommodating activities. Self-talk and self-care sub-processes and the elements which constituted them were explained. Interactional rather than linear processes, they were diagrammed separately and sequentially in Figure 6.2 only for purposes of clarity. Links between expectations, experience, meaningful interpretation and response became more explicit through reference to informant narratives.

One important way of finding comfort was through professional carers whom informants came to perceive as 'expert'. 'Expertness' for most of these informants was a blend of competence and caring: staff who were less caring were not perceived as fully competent, while staff perceived as caring were usually seen as 'expert'. The theme of the 'expert' nurse was one of several themes which emerged from the data to flesh out the experience of both comfort and discomfort which came out of this study.

The final chapter brings these and other findings together in a discussion which includes implications for nursing practice, management and research.
CHAPTER EIGHT
From Grounded Theory to Practice: Implications and Applications.

Comfort and discomfort are important concepts in nursing which have taken-for-granted meanings. While their meanings still remain implicit, there is increasing interest in investigating aspects of patient comfort and including it in nursing discourse. Discomfort, however, has been the subject of few research projects and is not a prominent topic in nursing literature, possibly due to its being subsumed under the concept of comfort as its inferred antithesis. In practice, discomfort is largely understood only in relation to pain, and as the obverse of comfort, so that if pain is relieved, comfort is seen to be assured and discomfort assumed to be absent.

This final chapter summarises the research problem and the research method adopted to explore it. It recapitulates the theory which was generated, outlines some important themes in the data and links these to existing nursing literature. Distinctive features which characterise the in-hospital convalescent experience in this group of patients are closely entwined with the comfort and safety work of both nurse and patient, and these issues are explored in this chapter. Limitations of the study are stated and applications of the theory to nursing practice, research, education and management are suggested.

8. 1. Looking Back On Comfort

We have moved on from a time in the 1960s and 1970s when comfort and discomfort were understood as normative components of the hospital patient’s experience. Patients’ needs for comfort and comforting were actively addressed through practical bedside care, with an additional therapeutic dimension of ‘tender, loving care’ (TLC) which was sometimes explicitly prescribed for
particularly vulnerable patients. These included the very ill, those with no visitors, or individuals who by common but not well articulated consensus, were perceived in some undefined way to need (or to deserve) ‘extra special’ care. In that era, formal discourse and research in nursing were largely unheard of. Nurse training, still hospital-based in Australia, focused on teaching ‘tried and true’ principles and practical skills, but the ethos of nursing as dedication to meeting patients nursing needs in a caring way was undeniably communicated through precept and example. The implicit understanding of comfort and discomfort was actualised through a range of deliberative nursing actions intended to comfort and relieve.

However, the meanings are still implicit, that is, present but not fully or clearly articulated. Patient comfort and nursing comfort measures have gradually become less prominent in professional nursing texts and nursing curricula and, it might be argued, even less prominent in practice. At this level it is common to hear that nurses seem to have little time to provide physical comfort, and that comforting is a lost or dying art. One could speculate that this has occurred because higher patient acuity and biomedical technology make increasing demands on nursing time, yet there is the apparent paradox that nurses in technology-laden high dependency units are more likely to provide holistic comfort for their patients than nurses in less busy wards. As patients move out of high dependency care, however, there are few rewards and little validation from senior managers, other than lip service, for what might be called the invisible or taken-for-granted work of human comforting and caring in nursing - physical comfort measures as well as the social, friendly, human sharing, the ‘being with’ and ‘talking with’ patients in ordinary but purposeful ways. The ‘being with’ is purposeful when it builds rapport and trust and facilitates identification of patient concerns, which informants in this study found so important for their comfort.
8.2. The Problem Re-stated

Many patients in medical and surgical hospital wards, patients whom one could regard as 'ordinary', experience a wide range of discomforts associated with their underlying health problem, hospitalisation and clinical intervention. These discomforts are more or less expected by patients. The problem I identified had two aspects. The first was that common discomforts of early hospital convalescence, predictable in the circumstances, were taken for granted, ignored, minimised or discounted by nurses. The second aspect was that in many cases, patients did not complain about nor report these discomforts. Twenty-five years ago, similar questions to some which guided this study were posed:

What factors in the work situation militate against an empathetic, helpful response from the nurse? ... What can be done to facilitate the patient's report of distress? ... Why do patients hesitate to signal for aid? (Graffam 1970, p.335).

In the process of professional theorising and reflection about the problem, I made an attempt to identify and map influences on the delivery of optimal nursing comfort care. An original conceptual framework was developed which went some way towards accounting for situational variables affecting the assessment and management of comfort and discomfort, including factors likely to influence adequate nursing assessment and patient self-disclosure. In moving to this current work I continued to surface and reflect on my assumptions about the nature of patient comfort and discomfort.

One of my assumptions was that comfort is firmly within the domain of nursing and is a fundamental responsibility of nurses to address. Comfort, in my mind, equated with nurse-initiated interventions, carried out pro-actively or responsively in a friendly, cheerful, prompt and considerate manner, which respected the wishes of the individual. With discomforts reduced the patient would feel nurtured, comfortable and able to rest and heal. A further assumption was that
nursing assessment which focused on functional abilities and deficits would be the basis for nursing care. Assessment would be facilitated by good interpersonal and communication skills, the early establishment of rapport with patients in one’s care and by a person-centred focus which took account of social, psychological and environmental stressors in the patient’s situation.

The question arose, did patients, particularly those in hospital for relatively short periods, view the matter in a similar way? What was the significance of comfort for them? Was discomfort transient and of little importance? When they felt uncomfortable, why did they not tell the nurses? Nurses routinely advise patients to let them know if they need ‘anything’, yet it was clear that patients often put up with discomfort without asking for help. What did patients understand by ‘anything’? Why did they not ask for help when it seemed such an obvious thing to do, and when nurses generally made it clear that it was appropriate for patients to do so? Was it difficult to ask for help? If so, why?

A literature review revealed that very little was documented, from either a nurse or patient perspective, about adult medical and surgical patients who were in the post-acute stage of hospital care. At that point I could see few connections between existing comfort or other literature and medical-surgical patients who may be characterised as ‘the walking wounded’, out of danger, medically speaking, expected to self-care, and going through a taken-for-granted process of early convalescence.

The purpose of this present study, then, was to understand adult hospital patients’ experiences of comfort and discomfort in the post-acute stage of their stay in hospital for relatively short periods, for ultimately non-life threatening conditions. The project was carried out through interviewing people about their experiences of comfort and discomfort. The majority of informants were interviewed after they had come out of hospital. I was satisfied that I had made an initial conscious
effort to confront my assumptions and to put them aside so that they would not distort data collection and interpretation. I found that I needed to continue to do so throughout the study.

8.3. Choice Of Grounded Theory

Given the nature of the research question, an interpretive approach was indicated. Grounded theory methodology was chosen since this offered a way to investigate a familiar situation about which little was actually known, but about which much seemed to assumed. Grounded theory seeks to discover meaning in context in order to clarify a situation which has elusive aspects, or to investigate phenomena which have taken for granted meanings. It lends itself to the study of contexts, interactions and processes over time.

Data interpretation was assisted by personal familiarity with the experience of hospitalisation as a relatively well person and by a professional understanding of the context. It was consistent with and informed by a symbolic interaction perspective. Symbolic interactionism is concerned with understanding the meanings of events to people in everyday situations and with the symbols used to convey those meanings. Symbols allow us to think hypothetically, to conjecture possibilities and recognise alternatives. Because of this we live simultaneously in the past, the present and the future. Meaning is constructed in social interaction and is time-bound, with past, present and future contributing to meaning construction (Wood, 1982).

Situations encountered by people in society are structured by common understandings and it is on the basis of these understandings that people initially perceive and interpret new experiences. From these common understandings they derive meaning, define situations and act towards others. However, as Wood (1982, p. 68) argues, "derived meaning will never correspond exactly with
intended meaning, so one person’s interpretation of another’s actions will not be identical with the interpretation placed by the actor on his or her behaviour”.

Within this symbolic interaction perspective, the human being has an objective self, a ‘Me’ with whom the subjective, processual ‘I’ can interact. “The conscious life is a continuous flow of things with which the self deals and takes into account” (Blumer, 1962, cited in Wells, 1978, p. 92). The ‘I’ may criticise, encourage, console, be angry with, set goals for and in effect, conduct an inner dialogue with the self. The processes of conducting the inner dialogue and of formulating actions takes place in a social context (but not necessarily in the presence of others) by identifying the things one must take into account: “...tasks, opportunities, obstacles, means, demands, discomforts, dangers and the like” (Blumer, 1962, cited in Wells, 1978, p. 95) then through assigning meaning and interpreting and defining the situation. The ability to engage in reflexive cognition is integral to these processes:

In observing people’s behaviour we derive hypotheses from our cultural knowledge to describe and explain their actions, and we test these against further information. We have to investigate the context in which the action occurs; have to generate possible meanings from the culture for other relevant actions (Hammersley & Atkinson, 1983, p. 16).

Within the framework of this study, adult patients with medical-surgical conditions brought cultural knowledge, experience, motivations and expectations to an Australian hospital context and to various situations within that context. They brought ways of behaving as adults as well as personal and vicarious experiences as patients. They had motivations of one sort or another (such as, to be a good patient, to act as one is expected to, to work at getting better, to not be a bother to others) which were culturally mediated. They had expectations (based on experience and socialisation) about what was likely to happen in the hospital context, and a capacity to freshly construct meaning, interpret symbols and define situations. Symbolic meaning directs the individual’s response to salient elements in a context including people, language, behaviour and object symbols.
For patients, salient features in the hospital context are the likelihood of pain and discomfort as well as the possibility of a return to wellness and of assistance from others. Nurses are with patients more than any other health professional and are important symbols of help and care. They in turn bring to the hospital context cultural knowledge of their own group as well as individual experiences, expectations and motivations, which could include the motivation to ‘survive’ in the face of considerable system pressures of one sort or another, as well as the motivation to provide care.

In summary, I wanted to understand the constructed meaning of comfort and discomfort to a particular group of hospital patients, and the actions which were taken - and not taken - in relation to these phenomena in a specific context. To gain this understanding I used a grounded theory methodology to sample the experiences of seventeen English-speaking adults who had been in hospital for two to seventeen days, in nine large and medium sized public and private hospitals in urban Australia. I engaged in focused, once-only, in-depth interviews with informants in their homes at some time following their hospital discharge, or in the post-acute stage of hospital care. Informants were selected for the likelihood of being able to construct a meaningful narrative, a series of descriptions of episodes and events, reflecting their comfort and discomfort experiences.

The interviews were audio-taped, transcribed, coded, categorised, compared, reduced and analysed at progressively higher levels of abstraction, with constant questions being asked of the data, “What is their perception of comfort and discomfort? What is happening here?”
8. 4. Analysis And Interpretation Of Findings

The process of analysis took into account the distinctive characteristics of informants and was achieved through activities of immersion in and distancing from the data through increasing levels of abstraction. Characteristics of the informant group are summarised below.

8. 4. 1. Distinctive characteristics of informants

In coming to an understanding of the nature of comfort and discomfort for these informants it was necessary to distinguish them from other patient groups. This is a different group of patients from others previously studied in relation to either comfort or convalescence. For the majority, there was no ‘woundedness’, no ‘brokenness’, no disabling or persisting severe pain, no significant life changes such as experienced by people with cancer, terminal illness, severe chronic conditions or disfiguring trauma, who had been informants in studies by Cameron (1988), Kirk (1993), Madjar (1991) or Morse, Bottorff and Hutchinson (1994). Informants’ situations were in the main, uncomplicated and straight-forward, requiring little medical attention once past the acute stage. They were essentially ‘well’ in a medical sense, temporarily displaced from some, but certainly not all, life-roles, activities and responsibilities, with every expectation of being able to resume these fully within a matter of weeks. Hospitalisation would be, on the whole, more an inconvenience than a catastrophic event. Accordingly, the existing literature on experiences of and adaptations to severe or disabling conditions was not relevant here for understanding the meaning to these informants of the comfort-discomfort experience in hospital.

8. 4. 2. The process of data analysis three levels

Analysis of transcribed interview data was achieved through a hybrid of immersion and distancing on three successive and deepening levels of abstraction.
The first level of analysis revealed a cluster of substantive themes which came from asking questions of the data about what types of comfort and discomfort informants described. The second level of analysis yielded a composite picture of the hospitalisation experience, written as a series of summative, descriptive statements (see Appendix 7) which was sent to those informants who could be contacted (twelve of the seventeen), for comment and validation. Each indicated substantial agreement with the second level of description.

Finally, after intensified efforts at analysis, asking not only 'what', but 'how', I was able to identify basic social-interactional and thinking processes which accounted for changes in the meanings being constructed by informants about comfort and discomfort. This level three analysis (Hutchinson, 1984) was a mix of strategies which when combined with a stage / phase analytic approach (Strauss and Corbin, 1990) and a return to the symbolic interaction literature (Bowers, 1988; Blumer, 1969) pulled together the grounded theory previously outlined.

The global problems of comfort and discomfort were clearly identified in the data. I found that, to deal with those problems, patients engaged in two major categories of active processes as they struggled with early convalescence in hospital. These were given the broad labels of finding comfort and of managing discomfort. Nested within these were sub-groups of processes which I labelled self-talk, an interpretive internal dialogue, and self-care, a personal action plan to meet comfort needs and reduce discomfort. Self-talk and self-care are constituted through a number of strategies, which are diagrammed below (Figure 8.1).
Figure 8.1  Study Findings Recapitulated

Adult Patient Experiences and Perceptions in Hospital

Experiences and Perceptions in Hospital

↓

Comfort / Discomfort  ↔  Self-Talk / Self Care  ↔  Finding Comfort / Managing Discomfort

↓

Comfort/Discomfort

Anticipating  ↔  Self Help

Interpreting  ↔  Seeking Help

Accepting  ↔  Accommodating

Making  ↔

Allowances  ↔  - Deferring

- Avoiding

Maintaining  ↔

- Persisting

- Desisting

Self Care

Finding Comfort/Managing Discomfort
While the diagram may suggest some linear relationships, the processes are in dynamic interplay with one another throughout the hospital experience. The theoretical findings were summarised, explained and sent to several of the original informants, as well as to selected colleagues. I invited individuals who had been hospitalised and who otherwise met informant criteria, and who were interested in the research, to comment and to point out any gaps or discrepancies they could find in the explanations I had derived from the data. Their responses fully confirmed the 'fittingness' of the theory.

While drafting this final thesis chapter, and seeking ways to link the study findings with existing theory, I came to appreciate that while immersion in the data was necessary if I was to remain true to it, distancing was equally necessary in order to reflect on and abstract additional meaningful interpretations. This distancing was assisted by returning to earlier literature and by searching the literature using different concepts suggested by increased awareness. For instance, I now found concepts such as the sick role and self-care particularly useful for thinking about convalescence and recovery. I also found connections which were now much more apparent between my data and studies on comfort and the aged, and comfort and oncology patients. These understandings about what the data was additionally suggesting, apart from the substantive theory, came gradually with continuing reflection on the narrative, the contemporary hospital context and on the experience of knowing (being, feeling, thinking) as nurse and as patient.

8.4.3. Important findings of the study

There were several important findings of this study. One of these was that comfort and discomfort were not opposite phenomena. As noted in the analytical findings they were often present simultaneously where, for example, attempts at providing comfort while well-intentioned and reassuring ultimately failed to
relieve a specific type of discomfort. Informants could be physically comfortable yet feel socially and emotionally isolated, cut off from empathic and companionable care. They could be intensely physically uncomfortable yet comforted by caring, protective, supportive and reassuring behaviours of staff which diminished the stress of discomfort.

While this finding might seem obvious to the reader, in clinical practice and in the clinical literature, comfort and discomfort have been taken to be largely mutually exclusive, possibly because comfort is seen to be assured by the giving of analgesia or other single measure. The nurse’s efforts to comfort are often confined within the narrow (but still important) parameters of adequate, regular amounts of pain relieving drugs, but limited to the period when pain is presumed to be part of the patient’s clinical problem, that is, commonly in the first hours or days of hospitalisation. Comfort viewed only in terms of pain and as the obverse of pain, is essentially a biomedical perspective and is ‘cold comfort’ indeed for the convalescing patient who no longer requires strong and frequent analgesia, but who expects nursing care to have a comforting dimension. Comfort was associated in the minds of this study’s informants with the notion of ‘the expert’, most often an ‘expert’ nurse who integrated physical and psychoemotional aspects of comfort in the care they provided. Informants arrived at a judgment of what and who was ‘expert’ using a variety of pragmatic criteria.

Comfort could come from support and advice of other patients who themselves were not seriously ill. However, being accommodated with sicker patients invited comparison with them, by both staff and patients, leaving informants with a kind of embarrassment at having to ask for nursing assistance and thus distracting the nurse from sicker and (perceived to be) more deserving patients. It was from contexts such as these that the meanings of comfort and discomfort were constructed by study informants. They were able to find numerous instances of caring and comfort, despite their varied experiences of discomfort. They engaged
in basic social and interactional processes of self-talk and self-care concurrently, in order to find comfort and to manage discomfort.

This study also contributes descriptions of the broad features of the convalescent experience for this group of patients, conceptualisation of hospital convalescence as transition and identification of the phenomenon of accelerated transition from high-dependency to self-care, which may involve in-hospital transfer and the severing of comforting social/professional bonds. The implications for recovery and convalescence of not re-forming these bonds with other staff following transfer, as well as the uncomfortable perception of some informants that no-one was now taking care of them, are issues of significance for nursing practice.  

8. 5. Self-talk And Self-care

As described in the paragraphs below, self-talk and self-care are the social, psychological and interactional processes suggested by the data and substantially confirmed by study informants as strategies they used to find comfort and to manage discomfort about a range of situations encompassed within the hospital experience. These statements are designed to provide a succinct conceptual summary of each of the processes and for this reason are written in a clipped, unelaborated style.

8. 5. 1.  Self-talk

Self-talk is a social and interactional process constituted of anticipating, interpreting, accepting, making allowances and maintaining perspective.
Anticipating: articulating to oneself in a broad way one's expectations of care in hospital; expecting as patients to be told what to do and what was happening, and expecting staff to give information and provide care; expecting hospitals to be busy places, and staff to be busy, but not too busy; expecting pain and discomfort; expecting help to get over these. Using context-specific information derived from interacting with staff and others to bring those expectations more in line with reality. As a result, anticipating and predicting via self-talk, how the next interaction might proceed.

Interpreting: noticing, being alert to and being involved with what is happening and attaching meaning to object, language and action symbols; having thoughts and feelings about what was happening; being able to 'size up' a situation, to 'take the role of the other' and make sense of what was happening; considering a range of options and finally deciding how to respond.

Accepting: weighing up a situation and coming to a judgment about its reality. When pain and discomfort were more severe than expected, or persisted for longer, or when care was less than expected, these adult informants acknowledged the situation in an inner dialogue. Accepting also meant acknowledging and valuing staff and others whose attitudes and actions lesseneded discomfort and/or were comforting.

Making allowances: being able to discern or imagine some circumstance/s which might account for the discrepancies between expectations and present reality, especially as they concerned hospital systems and routines and busy, well-meaning or over-worked staff. 'Taking the role of the other' in order to understand and tolerate the circumstances, and work through this via self-talk.
Maintaining perspective: a protective strategy of weighing up factors in the situation, enabling the individual to keep events in proportion and limiting the impact of discomfort, through comforting self-talk.

8.5.2. Self-care

Self-care is a set of social and interactional processes, constituted of self-help, and of seeking help and accommodating in one of four modes.

Self-help: when not fully physically dependent on others, the adult in this context is always in self-help mode, endeavouring within the physical, motivational or medically-prescribed limits imposed by illness, trauma or surgery, to be his or her own primary carer. The conscious, alert and oriented adult is always in self-care mode.

Seeking help: recognising when one's own resources were unequal to the task of achieving comfort. Self-help was maintained, but additional help was sought. The most obvious helper was the nurse; the most obvious strategy was to ring the nurse call bell or to go and look for a nurse, or ask someone else to do so. Occasionally seeking help from selected others may be appropriate.

Accommodating: adjusting and regulating help-seeking behaviour according to the meaning, constructed through an inner dialogue of self-talk, found in the current context. There are four options or modes for accommodating to the level of help available. Accommodation options included deferring, avoiding, persisting or desisting.
**Deferring:** putting up with ongoing discomfort and delaying a request until a nurse appeared, or was less obviously busy; or until a different nurse appeared.

**Avoiding:** thinking that you might, or should, be able to cope alone; or preferring to put up with pain or discomfort and not to ring the bell in case you were labelled a nuisance or your problem might be thought too trivial; choosing not to ask for help of some nurses because of direct or vicarious negative experience with them; or basing that choice on the interpretation of the nurse's present workload, or perceived attitudes or behaviour.

**Persisting:** making a choice to ask for help when no other course was feasible, that is, because pain and discomfort were becoming unmanageable; deciding that even if the nurses were busy, it was necessary to ask for help; deciding that even if the only nurse available might be annoyed at your request, you would take a risk and ring the bell, or you would get up and look for a nurse.

**Desisting:** deciding that asking for help was no longer an option, or was unnecessary, or would be useless or because the staff expected you to cope and/or would not have been able to help anyway.

### 8. 5. 3. Summary of the theory

In summary, a substantive and grounded theory was generated. It is a theory of patients finding comfort and managing discomfort in hospital, in non-life-threatening medical and surgical conditions, through strategies of self-talk and self-care.

The theory offers a set of credible explanations about the experiences of patients in a substantive area of medical-surgical nursing practice, of interest to
professional nurses. It met Strauss’ (1987) criteria for core categories and processes, in that finding comfort and managing discomfort through self-talk and self-care were a main concern or problem for people in the study. These processes accounted for and summarised patterns and variations of behaviour evident in the data, appeared frequently in the data, were central to the theory, are relevant and workable, and have significant implications for nursing theory (Benton, 1991; Strauss, 1987). They were derived from and ‘fit’ the data.

Theoretical concepts and propositions of the theory are consistent with concepts developed by George Herbert Mead and integral to the Blumer-Mead vision of symbolic interactionism. In particular, the centrality of interaction, notions of role, of the I-Me self in dialectical interaction, interaction with significant others in a symbolic environment, and the articulation of an inner dialogue through which situations are translated into understanding and through which the meaning of events, behaviour and conversations is uniquely constructed, are all clearly evident in the analysis of data and the grounded theory which was generated.

8.6. Links To Existing Theory

The degree to which a theory can be linked in some way to antecedent knowledge is one of its tests of strength. Finding comfort and managing discomfort are human, social and interactional processes which can be linked to existing established, recent and emerging nursing theory and scholarly writing about the nature of comfort (Beland, 1970; Cameron, 1988; Hamilton, 1989; Jacox, 1979; Kolcaba & Kolcaba, 1991; Morse, Borruff, & Hutchinson, 1994; Nightingale, 1859/1965, among others). The findings, for instance, are consistent with Beland’s (1970) description of discomforts as a significant physical stressor, with Cameron’s (1988) characterisation of patients as actively engaged in comfort-seeking, with insights from Hamilton (1989) on the multi-dimensional aspects of
comfort and discomfort, from Jacox (1979) on the reluctance of many patients to disclose their discomforts, sometimes out of fear of stigma, and from Molzahn and Northcott (1989) and Bergman (1983) concerning discrepant perceptions of comfort. Findings of this study are consonant with work by Morse (1983), who believes that comforting is the instrumental expression of nurse caring in the clinical setting, and with Morse (1992) and her observations of the varied ways in which nurses work with medical-surgical patients in acute situations to forestall and minimise discomfort.

The findings amplify the ideas of Lewis and Timby (1988) who in one of the few nursing texts to mention comfort, and to treat it as distinct from pain, characterise it succinctly as a constantly fluctuating inner sense of well-being, the outcome of physical and mental equilibrium, and discomfort as a change resulting from physical, psychological and environmental factors. However briefly alluded to in their text, comforting is included among those skills essential to nursing. Those skills are linked to the nurse’s understanding and acceptance of patients’ feelings and to the nurse as a stabilising figure during temporary illness. The findings also speak (albeit obliquely) to the results of an Australian nursing quality assurance review in 1986 which identified as constraints on quality nursing care, staff shortages and lack of time for education and for adequate documentation and evaluation of care (Lumby, 1986).

Consistent with the concept analysis of Kolcaba and Kolcaba (1991), experiences reported by informants were comforting in the sense of personal strengthening, transcendence or renewal, in addition to other experiences which reflected relief, ease and contentment. The need for patients to have wide-ranging support from nurses while healing is in progress is a Nightingale (1859/1965) dictum echoed in these informant narratives. Findings can also be linked to the growing literature on self-care and on factors influencing patient satisfaction with care, and of
compelling interest, the relationship between patient satisfaction and patients' perceptions of the interpersonal competence of nurses. These links will be discussed later in this chapter with implications of the findings for nursing practice. At this point, however, it seems relevant to focus on the notion of convalescence as it has been previously understood.

8. 7. Early Convalescence Re-visited

Historically, the return to well-being after illness, surgery or trauma was painful and protracted, with weeks of hospitalisation followed by possibly months of infirmity and gradual recuperation. It is only in the last decade or two that a number of factors have combined to speed up the recovery-convalescence phase, at least of hospitalised patients. These factors include advances in biomedical technology, anaesthesia, surgical techniques and post-anaesthesia care, extension of the intensive care concept to include units allocated to non-ventilated high-dependency patients, an understanding of the hazards of prolonged bed-rest and immobility, recognition of morbidity associated with nosocomial infection, and increasing demands on hospital services by high-acuity, aged and trauma patients requiring complex care. These appear to have resulted in a pragmatic classification of patients into two broad groups, the complicated and the uncomplicated. The discussion now turns to issues in convalescence, its contemporary re-conceptualisation and related assumptions.

8. 7. 1. Relative Lack of Literature on Early Convalescence

It was disappointing at first to find that much of the literature explicitly dealing with early convalescence is confined to recovery from myocardial infarction and open heart surgery, or to adaptation to chronic illnesses including stroke, angina, diabetes and rheumatoid arthritis (Ronayne, 1985; Glass and Matchar, 1993)
Writers who have themselves experienced the painstaking processes inseparable from rehabilitation (e.g., Cousins, 1979; Moore, 1991; Sachs, 1985) or who otherwise approach the subject from a broadly phenomenological perspective (Beckingham, 1995) deepen our understanding of climactic and anticlimactic experiences in illness and recuperation. Few writers, however, address the particular issues and population of relevance for this study. It was difficult to find contemporary literature on convalescence other than that on the topic of discrepant perceptions of patients and nurses about their needs, and surprising to find that most of what was relevant to the experiences of informants in this study was written twenty to thirty years ago.

8. 7. 1. 1. Nurses and short-term care of patients

Newman (1966) interviewed medical-surgical patients with a view to identifying patients’ needs and to discover ways in which nurses could meet those needs in short-span nurse-patient relationships. Her data analysis revealed that patients’ needs were predominantly emotional and psychological, stemming from fear, anxiety, loneliness and uncertainty. Patients needed information regarding their diagnosis and care plan and felt helpless due to lack of control over matters of most concern to themselves. Earlier studies cited by Newman (Skipper, Mausch & Tagliacozzo, 1963) reported that:

... patients in their study hesitated to ask for information from nurses because they perceived the nurses as being too busy, because they feared negative reactions and subsequent rejection, and because of their prior experience with unsatisfactory answers. It was hoped that nurses could help patients more clearly identify discomfort (Newman, 1966, pp. 78-79).

Newman, analysing her own interview behaviours, asserted the value of being alert to the patient’s cues, of taking a genuine interest in the patient as a person, and of presenting herself to the patient as ‘human’ and willing to appropriately self-disclose. Similar to Newman’s findings, both positive and negative
experiences were evident in nurse-patient interactions reported by informants in this present study.

8. 7. 1. 2. The work of getting well

Norris wrote about ‘the work of getting well’ after reflecting on her own recovery from a serious motor vehicle accident. She refers to convalescence as a number of formidable tasks which must be accomplished in the “not really well phase” (Norris, 1969, reprinted 1990, p. 49). Of particular interest is that, even in 1969, she refers to dysfunctional aspects of over-dependence and independence within in-patient care, and to the point in hospital care at which patients -

... are expected to get up and fend for themselves. Nurses attempt to force self-care on the patient without recognising that movement towards independence requires ... exploratory behaviour, initiative, some assertiveness ... new responses, greater responsibility and revision of goals; that is, reworking the tasks of an earlier phase of dependency ... independence cannot be demanded - it is an outgrowth of work, often of joint nurse-patient work (Norris, 1969/1990, p. 49).

Norris suggests that convalescence is arduous and that it must be negotiated between nurse and patient. She believes a nurse can make inferences about the tasks facing individual patients based on an understanding of the nature of the work of convalescence, and an assessment of the patient’s capacities to deal with them (Norris, 1969/1990). Mindful of the changes which have occurred in hospital care in recent years, some of which are clearly improvements, this present study has attempted to describe the still sometimes arduous work in hospital convalescence of finding comfort and of managing discomfort that patients with ‘ordinary’ conditions engage in. The work is physical, psychoemotional and social and makes significant demands on the diminished energy reserves of the vulnerable, recuperating individual. Patient work of finding comfort and managing discomfort is accomplished to a great extent without nurses particularly being aware of it, or assisting in it. The work is either unrecognised or taken for granted and because of this, nurses may neglect to
explore and develop, or indeed, may fail to retrieve, their crucial role as professional partners in patient care in fast-track, in-hospital convalescence of medical-surgical patients.

8. 7. 1. 3. Vital elements in the recovery process

Wolfer (1973) characterised recovery from surgery as both a set of biological processes of restoration and/or attainment of normal bodily functioning and a general psychological state, an evaluative continuum, "... the complex, multidimensional and changing affective and cognitive state of an individual as he (sic) undergoes hospitalisation and surgery" (p. 396). Combinations of both positive and negative feelings contribute to the person's sense of well-being at any point in time. Wolfer hypothesises that patient well-being would be relatively high

... when a hospitalised person has trust and confidence in the nurses and doctors, feels that he is being treated and understood as an individual person, understands to the point he wishes his illness and treatment, receives psychological support and reassurance when he requires it, believes he is a 'good' patient, accepted by staff and other patients, and is hopeful for a positive outcome ... [and that this] would be independent of his physical status and would reflect to a large degree how well is he being cared for (Wolfer, 1973, p. 397).

Wolfer's paper can be seen to reflect the humanistic focus on nurse-patient interaction and interpersonal dynamics prevalent in nursing theory and practice at that time, as well as an early research focus on the quality of patient care. He goes on to affirm that expressive nursing functions which support psychosocial needs arising out of hospitalisation and treatment, require nurses to develop and use high-order interpersonal skills which are at least as demanding as high-order instrumental-technical skills. These expressive interventions, provided within a total patient care framework and consistent with nursing theory, are intended to maximise the patient's comfort and psychosocial adaptation to recovery and rehabilitation (Wolfer, 1973).
In this present study, the excellent interpersonal skills of some nurses could be inferred, while others were clearly less aware of the importance of these for post-acute patients and for transferred patients. Such skills, because they facilitate rapport building, self-disclosure and meaningful assessment, often determine whether a patient will feel comfortable with the nurse, or be helped to become comfortable and at ease in a general sense. This finding has implications in the contemporary health care context for patient satisfaction, for the public perception of nursing as a profession, and of nurses as being ‘expert’ at what they are professionally accountable for doing, that is, providing skilled and caring nursing service.

8. 7. 1. 4. Concepts of the sick role

The literature on the sick role has considerable relevance for the way nurses interact with the convalescing hospital patient. The sick role has traditionally been considered a useful organising concept for discussing the expectations of others in relation to the behaviours of a person who is ill. The sick role, originally described by Parsons (1951, 1971) has undergone numerous re-conceptualisations and critiques and has stimulated research into illness roles and behaviour (Hover & Julesgaard, 1978). It is a structuralist-functionalist view of illness and illness behaviour, contrasting with more contemporary phenomenological and postmodernist understandings.

Expectations of the patient’s behaviours may vary with the understanding of caregivers about the phenomenological experience of illness, pain and discomfort and dependency (Campbell, 1975; Kretlow, 1990) as well as with the availability of resources. In very busy hospitals, a more stringent definition of patient dependency may be applied (Mechanic, 1968) with greater caregiver expectations of the patient’s self-care behaviours.
Several major weaknesses have been identified in Parsons’ work (Short, Sharman & Speedy, 1993). In particular, and of relevance for the findings of this study, the sick role concept does not account for changes in both illness and behaviour over time, nor for individual differences and variability in dependence and autonomy. Yet it seems possible in this present study that a simplistic understanding and uncritical acceptance by nurses of this and other narrowly-focused models of wellness-illness transitions might be continuing to influence nursing care. Patients were either in, or out of, the sick-role. If ‘out’, then there could be no legitimate claim on nursing energy and time, so that requests by patients to be made comfortable at any time after moving from the acute phase of care could be perceived (and occasionally were, in this study) as an unreasonable demand.

8. 7. 1. 5. Concepts of self-care

The literature on patient self-care and nurses’ management of it reflects polarised practices: either dependency is imposed inappropriately (Faugier, 1986) or nurses’ demands of patients exceed their self-care abilities (Kappeli, 1986). Kappeli described several categories of nurse helping behaviours in an acute medical ward and identified a continuum of nursing actions such as ‘enabling’, ‘tolerating’ and ‘showing interest’, through to ‘giving up’ and ‘withdrawing’. These latter resulted in a reduction of interactions with patients who had non-physical or atypical problems about which the nurses felt they could do nothing, in order to avoid uncertainty and ambiguity in the care situation. Nurses withdrew from patients who had “no nursing problems” (Kappeli, 1986, p. 42) despite their normative requirements for on-going support and pre-discharge health teaching. Kappeli’s findings are consistent with perceptions of informants in the present study about nurse behaviours which were either comforting (that is, at the facilitating pole of Kappeli’s continuum) or left them feeling very uncomfortable (at the ‘withdrawing’ and ‘giving up’ pole of the continuum). In
the present study, informants seem to have been viewed as generally requiring less nursing care rather than as requiring different nursing care.

A patient may be unaware of the likely length of stay in hospital or the anticipated time to resumption of usual life roles. He/she is thus unable to find consistency or predictability in the environment and is made more vulnerable through uncertainty. Compounding this is a lack of information about the system of care, about changed levels of care and of caregiver expectations (even requirements) that the patient take greater responsibility for his/her own care. In the acute stage of an illness, adults are generally willing to allow others to take care of them, relinquishing some of their self-care agency. In turn, nurses are willing to provide care for as long as they consider it appropriate, but may resent the perceived reluctance of patients to fully resume self-care. The patient is then obliged to be self-caring at a time when it seems reasonable to him/her to be given assistance.

8. 7. 1. 6. The place of caring in self-care

Nightingale (1859/1965) articulated the role of the nurse in caring for patients as one of supporting recuperative powers so that the patient would be in an optimal state for healing to proceed. If healing is seen as a process controlled to some extent by and within the individual, nurses can facilitate that process in a number of ways: through actualising values that centre on caring and quality of life, and by nursing actions which complement and may sometimes overlap medical care. Pellegrino (1985) notes that four senses of caring are integral to health care: (1) compassion for others, (2) doing for others what they can’t do for themselves, (3) using professional understanding and skill for the patient’s good, and (4) taking care in the sense of being diligent and skilful in actual practice. These enduring values of caring provide the motivation for the nurse to provide maintenance, restorative and preventive actions in order to promote health (Leininger, 1985
cited in Morse et al., 1990, p. 4). Caring also motivates comfort care and "... comfort is the most important nursing action in the provision of nursing care for the sick" (Morse, 1983, p. 6). One could also add that comfort is similarly important for the 'not yet well', that is, those who are in transition to wellness. This study highlights part of that transition and teases out the meanings informants gave to comfort and discomfort in this crucial period.

8.7.2. Transitions

Nurses deal with people experiencing a range of transitions. These may concern situational, developmental, existential and health-illness states. According to Meleis, transitions denote changed needs: "Transition requires the person to incorporate new knowledge, to alter behaviour and therefore to change the definition of self in social context" (Meleis, 1991, p. 103). People in transition have things in common. Citing earlier work (Chick and Meleis, 1986; Meleis 1986) Meleis (1991, p. 105) defines these commonalities as:

... disconnectedness from usual social networks and usual support systems; temporary loss of familiar reference points; new needs that may arise or old needs that remain unmet; old sets of expectations no longer congruent with changing situations.

Some of the findings of this study could be nested within the broad concept of transitions, with identifiable points of entry and exit. Entry of the person into the nurse-patient relationship, and similarly, into any patient-patient relationship, was a type of role transition. It was a transition from being someone unknown, to being someone at least recognisable; from 'outsider' or 'stranger', to someone familiar, someone having a degree of shared understanding of the world of the acute-care hospital, or at least a small part of it, through which a sort of camaraderie and human inter-connection could quickly develop.
8. 7. 2. 1. Transition to self-care

After high-dependency care, with mostly satisfying experiences of comfort and comforting, informants experienced abrupt transitions to self-care status without negotiation or explanation. Informants responded to such sudden transitions with an intensification of self-talk and self-care strategies. Transition to imposed independence could happen in a number of ways.

Firstly, informants were physically transferred to other wards, sometimes from a high-dependency to a lower dependency ward, or sometimes between wards with similar levels of care. This generally occurred without warning, with no information about the receiving ward being given to informants, which was interpreted as an alienating experience. It is likely that nursing staff were similarly abruptly advised of the impending transfer necessitated by an urgent admission.

The data indicate that staff of the receiving wards were slow to establish any kind of personalised relationship, sometimes to the point of not knowing or understanding the patient’s primary clinical problem, or of appreciating the possible impact of this on the individual. With inter-ward or inter-unit transfer, there was disconnection from the social support offered by friendly, caring staff, temporary loss of familiar reference points and expectations that were incongruent with the expectations of staff on the new wards. No matter that this support and familiarity had been engendered very quickly: this is the nature of nurse-patient interactions and characteristic of the kind of rapport which is rapidly established between experienced and skilled carers and willing patients and between individual patients having and sharing a wry acceptance of their situation. Not only was there social discontinuity, there was discontinuity of
service. For instance, transfer could result in less diligent wound care or lower analgesic cover, necessitating lengthy delays in obtaining comfort or pain relief.

Secondly, transition to self-care could be instigated by the abrupt withdrawal of supportive nursing care and effective transfer to self-care status of patients who remained in the ward but who were deemed now to be at a less dependent stage. Occurring for some informants as early as the second post-operative analgesic injection, the timing was less important than the impact of a lack of negotiation, consultation or preparation in relation to the move to greater self-care. Apart from a common-sense appreciation of the need to be active in their own recovery, a number of informants were dismayed by a feeling of vulnerability and felt a sense of disappointment about the absence of nursing attention, information and support.

Thirdly, informants who needed to return, however transiently, to a higher level of dependence on nursing staff after making ‘normal’ progress, sometimes met with difficult nursing attitudes. This could happen if they felt sleep-deprived, had a bad headache, were nauseated or especially fatigued, or even had developed some sort of complication such as a wound haematoma or infection. Nurses could become quite disgusted at what they perceived to be inappropriate requests for help. Informants who had minor set-backs early in their post-acute recovery felt they were blamed, or disbelieved, and that their clinical problems and feelings were of no interest to the nurses.

Finally, for some there was an abrupt separation from the hospital itself, with little notice being given of discharge, and little advice or preparation for post-discharge self-care. A number were simply informed by a doctor, not always one they recognised, that they were well, or at least well enough to go home. This
was followed by a social “Take care of yourself!” if a nurse happened to be in the vicinity, or even by an unwitnessed exit from the ward. These were, after all, medically uncomplicated patients.

Compton (1991), who investigated the meaning of illness to patients in Intensive Care, postulates that willingness to hand over control to medical and nursing staff “... explains why certain patients seem to resist resuming self-care after surgery or injury: they perceive a need to be taken care of [and] only later do patients define themselves as healthy and respond in socially acceptable ways such as joking with the staff” (Compton, 1991, p. 54). Compton’s conclusion here seems to be that the need to be taken care of is inappropriate in the circumstances. It seems that it is the responsibility of convalescing patients to live up to the expectations of staff about appropriate ways of behaving, that they really ought to do this sooner, and be good humoured about it into the bargain. This expectation is reflected in the constrained transition to self-care of informants in this study.

Madjar (1991, p. 238), in her discussion of the experience of severe pain in adult burn injured patients, stated that “... patients who continued to request pain-relieving medication were seen as relying on drugs to cope with pain, rather than relying on their own resilience and will to endure.” They were also perceived to be at serious risk of drug addiction. A distant parallel might be drawn here with informants in the present study, who were expected by nurses to be self-caring and self-reliant when they still needed nursing care. These expectations may have been shaped by a fear of patients coming to rely too much on nurses and this fear, vague and unexamined as such fears often are, may have been strong enough to justify distancing and routinised care.
As we have seen, inter-ward transfer often marked the exit point from a meaningful and therapeutic nurse-patient relationship and entry or transition to intermittent loneliness and vulnerability. One explanation of why this rapport was not established between nurses and patients after transfer may be found in the following section.

8. 7. 2. 2. Definitions of wellness

Perhaps caregiver expectations concerning the behaviour of convalescing patients as outlined in the previous paragraphs, are the key to the puzzle of scaled-down nursing assessment, interaction and care of these patients. Biomedical definitions structure the meaning of clinical situations for many nurses. Such definitions of wellness, which are narrowly conceived in relation to nursing and to phenomenological experiences of patienthood, may have influenced some nurses’ views of the meaning of early convalescence for informants in this study. The first step in alleviating discomfort is to recognise the way in which it is present or at least to confirm its absence. The focus of nursing assessment in this stage should be on functional well-being, on needs for nursing care, and the on particular knowledge needed by the patient to self-care in the present circumstances and after discharge. It was otherwise for a number of this study’s informants. This may have been due to remote, one-sided assessment and an assumption by nurses that ambulant patients were well enough to do without any but perfunctory nursing care. Adult patients try to be cooperative and to retain composure, they try to be ‘good patients’ and not to bother busy nurses. They may not overtly signal their discomfort and thus they make it easier for it to remain invisible, and to be ignored or overlooked unless there is deliberative assessment and continued nursing surveillance.
8. 7. 2. 3. Health-illness-health transitions

Another transition of some significance in this study was along a health-illness-health trajectory, that is, moving from relative autonomy as healthy adult, to relative lack of autonomy as a patient, then precipitately back to relative autonomy while still defining oneself as a patient. In symbolic interactionist terms, the 'definition of the situation' and the way that definition is arrived at are critical concepts. Again we need to consider the polarity of functionalist and interactionist perspectives.

The emphasis in functionalism is in looking at things from the point of view of the social system: all activities are considered in relation to the contribution they will make to the functioning of the system and in relation to the over-all pattern pattern of norms and of social integration. Actions are, therefore, viewed as rational or otherwise in terms of their contribution to the system as a whole (Worsley, 1977, p. 549).

In contrast to this, an interactionist perspective is that in an ordered society, while there is approximate agreement about how situations should be defined, different people will view a situation differently and just as validly. It is, therefore, important in researching from a symbolic interactionist perspective to understand how a situation is defined by the informants in a study. Their definition of the situation is their reality (Berger, 1963; Worsley, 1977) and at times, the reality as defined by informants in this study led to some uncertainty and dismay. Much of this came from informants' 'definition of the situation', that is, from defining themselves as patients needing some assistance and nurses as logically there to help, but finding that help was not provided. The nurses' definition of the situation may have been that the changed status of the patient meant that the patient was 'well' as distinct from early convalescent and 'not yet well'. This definition may partly be related to a dominant bio-medical model of care in the organisational context of the acute care hospital.
Structural-functionalist conceptions of the sick role underlie the attitudes of many health care professionals that patients regarded as 'medically well' should behave accordingly, that is, conform to normative expectations and not make demands on the staff (Bond & Bond, 1986). From a symbolic interaction perspective, this health-illness-health transition and patients’ and nurses’ role behaviours were mediated through both nurses’ and patients’ definitions of the situation and these shaped the expectations of each.

Informants quickly learned through nurse-patient encounters that self-care was expected of them. However, they were not adequately prepared for this by any facilitative or educative process. Figure 8.2 overleaf represents a health-illness-health trajectory for acutely ill patients with a good medical prognosis. The upper diagram depicts an Ideal Model of health-illness-health transition in which there is a gradual transfer of responsibility for self-care to the patient as he or she moves through convalescence. It broadly suggests the amount of care (comfort and safety work) which nurse and patient must do before the the patient leaves hospital.

The lower diagram of Figure 8.2 depicts findings from this grounded theory study indicating premature withdrawal of nursing care at some point after the acute phase so that the patient is left alone and unsupported. The point of withdrawal varies with the patient and their condition - it may be hours or days after a dependency 'finish line', defined by doctors and nurses, has been reached. With the exception of very short-stay patients and the first informant, all informants in this study experienced premature withdrawal of needed care. (The modes of withdrawal of nursing care in the post-acute stage of hospitalisation have been outlined in section 8.7.2.1.)
Figure 8.2  Comfort Work in Hospital Convalescence

Ideal vs Actual Model

Ideal Model
Patient Expectation & Nursing Assumptions

Actual Model
What Study Findings Show

Nurse Work
Patient Work

Pre-Hospital | Acute Phase | Convalescent Phase | Post Hospital

Nurse Work
(Pain & Comfort)

Patient & Nurse Variables

Patient Work:
Comfort & Discomfort

(Optional Arduous)

Pre-Hospital | Acute Phase | Convalescent Phase | Post Hospital
8. 7. 2. 4. Other variables in the transition to wellness

Two broad sets of contributing elements in health-illness-health transitions in this group of patients can be mapped in the following two figures as other/extraneous variables and as types of safety and comfort work done by the nurse, by the patient, and by nurse and patient dyads during hospital convalescence.

These important extraneous variables (suggested by Wolfer, 1973, and depicted below in Figure 8.3 constructed to depict these as ‘Other Variables’) influence the relative ease with which a person makes the transition back to wellness. They include such things as social support, family supports and economic supports, other structural supports including community health services, intrapersonal/intrapsychic factors such as temperament, hardiness, coping, locus of control, sense of humour, beliefs and belief systems, the nature and severity of the condition and of any co-morbidities.

It is important for person-centred care that nurses are aware of variables which influence the course of an individual’s recovery from illness, trauma or surgery. Some of those factors shape the meaning of what is happening and thus, the individual’s definition of the situation, particularly of those situations which are likely to have a negative impact on patient well-being. Such awareness by nurses ideally sensitises and shapes the care provided for each individual patient and assists nurse and patient in mutual goal-setting. However, some of the factors referred to above and depicted in the figure are clearly outside the sphere of the nurse’s influence to moderate, and therefore while recognised as significant, will not be further alluded to in the context of the following discussion on nurse and patient comfort and safety work.
8. 7. 2. 5. Nurse and patient work in the transition to wellness

Convalescence from acute medical-surgical conditions is a transition requiring at least two kinds of work by patients, by nurses, and by nurses and patients working together. The work is safety and comfort work on physical, social, environmental, spiritual and psychoemotional levels. Varieties of nurse and patient comfort and safety work evident in the analysis of transition in the context of this study include nurse work (comfort and safety), patient discomfort and comfort work (self-talk, self-care), interactive nurse and patient work
‘connecting’ or ‘bonding’ work) and nurse and patient partnership work (distinctive tasks for each, with the same desired outcome: successful transition through early convalescence.) I broadly clustered the work that each does as safety and comfort work.

8. 7. 2. 6. Safety work

Safety work broadly encompasses vigilance in surveillance and protection, both of which may be pro-active or responsive to particular threats. Safety work is accomplished in part by surveillance in an effort to anticipate, manage and limit threat and vulnerability.

The safety work of patients, their surveillance work, emerged from the data as an issue of threat and vulnerability, and of self-care in relation to potential or actual threats. This kind of patient work, exemplified in excerpts from the data presented in Chapters Five, Six and Seven, may well have gone unnoticed by staff. Surveillance of staff and equipment by patients in this study who felt vulnerable, was done discreetly (that is, covertly) and was part of their invisible work.

The work of nurses, especially their safety work, was only glimpsed in the data as suggested in Figure 8.4, overleaf. The clinical and psychological safety work of nurses was only occasionally visible to informants but would be easily detected by or inferred by any experienced nurse reading the transcripts.
Figure 8.4  Health-Illness-Health Transitions

Safety and Comfort Work in Hospital

Transition: Health-Illness-Health

Hospital Convalescence: Recovery from Acute Medical-Surgical Conditions

Patient Work
Nurse Work
Nurse & Patient Work

Other Variables

Physical
Social
Environmental
Spiritual
Psycho-emotional

Glimpses of Patient Safety Work

Surveillance
Safety/Comfort Work
Invisible Work of Patients
Anticipating
Managing/
Limiting
Threat & Vulnerability
Safe Practice

Glimpses of Nurse Safety Work

Surveillance

Safety & Comfort Work in Hospital
Nurse safety work was sometimes overt, such as checking on drainage tubes and other equipment, handwashing, putting bed railings in place and ensuring patient identity before drugs were given, as is consistent with safe practice. The safety work nurses did covertly was to anticipate, manage and limit threat and vulnerability through unobtrusive surveillance during technical care, in addition to discreet consultation and collaboration with other health care providers about clinical problems, with a tendency to minimise to the patient the significance of actual problems or potentially problematic clinical signs.

This covert safety work was intended to protect informants against unnecessary anxiety, but again, this work could take on a routine character. For instance, this routinised covertness was probably operating when staff withheld analgesia from a patient who on admission had acknowledged and sought assistance with an increasing alcohol intake. Staff seem to have decreased the dose or prolonged the intervals between doses without explaining why he would have to put up with his headache. From his point of view it was untreated for much longer than he could tolerate, to a point when he felt despair. With this informant, an explanation of his (probable) liver dysfunction and the risks of increased doses of analgesia might have made the pain more bearable or even may have opened up possibilities for dialogue and negotiation with care providers about his heavy drinking. On the other hand, routinising care leads to this sort of action which may not always be based on biochemical evidence of impaired liver function, or indeed, of any evidence.

8. 7. 2. 7. Comfort work

Patient comfort work has been explained in the grounded theory. Nurse comfort work was achieved through physical care such as re-positioning, attending to hygiene needs and providing adequate pain relief. Nurses enhanced physical
comfort care through attitudes and behaviours conveying empathy and interest, thus contributing to psychological, social and spiritual comfort. These attitudes and behaviours could offset discomfort, and could not be separated from a global perception of nurse competence. This safety and comfort work represented integrated caring. Both expressive and instrumental competence needed to be evident for most study informants to be comforted. Activities which demonstrate the nurse’s skill and compassion help patients come to a judgment about nurse competence. Perceptions of nurse caring and competence (that is, of their interpersonal and technical skills) constitute a major part of the global sense of satisfaction with care (Carey & Posavac, 1982; Hyland, 1993; Morales-Mann, 1989; Ware, Snyder & Wright, 1983). Carey and Posavac (1982) found that

... patient satisfaction with nursing care was strongly influenced by the perceived competence of the nurses and the clarity of their answers to patients' questions (Carey and Posavac, 1982, 42-48).

Thompson (1986) summarised findings on the relationship between interpersonal skills of caregivers and patient outcomes. Good interpersonal skills contribute to better patient assessment, greater patient satisfaction, quicker recovery and greater tolerance for pain and discomfort. This is supported by a recent Australian study which showed that technical and interpersonal skills of health care workers were the most influential factors in determining patient satisfaction (Westbrook, 1993). In reflecting on being a patient, Zaner (1985) saw trust and confidence as prerequisites for getting well.

Patients want to know that those who care for them, really care. To want to know what is happening to them, and to want to be cared for are wants that are most pronounced at the very time when people are most vulnerable, exposed, disrupted, even bewildered - when we are ill, injured and distressed, and thus not always able to say what we want or need. ...ways of relieving these forms of suffering are difficult to come by and quite low on the current totems of medical and nursing education and practice. ... Patients may be uneasy, ... or unhappy with the treatments they receive but commonly are reluctant to say so (Zaner, 1985, p. 98).

Where care is routinised by any level of nurse, from assistant to specialist, interaction between nurse and patient becomes superficial and the patient's
problems which potentially are amenable to nursing intervention, may never surface or be disclosed. Increasingly, patients are likely to regard professional nurses as functionaries, simply doing as the doctor has told them to. They are perceived, as a recent study of medical-surgical hospital patients who had been in hospital for at least two days has revealed, as being available only for physical care, and to whom they would be reluctant or unlikely to confide anything of a personal nature (E. Cameron-Traub, 1993, personal communication, June 16, 1993).

8. 8. Applying The Substantive Theory Of Finding Comfort And Managing Discomfort

This study throws light on the nature of adult patient perceptions and behaviours which can guide nurses in their verbal and non-verbal interactions with them. Informants in this study could be characterised collectively as undemanding, cooperative, sensible, mature, tolerant and flexible, able to size up a situation, accept it and accommodate to it, always in self-care/self-help mode, aware that nurses were very busy and seeking help from them only when necessary. They relied on nurses to interact with them as responsible but temporarily vulnerable adults who continued to require some kind of professional nursing care until discharge.

An understanding of early hospital convalescence and of the substantive theory developed from this study can equip nurses to interact purposefully and empathically with patients, to promote expectations in keeping with present day system constraints, to involve patients in some negotiation about what can or ought to be accomplished at various critical points in the transition to wellness. It is at these critical and vulnerable points in the hospital experience such as prior to or soon after transfer from high-dependency care, during any clinical set-back
which deviates from a normal trajectory, and in the period prior to discharge, that lasting impressions of care are created.

Lasting impressions of nurses as expert carers and comforters emerged from this study. Nurses who took time to smile, to listen, to banter, to share and to understand the moment, to respect vulnerability, to protect, to minister physically and psychoemotionally, to get patients through distressing situations and to move them forward with their encouragement, to sustain and to respect patients’ fortitude - all these were glimpsed through patient narratives.

As well, an indelible impression of nurses being too busy was imprinted on informants of this study. This is a common experience of patients and their relatives in many health care settings. Inevitably, some nurses were perceived to be too busy to be approached for help; they were too busy to make ‘nursing visits’ to assess and check on patients; they were too busy to stop and talk for a few moments. They came only to do tasks, and busily departed. ‘Too busy’ signals were sent via non-verbal behaviours such as not looking at the patient but looking at the equipment, only coming in to take and record observations, standing at the end of the bed, greeting patients in a casual way with no ‘follow-through’, speaking abruptly or hurriedly, showing indifference or exasperation and ultimately, failing to provide comfort or lessen discomfort on any level.

The theory contributes to an understanding of the nature of convalescence as a sometimes arduous process which is assisted by caring nurses who have a clear idea of their role in fast-track rehabilitation. The theory can assist nurses in anticipating the types and incidence of discomfort a patient may experience from admission to discharge and guide nursing responses, assessments and interventions which promote comfort on a number of levels.
8.8.1. The grounded theory: other applications

The findings from this study may be applicable to other groups of patients, because it reflects quite basic interactional processes which are enacted in health care contexts when cognitively unimpaired adults attempt to construct meaning from their past and present understandings. The findings of this present study could have validity and utility for nurse-patient interactions in many patient-care settings, and they remain to be tested therein. These findings resonate with the work of Jacox (1979) and Hamilton (1989) who studied aged residents in nursing homes, with studies in oncology patients, and with a recent study by Brown and Lumley (1994) dealing with obstetric patients’ perceptions of and satisfaction with care in Australian hospitals, all of which were closely linked to staff-patient interactions and the provision of comfort. In addition, the theory may be relevant to the significant others of child and adult patients, who in a close sharing of the patient’s experiences, may engage in similar processes, in similar constructions of meaning, and who may generate similar responses.

8.8.2. The grounded theory across cultures

Would this theory be applicable in other cultures? Wherever systems dominated by functionalism and economic rationalism constrain time, subtly structure interactions and limit the vision of nurses for the possibilities of making a difference which are inherent in their professional patient care role, this theory could be usefully applied as a way of understanding how expectations and context shape the meaning of interactions.

In a qualitative investigation by Finnish nurses, Finnish patients were reported to have similar expectations of nurses to those of informants in this present study, while nurse and patient expectations were found to be discrepant. Routine-like attitudes and loss of responsibility for the client through inter-unit transfers were
recognised by nurses and patients as significant barriers to good nursing care (Haggman-Laitila & Astedt-Kurki, 1994).

The informally verbalised experiences of people from Asian and Mediterranean countries in Australian hospitals suggests that there are more commonalities in their expectations of care than differences. Admittedly, we do not have a great deal of evidence one way or the other about the reasoning and meaning-making processes of people from dissimilar cultures and health care contexts. However, the intelligent, anticipatory, and culturally sensitive approaches advocated by Kanitsaki (1993), Kerslake (1988) and Stiles (1990) for culturally distinct patients, are required by all patients in health care settings in developed countries. Sociocultural and psychological comfort measures reflect the nurse’s willingness to acknowledge, respect and be sensitive to individual patient capacities, values and goals, to spend time in one-to-one communication, establishing rapport, determining patient care needs, and translating to the patient, and modifying as needed, the plan of care. These constitute comfort measures in that such actions were comforting and reassuring and were an important part of the satisfying experiences related by informants in this study.

8.8.3. Limitations of the study

Limitations in a qualitative study may be conceptual or methodological and are those which may decrease its auditability, credibility and fittingness. Conceptual limitations refer to the way in which the study was conceived. In nursing research, three broad questions must be asked about a project: Was the problem researchable? Was it of significance - did it pass the “so what?” test? Did it fill a gap in the literature? I posed these questions before developing the proposal and the answers, justified throughout the thesis, have remained confidently affirmative.
Methodological limitations of any interpretive study may be found in the choice of methodology and its appropriateness for the research question, in the strength of its link, if any, to an underlying epistemology, in threats to ethical and methodological rigour and ultimately in the fittingness of the analysis and the conclusions drawn about the findings. In this study, in keeping with Australian university practice, data collection, analysis and write-up were done by me as sole researcher, and were my first attempt at qualitative research. While I had support and guidance from the Faculty supervisory panel, any shortcomings in the quality of the analysis stem from my own limited research experience and my decision to use a challenging epistemological framework and methodology.

In collecting narrative data I was conscious of time constraints for the informant and for the study generally, and of being very much an apprentice in the realm of field work. Limitations may have resulted from the design which called for a single interview with each informant, although there was always an option to follow up particular aspects with informants. It was sometimes not possible to pursue every interesting avenue that presented, nor was it feasible in terms of the proposal I had written, to broaden the study to include nurses' perceptions of comforting.

My analysis was informed by, and at the same time risks being limited by, my ability to recognise and search the literature for meaningfully related concepts. The decision to seek confirmation from interested and articulate informants and others demonstrates 'elite bias' which Morse and Johnson (1991) defend in principle but which may possibly be questioned by others. Another possible limitation is my own tacit knowledge of the context and of patients such as these, and by my sense of nursing as commitment, both of which could infer a degree of intrinsic bias. The problem of the intersection of tacit knowledge and assumption in such a study continues to exercise my mind: does tacit knowledge strengthen or does it ultimately constrain interpretation? Can one ever be completely aware of
one's assumptions? Threats to the validity, credibility and fittingness of the data are therefore as outlined above but they have been reduced by rigourous supervision, by purposeful consideration of potential and actual threats and by a determination to keep these to a minimum throughout the entire study.

Symbolic interactionism has been criticised as culturally limited. Perhaps the grounded theory which emerged from this study is, in fact, limited to cultures and systems which profess to value the individual, to take account of subjective realities and to manage social change in stages and by consensus. However, it may not apply to recent migrant patients who may have significantly different experiences and expectations, or those from a different language background and social and health care system. It may not apply to culturally distinct Aboriginal and Torres Strait Islander people about whose hospital experiences there is little information and who may characterise comfort and discomfort entirely differently.

8. 9. Implications For Nursing Practice, Management, Education And Research

The findings of the study have implications in a number of areas of professional nursing.

8. 9. 1. Purposeful nursing assessment and communication

Being moved unpredictably through decreasing levels of care and finally separated from the hospital's services was quite purposeful, but only from a functionalist point of view, which did not take account of the patient's need to have it all explained. Given the likelihood of precipitate inter-ward transfer or discharge due to acute pressure on beds, nursing assessment in the early post-acute period should focus on the patient's definition of the situation, expectations
of care and confidence in their ability to self-care so that the nurse can identify education and information needs. Nurses could utilise a knowledge of discharge-planning principles and negotiation skills to prepare patients for inter-ward transfer as well as for eventual ‘separation’ from hospital, by advising them of a changed level of care and of the nurse’s intentional fostering of their independent self-care.

Comfort is important to patients and to their satisfaction with care. Nurse comforting on all levels begins with phenomenological understanding which guides assessment. Skilled comfort care is always person-centred. It takes time to assess, personalise, implement, evaluate and remediate, however efficiently these activities are carried out. When nurses are faced with undiluted pressures to be efficient and to contain costs, comfort is one of the first casualties of care. This must be of concern to nurse managers, but only they have the legitimate power to institute and support change in the direction of appropriate person-centred models of nursing care. Skilled comfort care takes time and costs money to provide and the dilemma facing nursing administrators cannot be overlooked. This is a dilemma for the nursing profession as a whole as Duffield and Lumby (1994), among others, clearly point out. Managers need the support, the energies and the creative insights of their clinical and academic colleagues in addressing this serious problem.

8.9.2. Fast-track rehabilitation and self-care

With the well-established trend to shorter hospital stays, day-only surgery and care-mapping, nurses are collaborating with other health care providers in streamlining patient education, preparation, evaluation and follow-up procedures. A number of medical-surgical patients will not have the benefit of day-only surgery or investigations and will continue to require slightly longer hospitalisations. They must be supported by a commitment to individualised care
based on careful, regular rather than once-only assessment of functional abilities and readiness to self-care. An additional measure would be a pre-arranged follow-up telephone call on days one and five post-discharge by the ward nurse who could provide any needed advice and reassurance to the patient at home. With discrepant expectations and no shared 'definition of the situation' between patient and nurse, avoidable patient discomforts, including psychological ones, will continue to constitute an unmanaged problem. The humanising and transforming potentials of nursing care are then under-actualised, and opportunities to highlight the important professional role of nurses in post-acute hospital care are missed.

From the foregoing it can be seen that existing practice in the areas of assessment, communication and individualised care planning need to be strengthened if nursing care is to make a difference. Expectations acted as a reference norm for these informants. The degree to which a set of care expectations is met is an important determinant of patient satisfaction with care. Patient satisfaction with care, while not being the only indicator of quality of care, is nevertheless an important dimension of it (Rempusheski, Chamberlain, Picard et al., 1988). This study suggests that patients' expectations of ongoing care were often not met, and that they were vulnerable and uncomfortable in the absence of skilled nursing care. When they needed nursing - as distinct from medical - care, it was often prematurely withdrawn and they were left to struggle alone through the remaining days in hospital.

A number of factors collectively influence and constrain the work of the nurse in hospitals, so that comfort is the missing ingredient in the care of many hospitalised persons. One crucial factor is an enthusiastic acceptance by some health finance managers of the ideology of self-care, a perspective which can be used to justify the precipitate withdrawal of caring and comforting interventions, including psychosocial ones, in the name of patient autonomy. When aligned
with an economic view of self-care as reduced reliance by this group of consumers on costly health care resources, self-care creates the illusion of patient empowerment without any substance.

Curriculum design, funding issues and clinical practice arrangements in undergraduate tertiary nursing education are another significant factor in the comfort and discomfort experiences of patients. Providing opportunities to examine the phenomenological nature of nursing, of empathy, of the meaning of patienthood, illness, hospitalisation and of their relationship to comfort and discomfort within the practice of professional nursing could lead to a revaluing of caring and of comfort. Setting student clinical practicum objectives relating to assessment and intervention for discomfort would support clinical nurse teachers in their efforts to emphasis and model comforting and comfort measures, and to encourage reflection on issues of comfort and discomfort.

8.9.3 Testing the fit of the grounded theory in practice

Some suggestions for testing the grounded theory were made in Chapter Four. Systematic testing or evaluation of the applicability for practice of any nursing theory (or any theory for nursing) is retarded by the difficulties inherent in measuring outcomes in and for those most affected by the implementation of the theory. The pressure on health professionals today is to demonstrate through outcomes research that they do, in fact, make a difference. To date, few outcome standards which would serve as measurement criteria for the theory's applicability have been developed. The difficulties, while not insurmountable, are compounded by the need to muster sustained administrative, financial and clinician support for such activities (Silva & Sorrell, 1992). Research to develop outcome standards and to measure/evaluate outcomes for acute convalescent care will be a vital ingredient of demonstrating that nursing care is effective - that it does make a difference.
The desired outcomes implicit in the substantive theory reported in this thesis would include improved nurse-patient communication, improved patient assessment, improved post-acute and post-transfer patient care, increased patient satisfaction with care and increased levels of work satisfaction for nurses. As nurses become more aware of the importance of research for professional survival, this support in relation to action research and microethnographic studies is likely to be mobilised more readily and initiated more effectively by nursing leaders in education, administration and practice. At a more pragmatic level, nurses who are able to understand the perceptions of comfort and discomfort of their patients, as well as the strategies used by them as conceptualised, explained and supported in this grounded theory, will be able to apply these understandings in a more coherent manner to their care of adult patients.

8.9.4. Further exploration of comfort and discomfort

A recent concept analysis of comfort by Kolcaba (1991) has provided a conceptual structure on which to build clinical nursing research and to develop comfort assessment tools. However, discomfort is not well understood apart from its few and limited descriptions. It is understood most simply in relation to physical pain (and then not in terms of the explanatory model of the attributions and meanings of pain provided by the gate control theory) and has not been conceptually analysed in the same way or to the same extent that other phenomena of relevance to nursing are beginning to be. Nursing interventions to relieve discomfort need to be framed as ‘trials of interventions’, accurately documented and carefully evaluated.

Discomfort is not the opposite of comfort, and this study has clearly shown that both comfort and discomfort can be simultaneously experienced. Rather, the two phenomena appear to be in more than simply an inverse relationship, and this
provides some direction for further investigation. This study has usefully served to open up the topic for future research.

Experiences of health care of 'ordinary' patients merit investigation, not only because of the significant numbers of hospital patients who lie within this non-critical care category, but also because of unvalidated assumptions which may be made about those experiences.

8. 10. CONCLUSION

The patients' work of finding comfort and managing discomfort through processes of self-talk and self-care has been explained. Much of the work was mundane, solitary and taken for granted by informants and nurses yet the work of self-monitoring, interpreting and finding meaning in the clinical situation had comfort and safety aspects which were important for patients' wellbeing.

To some extent, but not fully, pre-study assumptions have been validated. Comfort and discomfort are multi-dimensional, subjective and interdependent with the context in which meanings were constructed. The active role of patients in finding some sort of comfort and in managing their discomfort is shown by this study to be much more important than was earlier assumed. Intense physical discomforts were accepted by these informants with much less residual distress that I had previously thought. The range of psychoemotional discomforts revealed by informants was of clinical and research interest, as well as reinforcing the importance of interaction skills to support technical competence.

The findings of this study, which originated in questions concerning the awareness of and response to patient discomfort, challenge the assumption that comfort is an integral and consistent part of normative and therapeutic nursing care. They indicate the significance of the relationship of skilled (that is, both
technically competent and empathic) nursing care to patient comfort and thus to patient satisfaction. The theory generated in this qualitative study had been triangulated with existing theory (Sandelowski, 1993) on nurse-patient interaction and the nature of discomforts experienced by hospital patients.

The nurses' decisions not to 'mollycoddle' the recovering patient by giving 'too much' assistance, and the practice of remote surveillance and assessment were not comforting for these informants. The presence of the nurse is an important therapeutic symbol. The assertion that 'nurses must not assume that a well-intentioned act will be experienced as care' (Brown, 1986, p. 62) found strong support in this study. Nursing comfort and safety work need to be made more explicit to patients and their families, simply because it is comforting for them to know that their nurses are both competent and caring. Patients need to know that a particular nurse is looking after them.

Grounded theory ought to have explanatory power. This theory, grounded securely in the data, informed by a symbolic interactionist perspective and affirmed by informants as consistent with their experience and understanding, provides a credible explanation of the way in which adult post-acute medical-surgical hospital patients found comfort and and managed discomfort. Stronger associations between expectations, the manner in which 'definitions of the situation' were arrived at, and the way patients responded, have emerged.

This study provides new insights into the experiences and perceptions of a particular group of hospital patients whose situation had not been previously studied in this way, but which had aspects which have been, and are still being, taken for granted. By 'taken for granted' understandings in relation to the early convalescent period, I mean that it can be reasonably inferred from the findings of this study that there is an implicit, uncritical acceptance by hospital staff of the prevailing, objective functionalist view of wellness as absence of symptoms
requiring medical intervention. Early convalescence trajectories are narrowly conceived (if thought about at all) as a rapid and uncomplicated return to relative wellness for the majority of patients.

'Taken-for-grantedness' is a form of assumption, a kind of stereotyping which sets up particular expectations, directs attention towards particular phenomena and by inference, directs it away from other phenomena. It reduces the impetus to question or the need to consider other perspectives such as the patients’ subjective view of what is happening, or the possibility of conceptualising post-acute nursing care in terms of fast-track rehabilitation, or in terms of a partnership in which nurse and patient explore together self-care capabilities and deficits and collaboratively plan and assign roles and responsibilities.

Lastly, the theory can provide improved understanding of factors influencing patients’ perceptions of wellbeing, an increased sense of the importance of nurse-patient interactions and heightened awareness of the important role the nurse can play in early convalescence. Knowledge about the processes of finding comfort and managing discomfort by patients in early hospital convalescence can guide nurses in the selection of nursing behaviours likely to support and enhance self-care abilities and patient autonomy. It is vital for nurses to be (and to be perceived by patients as being) interested, caring, knowledgeable about phenomena such as illness, injury, healing and recovery, capable of intelligently assessing, and skillful in diagnosing, planning and negotiating therapeutic interventions which are appropriate and acceptable to the individuals in their care.
APPENDIX ONE

Patient Comfort Diary

Explanatory notes

The Comfort Diary was developed and trialed in the first four pilot interviews at the same time as audio taping and interview procedures were practiced and evaluated. The diary eventually took the form of an A5 booklet with a plain buff-coloured fine cardboard cover. It was either handed directly to recruited informants to whom I provided a verbal explanation, or sent with covering letter and explanation (included here) to those recruited over the telephone.

The introductory pages, two typical pages and the concluding page of the Comfort Diary are included in this appendix. Every other diary page concluded with a slightly different re-inforcing message to encourage continued entries.

While all informants were assured that the diary was private to them, several diaries pressed on me by informants were found to have interesting observations and descriptions which did not emerge in the interviews.
**Letter which accompanied the diary when posted to informants:**

Reseacher home address
and telephone number

Dear <Name of recipient>,

Thank you for agreeing to assist with my research in our recent telephone conversation. I enclose an explanation of the research and a diary for you to look at which may trigger some memories about your experiences of comfort and discomfort while you were in hospital.

The diary is private to you. You do not need to show me any notes you have made about your thoughts and experiences, but you may find it helpful to have nearby when we meet to talk.

I look forwarding to speaking with you and will telephone in a few days to arrange a convenient time. We would need to be in a fairly quite palace and free from interruptions if at all possible. Thank you for agreeing to my audio taping our conversation.

Yours faithfully,

________________________

Annette Clare Walker
Explanation of research procedures.

I am a university-based registered nurse conducting research about the way patients in hospital experience comfort and discomfort. Providing comfort is an important part of nursing care, but very few researchers have asked patients how they feel about comfort while in hospital and about what sorts of things make them uncomfortable. In attempting to find out about your experiences, I am hoping to be able to add to our knowledge of how to improve our care of people in hospital.

The study has been approved by the University's Human Ethics Review Committee. The study will be supervised by senior academic staff of the University. I am bound by strict rules to maintain privacy and confidentiality of all information and to respect your rights as a person helping in a research project. You have the right to withdraw your participation at any time. I would be happy to sent you a summary of the research findings at a later time, if you would be interested.

In this study I will ask people who have been in hospital fairly recently to talk with me about what was comfortable and uncomfortable for them in hospital. This will be at a time and place convenient for the person concerned, and could take upwards of an hour. You have agreed to have our conversation audio taped. You may wish to read a copy of the transcript; if so, a copy will be sent to you. I may have to clarify some points with you at a later time, and meet with or briefly telephone you in order to do so. Thank you.
COMFORT DIARY

As a nurse, I am interested in finding out how patients in hospital feel about comfort and discomfort.

You can help provide a picture of comfort and discomfort in two ways.

The first way concerns this diary - by thinking about comfort and discomfort, and about things that make you comfortable or uncomfortable, and by keeping this diary - A COMFORT DIARY - of your experiences of being comfortable or uncomfortable from now until you go home from hospital.

The second way you can help me better understand comfort and discomfort is by talking with me about your experiences of comfort and discomfort, a few days after you go home from hospital.

Please keep your Comfort Diary so that you can refer to it when we talk together later on.

Comfort is a very important part of the care that is provided in hospital.
Comfort can mean a lot of different things.

Comfort can be physical, emotional, or spiritual. Comfort can be related to all sorts of people in a hospital environment, and to things that go on around you in hospital.

The same applies to discomfort.

Discomfort can be physical, emotional, or spiritual. Discomfort can be related to all sorts of people in the hospital environment, and to things that go on around you in hospital.
I would be glad if you would take the time to note in your Comfort Diary as many of your experiences of comfort and discomfort in hospital as you can, from now on.

For instance -

What kinds of things help you to feel comfortable, or to become comfortable again?

What kinds of things make you feel uncomfortable?

Are there times, or places, or situations in hospital when you feel more comfortable? Are there times or places or situations when you feel more uncomfortable?

It would be helpful if you could make entries in your diary as many times as you feel like it, but at least a couple of times until you go home from the hospital.

Because the diary is personal to you, no one should ask to see your diary.

Please turn the page and begin your diary.
Would you please note the date and time of day for THIS diary entry.

Date: ________________  Time: ________________

What are your experiences of comfort and discomfort AT THIS TIME of your hospital stay?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Thank you. Please continue to make diary entries.

or

Thank you. Please be sure to make a diary entry as often as you can.
Would you please note the date and time of day for THIS diary entry.

Date: ________________ Time: ________________

What are your experiences of comfort and discomfort AT THIS TIME of your hospital stay?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Thank you. Your diary entries will help develop a broader picture of what comfort and discomfort means to you.

or

Thank you. Your diary entries are an important contribution to this project. Please keep making them.

or

Your thoughts and feelings about comfort and discomfort in hospital will be most helpful. Thank you for continuing to make diary entries.
Please keep your diary until we talk later.

I will contact you soon to arrange a further meeting. I can be contacted through (02) 685 9020 during the day. Thank you.

Annette Walker

FACULTY OF HEALTH STUDIES

UNIVERSITY OF WESTERN SYDNEY, NEPEAN

Hawkesbury Road, Westmead, 2145

(02) 685 9020

Thank you. Please be sure to make a diary entry as often as you can.
APPENDIX TWO

Explanation to Nursing Staff Facilitating the Study

Explanatory notes

The explanation below was given verbally and in writing to Nurse Unit Managers (NUMs) who had been approached to assist with accessing possible study informants. It was first used in piloting the procedures and in later in-patient recruitment in another hospital.
Explanation to those facilitating the study

My name is Annette Walker. I have worked as a registered nurse in hospitals since 1960 and as a lecturer in Medical-Surgical Nursing in the Faculty of Health Studies, University of Western Sydney, Nepean, since 1986. I am currently enrolled in the Master of Nursing (Honours) Course at this university.

I am undertaking a qualitative research project about the way patients in hospital experience comfort and discomfort. The study has been approved by both hospital and university Ethics and Research Committees.

Providing comfort is an important part of nursing, but very few researchers have asked hospital patients how they feel about comfort, what is uncomfortable for them, and what happens when they become uncomfortable.

Participants in this study are patients who are in hospital who are judged by the nursing staff on their wards as being well enough to be invited to be a part of the study. They will be asked to write down a couple of times a day for a couple of days their feelings and experiences of comfort and discomfort, and what they did to obtain relief. These notes will not be accessed by the research nurse or by staff.

The procedure for recruiting participants will be as follows: Patients who meet the criteria for the study (English-speaking adults aged 30-55 years, in the post-acute stage of illness or surgery) will be identified through NUMs of those wards where potential informants are located. NUMs will be asked to identify those patients who have toilet privileges, who can hear, speak and write and who are well enough to have a conversation with the research nurse. Thank you.
APPENDIX THREE
Informant Consent Form

CONSENT TO PARTICIPATE IN RESEARCH

I __________________________ hereby voluntarily consent to participate in the Research Project entitled:

"Hospital patients’ perceptions of comfort and discomfort"

being conducted by Annette Clare Walker of the Faculty of Health Studies, University of Western Sydney, Nepean.

The procedure set out in the information sheet, "Explanation of research procedures" has been explained to me. I understand the benefits and risks involved. I have agreed to participate on the understanding that I may withdraw my participation at any time without affecting my treatment.

I understand that the information obtained from this study may be used in future research and may be published. I have been given the assurance that any personal information about me will be kept confidential and that my right to privacy will be respected at all times.

Name: __________________________ Signature: ______________

Date: ______________

Witness name: __________________

Signature: ______________ Date: ______________
APPENDIX FOUR

Semi-structured Interview Schedule

Explanatory Notes:

This semi-structured interview schedule was developed as part of the pilot proposal. After evaluation of early pilot interviews, as noted in the Thesis Methods Chapter (p.109) the first question was subsequently omitted and replaced with a question about what had brought the informant into hospital. The questions below constituted the skeleton of the interview and were those which I felt needed to be asked at every interview. *Probe questions were varied to meet the needs of the interview. Other questions which were prompted by analysis of previous interviews were incorporated, in what might be termed “theoretical interviewing”*. I added a question about self-help in discomfort after the early pilot interviews, and was flexible about the order in which the questions might be asked. In a number of instances, the questions were answered without my having to ask. I took the schedule with me to every interview and before concluding, checked that I had covered all important areas.
CHECK AND TEST EQUIPMENT BEFORE LEAVING HOME

* Tape recorder, spare tapes, batteries and spare, neck microphone, pad and pencil

* Check name, address, phone number, time.

* Take flowers, chocolates, book vouchers.

INTERVIEW SCHEDULE

* Ensure informant has diary to refer to.

* Test equipment and set agenda with statement of purpose.

* One question to begin.

* ALLOW FOR SILENCES

* Make notes for points to follow-up and clarify.

* VALIDATE possible meanings during the interview.

BEFORE CLOSING

* Check schedule items have been covered.

* Ask if there is anything we haven’t covered about the informant’s perceptions and experiences of comfort/discomfort.

* Set up possibility of follow-up (brief) interview.

FOLLOW UP: Send a summary of the findings.
Interview Schedule

I would like to begin by asking What comes to mind when you say the word comfort?

Probes: Can you give me an example? What type of comfort would you call that?

The following will be asked if the respondent does not raise them

Were there times (or situations) when you felt especially comfortable?

Probes: Can you tell me a little more about that? What sort of comfort was that?

Did any particular people make you feel comfortable?

Probes: Can you tell me how they went about making you feel comfortable? What was important to you about the way they did that?

Were there times when you felt uncomfortable?

Probes: What happened then? Go on. Can you tell me what type of discomfort that was for you?

Some people talk about ways they help themselves to cope with discomfort. Was there anything you did which helped?

Did you want communicate you discomfort to others?

Probes: To whom? How? When? What happened then?

Was it difficult for you to speak about your discomfort?

Probe: Did you feel ignored or shut out, or unable to communicate effectively with a caregiver at any time?

Did you have any expectations about comfort or discomfort when you went into hospital?
Did your expectations change in any way?

Probe: Can you tell me a little more about that?

How important was comfort to you?

What kinds of comfort were most important to you?

CHECK WITH INFORMANT ABOUT ANY OTHER COMFORT/DISCOMFORT ISSUE.
APPENDIX FIVE

Typical Page of NUD•IST Transcript

Explanatory notes

NUD•IST (Non-numerical Unstructured Data Indexing Searching and Theorising), was developed in Australia by Lyn and Tom Richards of La Trobe University, Victoria. The package has many advantages for the computer literate, and is interactive and generally user friendly. The transcribed (word-processed) coded interviews are transferred into the program, which facilitates retrieval of large volumes of data and keeps track of expanding numbers of codes (nodes) and sub-codes (node trees) and any modifications to these. Interviews, lists of codes, as well as individual codes with supporting text, can be transferred back to a word processing file and printed out as results files as often as needed. The program produces statistics on the data and records the dates of any changes to node trees.

Each word-processed transcript when entered into NUD•IST becomes a separate document, which has numbered lines of text. Documents are printed out, manually substantively coded, and the codes labelled with accompanying line-numbered text are re-entered into NUD•IST. Any passage in any document may be coded for a number of data concepts, e.g., time, role, expectations, psychoemotional comfort, and so on. Statistical data on each document is available.

For the purpose of explanation, the excerpts on the next page were a small part of node 15, TIME. These same passages may also have appeared under other nodes. I organised this node on the date indicated and present it here in order to illustrate how one works with NUD•IST. TIME was a substantive code in all seventeen transcripts, but was merged in the analysis so that it did not persist as a core category.
**TEXT UNITS 1138-1157**

BT: Yeah, there's some that um haven't got the time of day with you and there's others um, like that sister, you know, I mean she spent ages ringing the library and sitting and talking to me and um she was great, she really was and then there's another one, you know, they'll come in and its um they'll do your obs and um, hardly pass the time of day with you, you know, and um, they're busy, you know, there was one nurse yesterday she came in yesterday afternoon, three times I asked her to put the hydrua, hydra, herodroid on my, on my bruises and she said kept saying I'll come back in a minute, I'll come, she never came back and in the end I got um, the little, I got Lynette to do it for me, she came in and I said, cause I can't do it myself, you know, so I said to her can you just put some um herodroid on this, cause I can Barbara, you know, no, nothing was any trouble, the other one, alright she probably was busy, you know, but um, those are little things, you know, that can build up into big things when you're in hospital, you know, at home you push it off, you wouldn't worry about it

**TEXT UNITS 1171-1176**

BT: Definitely, they got too much on their plate um and there's not enough um assistance for them it's um, they're just don't, they're just running around, they don't have a chance to, you can, I see why mistakes happen um and why they um don't have the time with the patient because there's, there's just not enough time in the day for them sometimes
APPENDIX SIX
Example of NUD•IST Node List

Explanatory Notes

This is a node list (list of codes) which had accumulated by the second stage of the analysis, when data collection was almost completed. The node list represented substantive codes identified in interview transcripts. NUD•IST allows the researcher to create a node tree with branches which initially permits teasing out of shades of meaning, or identification of sub-categories or sub-groups in the data (see for example, Node 2, People). This proliferation of nodes/codes is balanced by eventual re-arrangement and reduction in the number of nodes/codes through a process of questioning the meaning, relevance and place of each in relation to emerging cognitions and intuitions about core categories.

As data reduction proceeded, most nodes/codes were subsumed under constructs such as psychoemotional, physical, social, environmental comfort and discomfort and finally, under core categories of comfort and discomfort. Other nodes which did not fit well within these two main categories were kept separate. I found that Node 1 (demographic data) was irrelevant for my purposes and discarded it. Any codes which did not fit neatly, authentically and logically into these core categories were either discarded, or retained as important ‘other themes’ in the data which did not directly bear on the substantive theory eventually generated. Finally, twenty-four node clusters were reduced to two categories - comfort and discomfort. A single page is presented here for illustration only.

It should be noted that while this was an extremely helpful computer program, it did not replace analytical thinking and the development of my own constructs, propositions and substantive theory.
(2) / People
(2 1) / People / nurses
(2 1 1) / People / nurses / specialist nurses
(2 1 2) / People / nurses / non-specialist
(2 1 2 1) / People / nurses / non-specialist / enrolled nurses
(2 1 3) / People / nurses / night
(2 1 4) / People / nurses / busy
(2 1 4 1) / People / nurses / busy / too busy
(2 1 5) / People / nurses / good ones
(2 1 7) / People / nurses / NOT getting to know you
(2 1 8) / People / nurses / not good
(2 1 9) / People / nurses / night nurses and PE discomfort
(2 2) / People / doctors
(2 3) / People / ancillary staff
(2 3 1) / People / ancillary staff / cleaners
(2 3 2) / People / ancillary staff / wardsmen
(2 3 3) / People / ancillary staff / food service
(2 4) / People / other patients
(2 4 1) / People / other patients / helping each other
(2 4 2) / People / other patients / patients
(2 4 2 1) / People / other patients / patients / considerate of nurses
(2 4 2 2) / People / other patients / patients / perceptions of nurses
(2 5) / People / visitors
(2 5 1) / People / visitors / family
(2 5 2) / People / visitors / friends
(2 5 3) / People / visitors / others
(2 5 4) / People / visitors / nurses in and out
(2 5 6) / People / visitors / too many
(2 5 7) / People / visitors / inappropriate
(2 5 8) / People / visitors / collect
(2 6) / People / patients - self-care
(2 7) / People / physiotherapists
(2 8) / People / family

(3) / Comfort
(3 1) / Comfort / Physical
(3 1 1) / Comfort / Physical / Pain relief
(3 1 2) / Comfort / Physical / positioning
(3 1 3) / Comfort / Physical / hot shower
(3 1 4) / Comfort / Physical / shampoo
APPENDIX SEVEN

The Story, Covering Letter, Response Sheet

Explanatory notes

In early stage three of the analysis I had a lot of data, a sense of where it was leading me, a tentative substantive theory, but felt at an analytical standstill. I took the advice of Strauss and Corbin (1990), wrote the following story and sent it with a covering letter and response sheet to as many of the informants as I could contact. I had completed sixteen interviews at this stage. Of the twelve responses, all were in agreement and some added supportive and confirmatory remarks.
Covering Letter  Dear <Name of Informant>

Some time ago you spent time talking with me about your perceptions and experiences of comfort and discomfort in hospital. Your perceptions have added greatly to my understanding of the hospital experience for you.

As part of the analysis process, I have written a summary, a collective narrative, a story about the experience of hospitalisation which I have gleaned from interviews with people such as yourself who were informants in this study.

I would be glad if you could find the time to read the story and think about whether any part of it is consistent with your own experiences. **It is important for me to have a completely honest response from you**, since if the story does not reflect some of your experiences then I need to go back and re-think what I have come up with so far. To have to do this is not at all unusual, so please feel free to be quite candid about your response to the story. I have enclosed a response sheet with three options, and space for comment. The paragraphs are numbered so that if you found you did not agree with any paragraph, you could more easily identify it.

I am most grateful for your interest and time.

Yours sincerely

______________________________

Annette Clare Walker
A Story of Adult Patients’ Medical-surgical Hospital Experiences

This story is about the way hospital patients with medical-surgical and ultimately non-life-threatening conditions perceive and experience comfort and discomfort. From repeated reflection on the interviews with people who had been patients, I have developed a series of paragraphs, a summary of what I think you and others have told me. I have numbered the paragraphs here so that if you have a difficulty with any particular part of this story, you could indicate the problem paragraph.

1. Adult patients enter hospital with several expectations/anticipations. These have been acquired from previous experiences, both personal and vicarious. These expectations surface prior to, on, or soon after admission.

2. There is an expectation that care would be efficient and organised, that there would be routines, with someone in charge and that the work of caring for patients would get done, mostly by the nurses, who would be busy, and thus not be able to spend a great deal of time with any patient, but who would look in on you and be attentive and pleasant. The nurses would not be too busy to provide adequate care. Patients expected the nurses to know what to do, and that nurses would follow doctors’ orders.

3. Once in hospital, adults make a transition to a different role, the patient role. As patients they interact with staff in a number of ways and create meaning from each encounter, by noting and interpreting verbal and non-verbal cues given by others. Sometimes, encounters between staff and other patients are observed and interpreted and the meanings applied to the self. These meanings tended to either modify or to reinforce expectations of care.
4. Respondents in this study experienced comfort as **physical comfort** including pain relief, positioning, hot showers, shampoos, back rubs, pillow fixing and supportive devices, but it seems that in the main, comfort was experienced as **psycho-emotional and social comfort**.

5. **Patients’ psycho-emotional comfort** appears to be associated with:

a) a sense of being adequately looked after (staff concerned with safety, for their well-being; patients knowing what is going to happen, and having a general trust in the system and in the people running it);

b) with the friendly, professional relationships they make with empathic, caring and expert staff and

c) with the support and companionship provided by family, friends and sometimes (transiently but still significantly) by other patients (with some exceptions).

6. Hospital medical-surgical patients experience a variety of **expected physical discomforts**, such as wound pain, soreness, nausea, back ache, headache, the presence of various necessary uncomfortable tubes or pieces of equipment. Some respondents in the study reported discomforts which were not anticipated by the researcher and had not been mentioned very much in the literature, such as intense fatigue, sweatiness, uncomfortable beds and the side effects of drugs including taste alteration, loss of appetite, intense itchiness and hallucinations.

7. A considerable range of **negative emotions** were identified as psycho-emotional and social discomfort. Psycho-emotional discomforts which were more or less expected were apprehension, worry, concern, sadness, homesickness. However, a number of other negative feelings associated with hospitalisation
were reported as loneliness and isolation, vulnerability, apprehension, sadness, depression, frustration, annoyance, anger, disappointment, boredom, dependence; and varieties of discomfort associated with the patient role, with impaired communication, inadequate information and with a decreased sense of autonomy.

8. **Patients’ Psycho-emotional discomfort** appears to be associated with

a) a sense of not being adequately looked after (fear for safety, perceived lack of concern for their well-being, not knowing what was going to happen or what to expect);

b) perceptions of (some) staff as non-empathic, uncaring or inexpert and of hospital routines as rigid, and;

c) excessive, noisy or inappropriate visitors;

d) or distressed other patients.

9. **Staff attitudes** were important. The data indicate that “you sized up the nurse and decided whether you could ask for help.” How did you decide? - they way they talked, what they said, the way they “mucked around” with you, joked with you; their tone of voice, exasperated or kind; how often they came, how long they stayed, the physical, social and emotional closeness or distance; the content of communication, impersonal or personalised; were they “too busy” to be asked for help. Did they look at you, or only at each other or at the equipment?

10. Nurses’ attitudes were **interpreted by patients** as indicative of a number of things: how empathic, available, helpful the nurse was likely to be; were they seriously interested, so that they would be likely to listen to the patient, or notice if care or help was needed; or was sociability simply surface-deep?
11. Patients noted nurse behaviours and conversations such as being relaxed, talking about their families, seeing you as an individual, taking an interest in you, asking “How are you today?”, being attentive, i.e., checking on you frequently and asking, “Are you in pain?”, “Are you alright?”; and maintaining some level of assessment and observation throughout the hospital stay. These were interpreted as interest, encouragement, acceptance; even by some informants as evidence of expertness.

12. Most respondents in this study engaged in some kind of inner dialogue (“self-talk”) about people, events and situations they met with in hospital. This dialogue or conversation with themselves, was a way of interpreting and defining each situation, accepting its reality, sometimes making allowances for busy staff, and usually as a way of maintaining perspective, keeping things in proportion, in a stressful situation. Many patients found some form of humour eased their situation.

13. Respondents in this study recognised a need to be as independent as possible, as soon as possible. In a number of instances, how independent and how soon were a point of contention, not always openly addressed, between nurses and patients.

14. In some cases there was a perceived premature withdrawal of supportive nursing care without this being negotiated with patients. In this case, the patient would make some psycho-emotional adjustment to the situation and engage in self-caring behaviours, mostly without asking for further assistance unless it was absolutely necessary. This situation, where it existed, led to feelings of disappointment, anger, vulnerability and sadness or depression.

15. Nurse attitudes, behaviours and conversation could mean the difference between comfort and discomfort for patients. They were being noted and
interpreted by the patients as genuine, caring expert nursing behaviour; or as impersonal, inexpert or uncaring - the latter being regarded by most respondents as the exception.
Response Sheet

A story of adult patients’ medical-surgical hospital experiences

Please select a statement, tick the box and return the sheet in the pre-paid envelope provided.

YES: The story on the whole fairly accurately reflects many of my experiences as a medical-surgical hospital patient. [ ]

NO: The story does not reflect any of my experiences as a medical-surgical hospital patient. [ ]

TO SOME EXTENT: The story reflects a few of my experiences as a medical-surgical patient in hospital. [ ]

I did not agree with paragraph/s _______________________
(Please note the problem paragraph numbers.)

Comments: _______________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

If you would prefer to comment over the telephone, please ring (02) 631-4041 Thursday-Sunday evenings; or (02) 685-9020 during working hours. Thank you very much.

Annette Clare Walker
APPENDIX EIGHT
Testing the Theory

Covering letter and response sheet

Explanatory Notes

This letter, a compact version of the analytic findings (not included here) and a response sheet were dispatched when the discussion chapter was being drafted.

The title of the thesis was very tentative at this stage, and has since changed.

I requested two faculty peers, one of whom had recently had hip surgery, to read and comment on the shortened version of the analytical findings.

I sought as well as met by co-incidence two people who had recent hospital experiences and who otherwise would have met the criteria for inclusion in the study, who agreed to read the findings.

The findings were also sent to six of the informants whom I could contact with relative ease, after inviting their feedback by telephone, since I knew this could be an imposition. I was gratified to have full and enthusiastic confirmation of the findings.
Dear <Name of Informant>,

Finding comfort and managing discomfort:


Thank you for taking the time to read the attached overview of the findings of a study which investigated perceptions and experiences of comfort and discomfort of people in hospital. Informants in the study were seventeen adults hospitalised for a variety of medical and surgical conditions, in a variety of hospitals in eastern Australia.

My purpose was to uncover, by a careful analysis, social and interactive processes through which people in early hospital convalescence found comfort and managed discomfort. I believe they found comfort and managed their discomfort through processes of a self-comforting inner dialogue, self-talk, and through accommodating to the realities of their hospital experiences via self-care strategies.

The final write-up of the study is in progress, and your feedback will be important in that I will take account of your responses. The thesis will be submitted to two external examiners. It is common for examiners to suggest corrections and improvements, which leads me to my first request, that is that you consider this material a) confidential and b) tentative.

My goal is to make a contribution to excellence in nursing care, through eventual publication of the findings. What you will read below is a grounded theory, which came out of my understanding of what people told me of their comfort and discomfort experiences. You can help by reading it and seeing if you think it
is a reasonable account of the medical-surgical hospital experience, and something which could apply to other adult patients. If you are able to recognise some of your own experiences in what follows, it could help nurses in developing a better understanding of early convalescence in hospital, and of ways in which they could provide comfort for patients.

Please consider whether the findings are similar to your own experiences in any way. You may think that these findings are so commonplace that it is hardly worth the mention. If so, I will be delighted. In any case, you comments will be of considerable help. If what follows does not "ring true" or come anywhere near your own experiences, then I need to go back and re-think my conclusions. Whatever your response, please feel free to be completely honest.

I have included a form for you to tick, to indicate your response - the extent to which you can recognise the situations - and a reply paid envelope for its return. It would be most helpful to have your response within a week or two if at all possible. I am most grateful for your time and interest. Yours sincerely

__________________________

Annette Clare Walker
Response sheet:

Finding comfort and managing discomfort:


Response options:

YES: On the whole the findings reflect many of my experiences of comfort and discomfort as a hospital medical surgical patient.

I used self-talk strategies similar to those in your theory.

I used self-care strategies similar to those in your theory.

NO: The findings do not reflect any of my experiences of comfort and discomfort as a hospital medical-surgical patient.

I did not use self-talk strategies.

I did not use self-care strategies.

TO SOME EXTENT the findings reflect a few of my experiences of comfort and discomfort as a hospital medical-surgical patient.

I managed my discomfort in different ways, such as:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

I found comfort in different circumstances, such as:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________
APPENDIX NINE

Abstracts and publications noted here were either presented at conferences and/or submitted for publication during the course of the study.

Conference Abstracts:


Papers:


Conference Abstract:

Conference: The Adventure of Nursing Practice through Research:
A Brave New World.

Sub-theme: Critical issues facing the nursing profession.

Title of Paper: The Comfort and Safety of the Hospital Patient:
Are we losing sight of the essentials?

Author: Annette Clare Walker, Faculty of Health Studies,
University of Western Sydney, Nepean. Tel:(02) 685-9020; Fax: (02) 685-9059

Purpose and objectives: To explore the comfort and discomfort experiences and perceptions of adult medical-surgical patients hospitalised for non-life threatening conditions.

Significance of the research problem: Patients and nurses believe that providing comfort is an important part of nursing work. However, many health professionals now equate comfort only with pain relief and the administration of analgesic medication. Comfort and discomfort are felt on many levels of experience. Discomforts are serious stressors which are often not perceived as pain, and may be under-reported and left unremedied because patients think that nurses are too busy, and should not be bothered. Comfort and discomfort are broad concepts which are in danger of being lost from the conceptual lexicon of professional nurses engaged in direct patient care.

Methods, design, analysis: A qualitative research design was used. Informants were seventeen adult patients who had been discharged after periods of between two to fourteen days, from nine hospitals in Australian metropolitan areas. Data were collected and analysed using grounded theory methods. Results suggest that patients a) suffer a wide range of discomforts which are persistent, variable in intensity and amenable to non-technological nursing interventions; b) are extremely reluctant to ring the buzzer for nursing help and would rather tolerate discomfort if they sense the nurse is busy; c) experience accelerated, un-negotiated transition from high dependency care to self-care; d) may not associate professional nurses with their safety and comfort; e) actively work to restore their comfort and to manage discomfort.

Implications for nursing research and scholarship: Reductionist perspectives ignore the comfort/discomfort work done by patients. Non-technological nursing care may be undervalued and invalidated. Discomfort is poorly assessed, documented, managed. The therapeutic effectiveness of nurses may be diminished by abbreviated algorithmic assessment in an acute biophysical model which influences much of the nursing care provided in hospitals. Studies are needed which shed light on the complex contextual factors influencing the assessment and management of comfort and discomfort by professional nurses in Australian hospitals.
Conference Abstract:

*Today's Research for Tomorrow's Practice*

The experience of hospitalisation.

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**Aim:** To investigate the experiences and perceptions of comfort and discomfort in hospital, of adults admitted for non-life-threatening medical and surgical conditions.

**Main methods:** A qualitative approach and grounded theory methods were used. A symbolic interactionist perspective underpinned the study. Seventeen adult Australians aged between 30 and 69 years were interviewed within weeks or months of discharge from hospitals. Informants, admitted for a range of common medical and surgical conditions, had spent between two and seventeen days in nine accredited Australian hospitals, both public and private. Data analysis was achieved progressively, on three levels. A number of themes were uncovered, and a substantive theory of finding comfort and managing discomfort in hospital was finally generated. This paper provides an overview of the experience of hospitalisation which emerged out of the Level II analysis.

**Results:** Informants expected physical discomforts, and that nurses would be busy, but not too busy to help them become comfortable. They expected to have a sense of someone looking after them throughout the hospital stay. Comfort and discomfort were primarily psychoemotional, physical and social. Psychoemotional comfort was associated with a sense of being adequately looked after; with professional-social bonding; with knowing what is going to happen; and with trusting the system and the people running it. Nurses who integrated technical and expressive aspects of caring were viewed as expert. Psychoemotional discomfort was associated with perceptions of (some) staff as uncaring; impersonal hospital routines; excessive, noisy or inappropriate visitors; other patients who were distressed. Informants were extremely reluctant to ring the buzzer for nursing assistance. They were always in self-care mode and recognised the need to be independent as soon as possible, but how independent and how soon were not negotiated. When informants experienced premature withdrawal of supportive nursing care, they accommodated to the situation and intensified self-caring behaviours but with a sense of vulnerability, disappointment, anger. Nurses' attitudes, behaviours and interactions could mean the difference between comfort and discomfort.

**Conclusions:** The adult experience of hospitalisation for this group of informants was bound up with expectations of care, health-illness-health transitions and interactions with caregivers. The findings bring their perceptions of comfort and discomfort into clearer focus and have the potential to enhance understanding of the short-term acute care hospitalisation experience.
RESEARCH FOR PRACTICE

Making a Difference

Making a difference in Nursing Practice: Patients’ perceptions of the ‘expert’ nurse.

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Introduction. The aim of this study was to investigate the experiences and perceptions of comfort and discomfort in hospital, of adults admitted for non-life-threatening medical and surgical conditions.

Method. A qualitative approach and grounded theory methods were used. A symbolic interactionist perspective underpinned the study. Seventeen adult Australians aged between 32 and 67 years were interviewed mostly within weeks or months following discharge. Informants, admitted for a range of common medical and surgical conditions, had spent between two and seventeen days in nine accredited Australian hospitals, both public and private. Data analysis was achieved progressively, on three levels. A number of themes were uncovered, and a substantive theory of finding comfort and managing discomfort in hospital was finally generated. This paper deals with informant perceptions of the ways in which ‘expert’ nurses made a positive difference to their experiences of comfort.

Findings: Perceptions and experiences of comfort and discomfort were shaped by informant expectations that nurses were there to help you and that they had a role to play in healing. There was an idea of the ‘good’ nurse as one who would “go out of their way” to see that patients were comfortable, and to whom nothing was a bother. Information and explanation were important to informant comfort, and staff who provided this helpfully and patiently were regarded as “excellent”. Informants provided brief vignettes of ‘expert’ nurses and glimpses of skilled nursing which depicted deliberate casualness and ordinaryness when patients’ well-being was under threat in some way, and which distracted and supported patients through painful procedures. There were also glimpses of nurses who were perceived by informants as “too busy” to give care that was adequate in terms of relieving discomfort or of providing comfort. While no one could question the complexity of demands made on nurses’ time, it is evident that nurses whom informants regarded as ‘expert’ were able, in a few moments and convincingly, to convey verbally and non-verbally, that they knew what they were about and that they cared. Expert staff were an important source of comfort: nurses who “knew what they were doing” in Casualty, in Intensive Care, in high-dependency wards, in medical, surgical and post-natal wards and in short-stay wards, were reassuring. They gave informants (as temporarily vulnerable adults) confidence that all was as it should be, that someone was looking after them. Nursing comfort and safety work need to be made more explicit because it is comforting for patients and families to know that nurses are both competent and caring.
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