INTRODUCTION

We often discover what will do,
by finding out what will not do.

Smiles, Samuel1 (1812–1904)

My personal experience of being a patient in hospital suggested the possibility that the patient has a different perception of the quality of nursing care delivered from the perception of the nurse providing the care. Smiles aptly captures the impetus for undertaking research into the experiences of nurses receiving nursing care.1 As we have entered an era of economic rationalization and the complexity of technology has increased, so the demand on the nurse’s time has increased. The boundaries defining quality nursing care are continually changing. In particular, there is uncertainty as to what patients value about quality nursing care.

We have all heard a variety of stories of patients’ hospitalization and, in particular, stories from nurses who have had the experience of being a patient. This is not reflected in the literature, where there is little information available about the experience of nurses as patients except for some articles that focus on anecdotal accounts, a few letters to editors or occasional editorials. Specifically, there is no reported systematic inquiry concerning the experiences of nurses receiving nursing care. For these reasons, I embarked on a research project to facilitate the development of an enhanced understanding of the experience of patients receiving nursing care, choosing the setting of acute care nursing.

This project resulted in an interpreted description of the experience of nurses receiving nursing care as patients. In providing a nurse’s ‘view from the other side’ it is hoped that nurses will have a greater insight into the experiences of patients, in particular an understanding of aspects of nursing practice that reflect quality care.

In presenting this research project I have included a brief overview of the research approach, the findings and
Nurses as patients

the implications for nursing practice, supported by findings from the literature. In doing so I hope to provide some insight into the experience of being a patient, through nurses’ eyes.

THE APPROACH: HERMENEUTIC PHENOMENOLOGY

In an attempt to provide a unique view ‘from the other side’ and to fill an identified void in the literature, I wanted to explore the experience of being a patient through nurses’ eyes. Exploring the experience of being a patient is very broad. My personal interest was nurses as patients. This was still quite broad and encompassed environment, illness, interactions with other health-care professions and patients. What I wanted was insight into the experience of nurses who were patients and insight into their perspectives of receiving nursing care. I felt that nurses as patients could provide a distinctive perspective on receiving nursing care as they are particularly well-informed consumers of nursing care. The focus of my research became not nurses as patients, but nurses receiving nursing care. The method which seemed most appropriate to provide insight into this experience was hermeneutical phenomenology.

This interpretive research approach is based on philosophical hermeneutics and components of phenomenology. Hermeneutic philosophy is concerned with understanding, in this case an experience, through the interpretation of text. Inquiry founded on this philosophy is not so much focussed on an event, as the meaning that event holds. Hermeneutic phenomenology’s ontological basis is relativism, with ‘local and specific constructed realities’ (p. 109). The constructions ‘... are not more or less “true”, in any absolute sense, but simply more or less informed and/or sophisticated’ (p. 111). The phenomenologist’s primary focus is to investigate and describe events, in particular human situations. What needs to be emphasised is that while phenomenology can be a research method, hermeneutic phenomenology is not, it provides the framework that guides and underpins research. This form of inquiry aims at uncovering hidden meanings in an experience, in this case the richness of nursing practice by the interpretation of language and text.

Hermeneutic phenomenology is necessary in order to explore nurses’ stories about their experiences as patients and to elicit individual understanding and meaning of the experience. To extract meaning and understanding from text through exploration and interpretation, it is important that the text holds a wealth of information. One form of text, congruent with the exploration of nursing practice is stories.

Method

Participants

Four registered nurses were recruited by nominated and purposeful sampling. These participants had insight into the experience of being a patient and were willing to share their stories. The participants: (i) were registered nurses who had practiced for more than 2 years; (ii) had undergone an uncomplicated surgical procedure; and (iii) had a personal experience of surgery that was recent but more than 6 months ago.

Text generation

The generation of text involved the participants telling stories of their experience of receiving nursing care. The interviews occurred in the participant’s choice of setting and consisted of an unstructured interview following the prompting statement, ‘Please tell your story of the experience you had of receiving nursing care. Share all your thoughts, perceptions and feelings until you have no more to say about the situation’. As the narrative unfolded, questions were asked for amplification and/or clarification of specific issues. The collection of the narratives was undirected and involved a conversation between each participant and the researcher. It was felt that more information-rich text would be gathered in a conversational setting rather than a formal interview, telephone interview or written story. The narratives were transcribed from an audio recording and the transcripts became the text for interpretation.

Informal interpretation of the text occurred as the narratives were collected, including narrative comparison and linking with the literature. Formal text interpretation of the experiences did not commence until all the narratives had been collected and transcribed, as is congruent with the research approach.

Text interpretation

Different versions of procedural steps have been described as methods for interpreting text. A composite of these versions was developed for this research project; it was based loosely on the method proposed by Colaizzi. Unfortunately the procedure developed by Colaizzi is only described once by the author and little discussion is pro-
vided about the influences and evolution of the process. In his statements preceding the description of his research procedures of analysis, Colaizzi suggests his steps are intended only as a guide to analysis of text and that there is ‘much overlapping among them and their sequences should be viewed flexibly and freely by each researcher’ (p. 59). Hence, the composite that was personally constructed and used in the present study was enhanced by the writings of Munhall, and Phipps in Streubert and Carpenter.

The following is a summary of the steps of textual interpretation used in the present study.

**Step 1** All participants’ stories of their experience were read and re-read (contemplative dwelling) to allow the researcher to obtain a feel for the whole and to become immersed in the text.

**Step 2** Significant statements and phrases pertaining directly to the investigated phenomenon of being a patient were extracted. Each narrative was reviewed, highlighting the aspects that related to the phenomenon of receiving nursing care. It was found, as described by Sandelowski and Taylor that the narratives generated a wealth of text. During this step, it is important to focus on the details that illuminate the phenomena under study and disregard those details which have no contextual bearing on the research.

**Step 3** Meanings were drawn from each of the significant statements and phrases. This process allowed exploration and highlighted the meanings hidden within the nurses’ experiences contained in the individual stories. In some cases, the significant statements were in fact the meaning.

**Step 4** Meanings were clustered into themes common to all informants’ stories. The interpretation of text involved breaking the narratives down into parts, bringing these individual parts from each story into one whole, and then returning to the individual narratives in an attempt to understand the whole experience, ‘We reflect, reinterpret, refine, and retell our stories’ (p. 565).

**Step 5** Results were integrated into a description of the phenomenon of nurses receiving nursing care as patients, using examples to highlight the themes, support the clusters and examine discrepancies.

**Step 6** The interpretation of the experience was returned to participants to ensure that it was an accurate reflection of the features of their own experience.

**DISCUSSION**

**Themes of meaning**

My interpretations of the four participants’ experience of receiving nursing care as a nurse–patient resulted in 10 themes. In describing the 10 themes, I hope to provide an insight into the aspects of nursing care that nurse–patients believed reflected quality nursing care. The implications of the themes and the findings from the literature will be integrated into the following discussion.

**Finding a balance**

‘Finding a balance’ refers to the patient acknowledging the need for assistance while valuing their own independence. When the nurse–patients recognised their need of assistance, they appreciated help when it was offered and felt frustrated when it was not forthcoming. As one participant describes:

> I remember being helped into the shower but not actually being helped with the shower and I had a drip in so it probably would have been appropriate but I didn’t actually care that much. I was quite happy with them just making my bed and making it all nice so that when I came out I could get into this nice bed and have things around me.

While acknowledging the need for assistance with simple activities from nursing staff, there also comes a sense of control when independence is attained. The same participant described her recovery: ‘I was independent then and everything was okay’.

**Being in control**

The sense of control the patients felt they had over themselves extended to control of the experience of being a patient. A feeling of control arose from situations that included being able to prepare for being a patient and the provision of information. One participant described feeling compromised once ‘in the system’. After being told she needed an operation her experience was:

> A bit of a snowball effect. I can see that now, being on the other side of the bed, as it were, you tend get a bit on a rollercoaster or conveyer belt and do sort of get churned into the system a little bit
and you are sort of fairly compromised too, I think being under effects of narcotics.

The elements and attributes that illuminated this experience included: (i) being on a rollercoaster; (ii) a loss of control; (iii) ‘losing it’; (iv) the power nurses had over me; (v) the effect of being a registered nurse; (vi) having time to prepare; (vii) being in control; and (viii) being informed. A sense of loss of control might occur during the simplest of activities. Using a bed pan highlighted this:

You’re sitting next to it, like it’s sitting there, isn’t it? You can’t actually reposition yourself or do anything else until that damn pan is gone. So you are out of control again, so you are ringing the bell again! You had to ring it to get it and then you have to ring it again to get rid of it. There was no way of getting rid of that pan without ringing that damn bell.

The nature of being a patient also removes control:

. . . this incredible frustration of loss of control, of not being valued, of all of those sorts of feelings that you had and just totally losing it. . . . I had a total spass out. It was like I totally lost my plot completely and I was crying, I was hysterical, I was terrified. . . . everything that could go wrong, would go wrong, as far as I was concerned.

The stories revealed the way an individual’s own coping mechanisms contribute to the experience of loss of control and the important role the nurse has in giving a patient a sense of control. Some stories described instances where the patient being a nurse influenced the power the patient had over a situation, while, in other situations, being a nurse compounded the patient’s sense of having no control.

Acknowledging me

‘Acknowledging me’ refers to the sense the patient has of being recognised as an individual. This recognition results from an establishment of a nurse–patient relationship, a sense of connectedness between the nurse and the patient. One participant explains:

I think I must have been difficult for them to manage in some way. Not in the traditional way we think of it, but in a way that they weren’t able to have a relationship with me. . . . I remember people fiddling with my drip, but it was like the drip was there and they would come in and do something to the drip but it wasn’t as though it was connected to me.

The textual elements and attributes that illuminated this theme included: (i) a sense of isolation; (ii) the way nurses related to the individual; (iii) continuity of care; (iv) reaching out; (v) and the influence on patient experience of being a registered nurse. ‘I mean I had someone different everyday. I can’t remember seeing the same face twice and that can’t help can it?’

In comparison, another participant acknowledged that seeing and interacting with the same nurses throughout her admission was a positive aspect of her experience: ‘. . . that was good I had the same ones’.

In relation to being a registered nurse and a patient another stated, ‘Some knew, some didn’t, some cared, some didn’t, some were quite defensive, others weren’t’.

Spirit of caring

‘Spirit of caring’ refers to the feelings that the patients believed emanated from the nursing staff. It describes the attitude of the nurses as revealed by the way they delivered nursing care and interacted with the patients, it describes how these attitudes can influence the nurse–patient relationship. As one participant said:

‘. . . for me it’s not so much what people do for you as far as drips and obs and stuff, it is just the sitting and talking and the hand contact’.

In reference to the positive interactions encountered, one individual commented:

They’re sort of overwhelmed by nurses who were indifferent I suppose at the best and at the worst uncaring to me as a person.

Adjectives used by another participant to describe the way she interpreted the care delivered by the nurses included, ‘Off hand, yelling, demanding, aloof, unfriendly and gruffness’ . She felt, ‘What they lacked in nursing skills they didn’t make up for in personality’.

The little touches

‘The little touches’ refers to nursing activities and interactions that provided the patient with a sense that the care was special:
An enrolled nurse stayed with me . . . I remember her as one of the positive experiences as she didn’t leave me. She came really close to my face and touched me, and just did the same thing, you know stroked me and that was like enough distraction.

The aspects of nursing practice that were valued by the nurse–patient included: (i) spending time with a patient; (ii) being assured; (iii) instilling confidence; (iv) making a difference; and (v) provision of information:

I had different nurses and it does make a difference, nurses do make a difference. Certainly you do feel confident with some nurses, more than others; I mean it was alright because I wasn’t having major heart surgery or anything, but you do get a sense of confidence, more confidence with some people than you do with others . . . some people have got a way of, like a more open way of talking with you, but you are just not another set of obs to get done and bed to straighten, it is more personal, and others get in and do the task and then leave.

Nurse–patients were able to acknowledge nurses’ human failings when providing care, as exemplified by this story about a nurse collecting information for the bowel book:

Being asked in front of the visitors ‘have you had your bowels open?’ Yeah, I mean you’ve got to be on the other side of the bed and I think most of us are probably guilty of it, doing the bowel book during visiting hours, it’s the ideal time but not a good thing.

Patients appreciated the feeling that they were receiving a few of the extra little touches. Aspects of nursing care that participants considered as ‘special’ and making a difference to the nurses’ experience of being a patient included: (i) access to their own clinical record; (ii) back washes; and (iii) having a sense of confidence in the skills of the nursing staff.

Therapeutic environment
The environment was also considered influential to the experience of inpatient stay. Although not directly related to receiving nursing care, nurses are integral to the patient environment. The ‘therapeutic environment’ includes the physical environment, other patients as neighbours and feelings of going home.

Physical environment Private rooms were a recurring theme, whereby nurse–patients were appreciative of being allocated to a private room and recognised that this was a privilege for staff when such a room was available. A quiet environment was also valued.

Patients as neighbours Two of the stories describe scenarios where the nursing staff did not appear to be perceptive to the interactions between patients. This included the number of visitors to other patients (exaggerated numbers quoted in the stories ranged from 372 to 20000) and the need to support other patients to fill a void where the staff were unsupportive of a neighbouring patient.

Going home ‘Going home’ refers to the experiences of being admitted to a hospital to which the nurse–patient had a personal association. Returning to the place where one had trained and lived for 4 years provided a feeling of going home:

It was good running around after I’d arrived and seeing what was being built on where it used to be. The staircase at the back where I often went down the banister was still there, so there was a lot of memories, so on that score I was very comfortable. It wasn’t as if I was in a foreign place at all, it was almost like home.

Having been a theatre nurse in the same hospital, another participant describes her feelings of returning to that environment, ‘It was wrong time, wrong place, wrong person’.

I’ll be back
‘I’ll be back’ refers to the sense of time passing that a patient has, especially after the nurse has said ‘I’ll be back’. It portrays what the patient feels while waiting, and their interpretation of what ‘I’ll be back’ means. The two elements and attributes that describe this theme include: (i) needing assistance; (ii) and accessing information.

A typical example follows:

They put me in the shower, I still had an IV up, catheter, the works . . . I’ll be back in a minute’. Well, when she got back I’d showered, washed my hair and dried everything except my back. I said, ‘Could you dry the back off’. She said, ‘Oh have you finished?’ and I said, ‘Yeah, except for my back’ and she said, ‘I’ll come back’ and I said, ‘Oh, could you dry the back of my legs and my back for me?’ and very ungraciously she, you know, this was 24 hours post op, she very ungraciously dried the back of my backside.
The need for information in relation to time schedules is highlighted in another story:

. . . getting the information, getting a quick answer back that someone says, ‘is it urgent?’ ‘can it wait?’ ‘I’ll be back in 10 or 15 minutes’ and then actually turn up.

Patients encounter a large degree of uncertainty once the call bell has been rung. They experience concern in knowing how long it will take to get a response from the nursing staff.

Expressing feelings
The theme of ‘expressing feelings’ covers the many feelings evoked and expressed while in hospital as a patient. In particular, the stories describe feelings of fear, paranoia and the need for closure of the experience. As one participant stated:

I got frightened after thinking that I am having some sort of massive brain haemorrhage, like nurses tend to, so I got really frightened and made myself really anxious.

Another example of expressing feelings was provided when a nurse–patient described being moved to a private room opposite the nurses’ station at handover time:

. . . you could hear, not everything, but you could hear bits and pieces of it and because by that stage I was a total paranoid wreck, any little bits that I heard I would turn around for them saying something negative about me which probably most of it had absolutely nothing to do with me.

The issue of closure seemed to add a new dimension to the hospital stay. Two participants described a feeling of needing to close the experience of being a patient:

[T]hat when you’re ready to go home it ought to mark some kind of point but it’s not finalised in a very satisfactory way. Because the nurses don’t/aren’t interested, because you are not sick any more, in a sense, but what there is nothing that actually says, ‘You know, you’ve made it’.

The other participant described her sadness as she was unable to say goodbye to the nursing staff on discharge, ‘They were too busy’.

I’d done wrong
‘I’d done wrong’ is the sense of non-compliance evoked in the nurse–patients, based on self expectations or their interactions with the nurses or the system. The elements and attributes typifying this theme include, feeling that they were doing the wrong thing by making demands on the staff, and their own expectations of self. For example, one participant described her feelings of doing the wrong thing after her catheter was removed:

They dumped a commode and they said, ‘Oh yeah, we’ll be back’. Well, when they came back eventually I’d voided four times. ‘How could you possibly have?’ I’d jumped the gun, you know, I’d done wrong.

Another example of feeling non-compliant occurred when a participant had:

. . . a sense I was making a lot of demands on the staff, I don’t know if that was my problem but then it shouldn’t have been because I shouldn’t have been given that feeling, should I? But I had this feeling . . . it must have been their attitude when they came in, because you called the call bell and no one would come and it would be for like everything, like when my drips ran out and I needed pain relief, and it was like my hot packs had gone cold.

The stories portrayed how the nurses’ reactions to situations either exacerbated or abated the nurse–patient’s feeling of doing wrong.

Being comfortable
The last theme, ‘being comfortable’, refers to the sense of physical and emotional comfort the patients felt. The stories describe various experiences of being comfortable, in particular of having pain and receiving pain relief. The patients explored the many different emotional responses comfort evokes. Elements and attributes that emerged from the stories relating to comfort included the power and perception of pain and being at ease.

There were many stories describing difficulties encountered in obtaining pain relief. As one participant stated:

[I was] being placed in the de-humanising position of having to almost beg for something, and there was more than one occasion.

Another described the nursing staff, ‘As trying to push pain relief onto somebody that didn’t need it’.
Personal expectations were challenged, ‘It wasn’t the dreadful physical, you know, pain that I thought it was going to be. I was pleasantly surprised’.

Other aspects causing discomfort included the standard of nursing care delivered and, on a lighter note, using a bed pan:

It was alright, it wasn’t the greatest but it was fine...I cringed a bit about who’s been on the bed pan before me, but no, it was fine and the nurse was great, it was easier to use than I thought.

IMPLICATIONS FOR NURSING CARE
While gaining insight into aspects of the patient experience that are integral to the experience of being a patient, it is also important to consider what this means for the nursing profession. The final section of this paper is an overview of some specific implications of this insight into the experience of nurses as patients. It is presented in an attempt to highlight aspects of nursing care that the nurse–patients in this study believe reflect quality nursing care.

Patients are patients
The narratives demonstrated that the quality of the nurse–patient relationship is central to the experience of being a patient. A connection between the nurse and the patient contributes to a positive experience. A connection is achieved by acknowledging the patient as an individual which invokes a feeling that they are special. This occurs in everyday encounters where the delivery of nursing care is not task orientated, but people focused. Being acknowledged as an individual includes treating the nurse–patient as a colleague. There are difficulties for both the patient and the nurse inherent in the change of roles from nurse to patient. Caring for colleagues can be daunting and the desire to provide extra care is offset by the fear of treating another nurse.

It is by taking the time to be with a patient that the nurse–patient relationship can flourish. This incorporates listening, touching, being with and meeting a patient when they reach out, often through tears and humour. Continuity of care also facilitates the development of a connectedness in that it allows nurses and patients to spend time together. There follows a need for closure of this relationship and experience. Acknowledging a patient’s feelings is important. Allowing them to express their fears, reassuring them, providing company and information are all strategies to assist in abating fears. As Taylor states, ‘Nurses can help alleviate patients’ fears through explanations and general talk and company’ (pp. 223–224).

The manner in which care is delivered was described by participants as being as important as the care that is delivered. The spirit of the nurses providing the care makes a difference to the experience of being a patient. Nurse–patients are readily able to differentiate task-oriented practice from the caring aspects of nursing. This was found by Prentice who described that the way the tea is delivered is as important as the quality of the tea itself. Nurse–patients are able to discriminate appropriate and skilful nursing care and appreciate those extra touches. The literature cites other examples of those little touches, including listening, touch and conversation. Nurses do make a difference to the experience the patient encounters.

The patient is in the centre of the situation as a knowing, feeling, interpreting human being who can both constitute and be constituted by the situation, and the nurse as a genuine presence who can make a difference to the situation (p. 42).

Facilitating a patient’s sense of control is important. Nurses can facilitate this feeling of control by acknowledging and encouraging the patient’s individuality, independence and sense of being informed. Being informed includes having time to prepare for hospitalization, having access to one’s own clinical record and having knowledge about inpatient routines and daily activities. Nurse–patients are aware of the humanity of nurses, but that does not always make nurse–patients more accepting if problems arise. Nurse–patients, while acknowledging perfect situations cannot always be found, can still experience a sense of frustration when perfection is not achieved. Nurse–patients have certain expectations about the broad categories of usual patient education and can easily identify when this is not provided. Keeping nurse–patients informed is important in allowing them to retain some sense of control.

Nurses need to find a balance between encouraging independence and offering assistance. The nature of being a patient means that patients require and value the help they receive. While appreciating assistance when it is offered, there is a sense of frustration when assistance is not forthcoming. With independence comes a sense of control.
Assisting the patient to be comfortable is central in nursing care. Nurses should assist patients to be comfortable physically, emotionally and with the environment. Pain and pain relief is a large component of nursing care. Nurse–patients have their own history and knowledge of the system. They are aware of the working of system and the hospital environment may be familiar to them. They are aware of problems that can arise and they have cared for patients. Nurse–patients cannot help but to compare these experiences with their own situation and this can increase feelings of fear and paranoia. Nurses can help allay these feelings in their patients by being with, reassuring and acknowledging their patients’ feelings.

CONCLUSION

The interpretation of the experiences of nurses receiving nursing care as patients provides an enhanced understanding of the experience of being a nurse–patient. By using a hermeneutical–phenomenological approach, the uniqueness and commonalities of the nurses’ experiences have been interpreted. This has included a comparison between individual narratives and the perceptions of nurses and patients in general. The themes offer insight into what patients may value as quality nursing care. This research has hopefully contributed to nursing knowledge by: (i) illuminating the experience of nurses receiving nursing care; and (ii) offering insights into some essentials for quality nursing care.

Nursing is undergoing immense change due to financial constraints, increased technologies, changes in education and an emphasis on best practice. However, in the context of the big picture, have nurses forgotten the basic nature of nursing? Scully asks the question, ‘The basis of the nursing profession is the provision of quality nursing care, is it not? Nursing research, education and management should focus on optimising nursing care, this is what nursing is about’ (p. 3). Nurses should be more aware of what it is that our patients want, need, appreciate and believe assists them in their recovery. This must be balanced with the physical, professional and financial factors that impinge on the nurse role. The optimal word is care. Nurses can deliver nursing in all manner of ways, actions, interventions, treatments, but it is the care in nursing that makes nursing what it is.

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