

What is the lived experience of hospitality for adults  
during their hospital stay?

Rosalind Kelly

A thesis submitted to

Auckland University of Technology

in partial fulfilment of the requirements for the degree

of

Master of International Hospitality Management (MIHM)

2015

School of Hospitality and Tourism

## **Abstract**

Evidence suggests that hospital patients receive the medical treatment they need but are sometimes left feeling depersonalised and alienated with their overall treatment. The patient may be treated for their illness but the person may not be treated in a holistic way. Therefore this New Zealand study posed the question, “What is the lived experience of hospitality for adults during their hospital stay?”

This study used a hermeneutic phenomenological methodology, guided by Heidegger and Gadamer. Participants were purposively recruited and consented in writing to take part in the study. The criteria for inclusion involved participants who had been admitted to hospital within the last two years for elective surgery and had remained in hospital for a minimum of three days. The seven participants were aged between 22 and 65, all female, and lived in the Auckland Region. Data were gathered using semi-structured, conversational style, individual interviews which were audio taped. The interviews were transcribed verbatim and coherent stories of hospitality moments were drawn from the transcripts. These stories were returned to the participants for validation. The stories were analysed using van Manen’s iterative method to uncover an understanding of the meaning of hospitality for these surgical patients. This interpretative approach involved being within the hermeneutic circle to gain an understanding of the meanings within the text.

The findings revealed that hospitality showed itself in different ways to the participants, interpreted under the notions of ‘hospitality just is’, ‘being at ease’ and ‘being healed’. Participants’ stories revealed that when hospitality was present it evoked feelings of comfort and when it was absent they sometimes felt alienated and ignored. These findings suggest that when the patient is treated in a holistic way, attending to not just the illness but the person within, the patient feels cared about. It is this willingness to

get to know ‘the stranger’, through healthcare workers’ often small actions which hold the possibility of creating an emotional and socially connecting experience which may be experienced by the patient as hospitality. When hospitality exists in the lived moments of hospitalised patients it evokes feelings of being healed and improves subjective wellbeing.

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## **Attestation of Authorship**

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

Signed:

Dated:



## **Acknowledgements**

In the completion of this thesis I would like to acknowledge the assistance which I have received from several people without whom this study would not have been completed.

Firstly, I must thank the seven participants, who gave their time and their personal experiences to this research, without them I would not have been able to complete this study.

I would like to take the opportunity to thank both of my supervisors, Erwin Losekoot and Associate Professor Valerie Wright-St Clair who have guided me along this very meandering journey. Their wisdom, kindness, encouragement and patience has been never ending and I have been privileged to have had them both as my supervisors. A sincere thank you to you both.

Lastly I would like to thank my family, my husband John and my two boys Joshua and Benjamin who have given me the opportunity to dedicate a great deal of time over the last few years to the completion of this thesis. You have all been very supportive and understanding, for that I am very appreciative.

Ethics approval was granted by Auckland University of Technology Ethics Committee, on 14<sup>th</sup> August 2013 and given the approval number 13/193.

## Chapter One: Introduction

*“Hospitality involves opening one’s mind and life to others. It concerns itself with honouring another’s uniqueness, respecting differences, and seeking to understand another’s lived experience without judging or labelling.” (Bunkers, 2003, p. 308)*

### Focus for this research

This chapter introduces the scope of this study and will explain my motivation for asking the question, “What is the lived experience of hospitality for adults during their hospital stay?” This study is located within the context of New Zealand and sets out to explore if the phenomenon of hospitality plays a part within a hospital setting and more specifically for an elective surgical patient. This study is not concerned with a critique of the medical, technical or nutritional treatment which is given by healthcare professionals to patients; it is concerned with the ‘other’ factors which play a part in the overall patient experience and their sense of wellbeing. Specifically this research sets out to understand more about the nature and meaning of hospitality and its importance in a hospital setting.

Historically, hospitality centred around offering physical comfort in terms of food, beverage and accommodation as well as psychological comfort to others by a host (Burgess, 1982). Hospitality was not only offered to the traveller but also to the sick - indeed care of the sick was considered to be an act of hospitality in religious times (King, 1995), and it is from the monastic hospitality which was given to the sick in the Middle Ages that the first hospitals evolved (O’Gorman, 2006). The connection between the church and hospitals has been eroded and hospitals are now mostly either privately or publicly managed, although there are still some examples of religious orders working in hospitals for example, Mercy Hospital in Auckland. However, this study will

question if those early concepts of hospitality which formed the basis of the first hospitals are still of significance in hospitals today.

The healthcare literature suggests that hospitality in healthcare is an important emerging concept (Bunkers, 2003; Gilje, 2004), with much of the research focusing upon the delivery of customer service, through the implementation of service delivery systems which are focused upon measuring quality through systems and procedures (Descombe & Eccles, 1998; Randall & Senior, 1994; Severt, Aiello, Elswick, & Cyr, 2008).

Although this is important for the effective management of hospitals it has been recognised that other factors including hospital amenities and interpersonal relationships play a significant part in meeting the expectations of the patient (Jenkins et al., 2011).

The literature suggests that it is the interpersonal relationships between the healthcare professional and the patient which are viewed as the most significant to a patient in terms of their overall care and wellbeing (Patten, 1994). This study aims to explore this further as much of the existing research has tended to use a quantitative approach for its methodology analysing customer satisfaction surveys (Severt et al., 2008). This positivist approach has not allowed for a more in depth understanding of the thoughts and emotions of the patient.

For this reason I have adopted an interpretive methodology for this study. I have used a hermeneutic phenomenological approach (van Manen, 2001) to seek a better understanding of the lived experiences of the hospital patient. I have interpreted the lived experiences of seven participants who have had elective surgery and who stayed in an Auckland hospital for at least three days. Hermeneutics aims to seek a better understanding of the meaning of the words which are spoken (Gadamer, 1993) and this is consistent with this study which aims to uncover a deeper meaning of the experience of 'hospitality' for a hospital patient. Interpretive phenomenology guided by Heidegger (1927/1962) will be used to seek to further explore the lived experience of being a

hospital patient for these participants in relation to the 'other' factors which surround their medical care.

### **The reasons for choosing this topic**

I have worked in the hospitality industry for many years and during that time I have worked within different sectors of the industry. One of my earlier jobs was to manage a private café in a National Health Service (NHS) hospital in London in the early 1990s. At that time, in public hospitals, it was quite unusual to find a place where patients could bring their visitors away from the ward to have some food and a cup of tea. I can remember quite clearly that in the early months of opening this new catering operation just how surprised staff, visitors and patients were that such a place existed - it really was quite a revelation to have anywhere like this for people to go to. Over the years it has become quite common for hospitals to have cafés for patients, it is now probably the norm rather than the exception in the way that it was back then in the nineties. However, it was obvious to me quite early on just how important the café was for the patients and the visitors of that hospital, as the cafe became a haven that they could go to and have some private time with their visitors away from the ward. Some patients were long-stay patients and they became regulars at the café, so I got to know them and their families quite well. We would welcome them, often by using their name and we soon became familiar with their regular food and drink orders. It was a very casual self-service style operation, yet I was often complimented on the friendliness of the café staff, how nicely they interacted with customers and how they would often assist customers by carrying their food and drinks for them to their table.

Even though most of the patients were in hospital gowns or pyjamas and some had drips or carried various items of medical equipment with them, they were not looked upon in a strange manner they were accepted and thus they felt comfortable in the café. It was also a time when patients were able to gain some independence, to be themselves, the

‘person’ rather than a ‘patient’ with a ‘condition’, and exert some control with regard to their hospital experience. I sometimes think back to the time that I worked there and would like to think that the hospitality which that café provided may have played a small part in improving (and possibly even shortening) the stay for some of the patients in that hospital.

I have worked within various sectors of the hospitality industry providing food, drink and accommodation in a variety of different operations to customers, from those with low budgets to those with a high spend. To me it is inconsequential how much a customer spends for a particular product or service - they should be able to expect an appropriate level of quality and service for whatever price they pay. They should also expect that within a hospitality environment that they are made to feel welcome in a manner which is genuine. Even when this is a brief encounter, an acknowledgment by way of a smile and direct eye contact can demonstrate hospitableness. To me it is this element of the encounter which is important and which I have always encouraged in the hospitality operations that I have been associated with - to ensure that a guest feels valued. It is this element of hospitality which has shaped my thinking for this study.

As well as working within the hospitality industry there is another aspect of my life experience which has also played a role in why I decided to complete this research. During my adulthood I was a patient myself on several occasions and was hospitalised most recently in Auckland for five days when I had a surgical procedure which initially left me very physically dependent during my stay in the hospital. As a person who is usually fit and is able to take care of oneself I was struck by just how frightened and vulnerable I felt at losing my independence and having to rely upon others (particularly strangers) to do things for me. There was an occasion when I felt scared and I remember that a nurse came and sat with me while I explained my anxieties. She talked me through what was happening to me, she told me she would not leave me, she even held

my hand. She did stay with me until I was comfortable and no longer upset, and that was such a good experience for me. During my stay I had many good experiences, from the health care workers who would wash me, to those who just said hello in a manner that seemed to show that they were actually interested in me.

Yet I also had experiences which were not so good and in fact surprised me in the way that they affected me. There was an elderly patient next to me who kept talking to me, to the extent that she would not let me rest and when I pulled my curtains in the hope that she would leave me alone she would kick my curtains to let me know she was there, that I was ignoring her and she even complained that she could no longer see out of the window because of me. Her visitors actually asked if I would move to allow her to be by the window. This was a strange scenario, and upon reflection I felt a bit upset and also angry that this patient's behaviour should so have affected me, as it would not have occurred to me before that my experience would be so affected by the interaction of others.

It was odd but while I was on this ward for the first few days I did not receive a food menu. This became a problem because I was brought some food which I just could not eat; I do eat most things but not white fish. This was the first meal I was allowed to eat since my surgery and I was really looking forward to it but my face fell when I was given white fish. So I asked the nurse if I could please have something else. She told me that would not be possible and to eat the vegetables around the outside of the plate and have another jelly. Another jelly! The effect of her comments left me feeling very upset probably because I was so hungry and she was just not very hospitable. Then a strange thing occurred - another patient's visitor walked after this nurse and I heard him tell her off for being so mean to me. Then he came back and asked me if I was alright. I thought that was very kind of him but he should not have felt he had to do that - all that needed to have happened was that I should have received a menu and then I would have been

able to order some food. The implications of not eating ultimately impacted my recovery period and meant I stayed in hospital a day longer. This would have been an additional cost to the hospital.

It was upon reflection on this stay as I observed the coming and going of patients, visitors and various health care professionals that I became aware of the ‘other’ factors which play a crucial part in the overall patient hospital experience. It seemed to me that I received very good medical treatment and generally I was treated with respect, dignity and kindness. However, there were occasions when this was not the case and I began to question whether some of the concepts of hospitality could be applied or considered to be appropriate within a hospital setting. A hospital after all may be described as a hotel; it offers accommodation to a stranger, although in this instance the stranger is unwell. It is when a person receives an emotional social connection with another that genuine hospitality is created and they feel satisfied (Lugosi, 2008). This may be interpreted in healthcare of treating the whole person rather than just the illness within the body and it is suggested that this approach may be very beneficial in a healthcare situation (Bunkers, 2003; Patten, 1994).

Although I have worked in several sectors of the hospitality industry I now find myself as an educator of hospitality to students studying certificates, diplomas and degrees of hospitality management. As an educator I feel it is important for students to understand more about the implications of hospitality in other areas of life and business. It is through my experiences of working within the hospitality industry, my experiences as a patient in hospital and now as an educator that the idea for this study has evolved. These initial thoughts have led me on a challenging and interesting journey, to question the very nature of hospitality and the implications of this phenomenon to the healthcare industry.

## **My pre-understandings**

It is at this point that I should acknowledge that my life experiences and my history of understandings which I have discussed here have shaped the person that I am today and the knowledge that I have. When using a hermeneutic phenomenological mode of inquiry the researcher does not separate themselves from who they are (Gadamer, 1993; Heidegger, 1927/1962) when interpreting data from their participants. It is the pre-understandings that I have which have led to me scoping the knowledge base in the literature and ultimately asking this research question, yet it is important for me to acknowledge what these are as they will clearly have a significant impact on the way in which I interpret the data from my participants. Further explanations of pre-understandings and their significance to hermeneutic phenomenology are discussed in the methodology chapter.

## **Definitions and terminology used in this study**

Throughout this thesis I will refer to the word ‘hospitality’ and what aspects of hospitality affected or influenced the experiences of the participants. The word hospitality can be defined and interpreted in different ways and for this reason I will not define it at this point of the thesis because a full and detailed discussion around the phenomenon of hospitality is outlined in the literature review in chapter two.

The term ‘patient’ is used within this study and describes a person who has been admitted to either a public or private hospital. It should be made clear that the participants were not interviewed while in hospital but within a period of two years of having stayed in hospital. I will use the word ‘participant’ and ‘patient’ when referring to them in the interpreting of their stories.

This study wanted to uncover significant moments of what it was like to have a ‘lived experience’ of being a hospital patient, to have stayed in hospital for a certain number of



days to truly have lived an experience. As discussed further within the methodology chapter, only patients who were admitted for at least three days were recruited for this study.

## **Overview of the thesis**

Throughout this study the focus is upon gaining a better understanding of the relationship between hospitality and the surgical patients' hospital experience. In order to better understand the lived experience of "what it is to be a hospital patient?" I needed to uncover a deeper meaning in the words and phrases of the participants' stories which I was able to do through adopting a Heideggerian hermeneutic phenomenological approach. It is by using this approach that the research question can be opened up in such a way that a situation can be better understood, as sometimes something that has always been there is suddenly uncovered and can be seen in a slightly different way. The hospitality factors which are uncovered in the stories retold by the participants suggest that there is an opportunity for a better understanding of the creation of hospitality within a hospital setting.

I will now give an overview of each chapter with a brief introduction as to what each will cover.

## **Chapter One**

In this chapter I introduce the research question and I explain my reasons for choosing this topic. I introduce myself and declare my prejudices, the pre-understandings that I bring to this study which have created my knowledge and will influence the way in which I interpret the participants' stories recognising that they will shape my overall findings. I also describe the context within which this study is set.

## **Chapter Two**

This is the literature review chapter and it is divided up into several parts because this research sits between two academic fields; hospitality and healthcare. The first part of the chapter is about understanding hospitality, and it describes the history of hospitality before moving on to defining hospitality in its many forms. It then discusses hospitableness and the hospitality experience before explaining the emotional and social aspects of hospitality. The chapter moves on to discuss parallels between the hospitality industry and hospitals before investigating the literature of hospitality in healthcare. There is discussion surrounding the concept of true presence in healthcare and the factors surrounding the patient experience. The chapter concludes by discussing the limitations of previous studies and identifies the gap which this study will address.

## **Chapter Three**

This is the methodology and methods chapter. It describes the overarching philosophies guiding the study and the journey which I have taken during the research for this thesis. In so doing it explains why I decide that a hermeneutic phenomenological approach is best suited for this study. This study is an inquiry into the lived experience of hospitality, and it is suggested that when trying to understand more about the nature and meaning of the lived experience that Heidegger's phenomenological approach is used (Lavery, 2003). This chapter will discuss this methodology in more detail before moving on to discuss the research methods I used, which were guided by van Manen (2001).

## **Chapter Four, Five and Six**

These are the findings chapters. In order to write each of these chapters I spent considerable time reading and re-reading the transcripts until I was able to write coherent stories of the most significant moments of the participants' experiences. I wanted to highlight those moments which related so directly to my research question. I

then spent a period of time immersed amongst these stories, moving in and out of the hermeneutic circle interpreting the stories to uncover a deeper meaning and understanding in relation to the context of my research. I then began to group stories together, into those which revealed a similar notion, and I selected those which expressed most powerfully the impact of hospitality to the patients during their hospital stay. This resulted in three findings chapters with each discussing a specific aspect of hospitality in relation to the patients' lived experience. These chapters are called, chapter four; hospitality just is, chapter five; being at ease and chapter six; being healed.

## **Chapter Seven**

This is the discussions chapter, the last chapter of the thesis. This chapter draws together the findings chapters, it discusses the meaning of hospitality within a hospital setting and how it shows itself within the participants' stories. It discusses the implications of this within healthcare practice and suggests ways in which a deeper understanding of hospitality may be beneficial to healthcare workers, patients and hospital management. This chapter also discusses the strengths and limitations of this study and make recommendations for further research. It concludes with my articulation of the meaning of hospitality for these hospital patients.

## **Chapter Two: Literature review: Understanding hospitality**

*“Hospitality is not a matter of objective knowledge, hospitality exists within the lived experience, it is a gift given by the host to the guest which is shared between them. The true gift of hospitality is an act of generosity experienced by the guest, which turns a stranger into a friend for a limited period of time.” (O’Gorman, 2007a, p. 201)*

### **Introduction**

This chapter will review the literature surrounding the phenomenon, history and concepts of hospitality before going on to attempt to define it for the purpose and context of this study. A scoping review of the literature was completed which involved searching databases across two academic fields, to identify what is understood about hospitality and hospitality within healthcare. The key search items used were “hospitality”, “hospitality experience”, “defining hospitality” and “hospitality in hospitals”. All journals were accessed through the electronic databases available in the AUT library. I used the EBSCO health database to find journal articles which related to healthcare and the Emerald and the Hospitality and Tourism Complete (EBSCO) databases to search for literature published within the hospitality field. My supervisors also assisted by directing me towards key authors in their respective fields of expertise. While the majority of sources used were academic peer-reviewed journal papers, a number of academic books and industry reports were also found to be very useful. All sources were accessed as full-text and in English or English translations.

Articles were sought which contained recent research literature spanning the relevant fields as well as literature defining the phenomenon of hospitality and concepts of hospitality within different settings. I found journal articles and books which gave good accounts of the history of hospitality and discussions of commercial hospitality and the

way it has evolved. I sought a deeper understanding of hospitality in a social and emotional context and by searching hospitality and experience I was able to uncover several articles. When searching for hospitality within healthcare I found that my search yielded only a few articles, however, additional articles and texts were traced through scanning the reference list of these articles. I also searched “patient experience”, this produced articles about service quality in relation to the medical care of the patient. Whilst some studies recognised that other factors played a part in the care of patients, it identified a gap, there are very few studies which focus on these “other” aspects of patient care. Additional references used were books and journal articles which were already familiar to the writer.

## **Overview**

Hospitality has become a recognised field of academic study with much emphasis on the exploration of hospitality concepts (Hepple, Kipps, & Thomson, 1990; O'Connor, 2005; O'Gorman, 2007a). It does however, have wide application by varied users, depending upon the academic discipline or industrial context within which it is framed, making a definition difficult and sometimes ambiguous (Hepple et al., 1990; Lynch, Molz, McIntosh, Lugosi, & Lashley, 2011). Perhaps this is in part because hospitality may be constructed as much by those disciplines which engage it, as by the cultures and societies who actively partake in it and give it value and meaning (Lynch et al., 2011).

The history of hospitality and the significance of religion will be explored to determine how the current hospitality industry has evolved. There will be discussion surrounding the definitions and forms of hospitality from various academic perspectives and practitioners as well as an exploration into the significance of the hospitality experience. This chapter will then review the healthcare literature to investigate the value of the application of hospitality concepts within a hospital context. As the research is concerned with the lived experience of hospitality for a hospital patient, it is

fundamental that hospitality is defined in the context in which it will be applied within this study.

## **History**

An exploration of the roots of hospitality may be beneficial in determining the meaning of hospitality in contemporary society (O'Connor, 2005) and this may also give a better understanding of the part it plays within a hospital context. Throughout history hospitality has centred around offering physical and psychological comfort to others by a host (Burgess, 1982), with evidence of its origins coming from the Greek and Roman civilisations (O'Connor, 2005; O'Gorman, 2009). It was the Greeks who believed that the willingness to offer hospitality defined the civilised person from the barbarian (Lashley & Morrison, 2003). Hospitality began within the home then developed further into more public forms, firstly within religious orders and then evolving over centuries as both cities and nations grew as a result of the growth in travel (Walker, 2013).

## **Domestic hospitality**

The ancient practice of hospitality was closely related to the household and was considered to have great social value where a guest was greeted and entertained in a hospitable manner (Gilje, 2004). Hospitality in seventeenth century England was highly valued in society and regarded as a virtue and it was seen as a focal point in social life in Greek and Roman times (Gilje, 2004; O'Connor, 2005). Giving hospitality to a guest or stranger, often between conflicting orders of society, was considered to be highly important in terms of social status and advancement in society and to be discourteous or ungenerous was seen to be dishonourable (Gilje, 2004; King, 1995).

The nature of the hospitality given within the household involved providing food, drink and accommodation to both neighbour and stranger, to the rich and poor (Heal, 1990).

A set of agreed social rituals between the guest and host developed in the 15<sup>th</sup> century to

include entertainment, protection and courteousness. Entertainment would involve some form of theatre, as well as music and dancing for the guests' enjoyment and King (1995) describes "entertainment" as synonymous with the way hospitality is viewed today. There were expectations that a guest should offer gifts upon their departure and it was expected that the hospitality would be reciprocated in the future (King, 1995; O'Gorman, 2011).

In order to maintain one's reputation for the treatment of guests some rules of etiquette evolved pertaining to three divisions of hospitality, these were family with whom one showed generosity, the stranger where one was polite and the poor to whom charity was given (Gilje, 2004). By the 18<sup>th</sup> century the meaning and form which hospitality took began to alter and the free and open offering to guests became more closed, offered only to family and friends. This type of hospitality involved a relationship of closeness which could not be offered to outsiders and the poor as it was believed that charity involved distance without a close relationship (Gilje, 2004; Heal, 1990). With the growing need for travellers to be accommodated and the poor to be cared for, the meaning and language of hospitality developed to encompass legislated duties of how to behave towards the stranger or outsider in the form of public and civic hospitality (King, 1995; O'Gorman, 2009).

### **Religious hospitality**

Within religious orders hospitality has a long history, most notably rooted in monastic hospitality where monks were both practising hospitality and writing about it under St Benedict's Rule (Lashley & Morrison, 2003; O'Gorman, 2007b). Under this Rule there was much focus upon the reception of the stranger and emphasis on how the traveller who may arrive unexpectedly is greeted. Travellers were invited in to monasteries and treated as though they were God, hospitality was generous and freely given, however meeting the physical needs of the guest counted for little if not carried out in a sincere

manner (O'Gorman, 2006). Being hospitable and showing genuine acts of hospitableness is emphasised here and monks would often perform acts of symbolic kindness to the stranger, for example washing their feet. Monks were also reminded that it was the poor, rather than the rich, who had the greatest need and should receive special care (King, 1995; O'Gorman, 2006). The monastic hospitality offered to strangers in the Middle Ages offered retreats to scholars and was a meeting place for religious hospitality as well as offering care for the sick and poor. After the period of St Benedict, monasteries offered a more comprehensive form of hospitality in terms of accommodation offered to travellers, tending to the sick and charitable help to the poor which was given for a period of up to two days (O'Gorman, 2006). The care of the sick was considered to be hospitality in religious times (King, 1995) which centred around the host providing guest security, physical comfort and psychological comfort (Hepple et al., 1990). There was a strong belief within ancient religious teachings that any person may be a divine being, so the treatment of a stranger played a significant part to the lives of other people as it resulted in reward or punishment either on earth or in the afterlife (Lashley & Morrison, 2003).

It was from the hospitality given to the sick in early monasteries that the first hospitals evolved in the Middle Ages. The close connection between caring for the sick and the church gradually developed into institutions that were eventually to be controlled by municipalities becoming a public service for the community. During the 14<sup>th</sup> and 15<sup>th</sup> centuries European cities took more control over the running of hospitals and so the link between Christian hospitality and hospitals was eroded (O'Gorman, 2006).

### **Social rules of hospitality**

Historically hospitality has played a significant part in developing social meaning and order to societies. In ancient times as people began to travel there was a need for travellers to have some kind of accommodation due to the acute perils associated with



being without shelter for the night, such as the danger faced by the traveller from extreme weather, robbery or even death from highwaymen. Many societies began to develop an ethical stance towards hospitality in order that a traveller was safe and for the importance of trade (King, 1995). This translated into a social code whereby the host and guest were bound by obligations in which the host must take care of the guest ensuring he was safe and in return the guest was obliged not to harm the host (King, 1995). This was in part because the stranger was often feared, for not only may they be dangerous but have mystical powers; thus the custom of the Ancient Greeks of offering safety and hospitality “‘philoxenos’ literally love of strangers” (Lashley, Lynch, & Morrison, 2007, p. 18) can be seen to be a very early origin of hospitality.

The ritual performed upon the arrival of the traveller into a new group or society would define acceptance into the group, which often involved feasting or the sharing of food, which was observed in societies globally from the Arab world to the Amazon rainforest (King, 1995; O'Connor, 2005). Acceptance was not always given, with rejection of the stranger in some societies turning feasts into fights. O'Connor (2005) suggests that hospitality has an opposite which is hostility and there is in existence a relationship between them. The social significance of giving hospitality to a stranger was used as a form of currency in Pastoral societies and hospitality was used as a basis for social order, hence a perceived lack of hospitality given to the stranger may invoke hostility and feuding (O'Connor, 2005).

Derrida (2000) suggests there is usually an element of hostility in all aspects of hosting, which he calls ‘hostipitality’. The master (host) may welcome the stranger to their home but he is careful to let them know that there are rules to be followed and to remember this is his home not theirs, that he is the master. As long as the rules are followed the stranger has the right to be treated without hostility and in a hospitable way; suggesting there is a “juxtaposition between hospitality and hostility” (Lashley & Morrison, 2003,

p. 32) because of the obligation to welcome the stranger for the host which may result in their fear or anger in having been obliged to do so.

Nouwen (1976) purports the spiritual aspects of hospitality exist from the perspective of creating a free and friendly space where, as host, we ‘reach out’ and invite the stranger to become our friend, to be nurtured and cared for. He describes this in relation to three types of human relationships through a hospitality perspective. Such relationships are between parents and children, teachers and their students and professionals and their clients, for example a minister and his parishioners, a counsellor and his counselees and a nurse and their patient. People move within these different relationships throughout their lives sometimes being involved in all three at the same time and Nouwen suggests that the complexities of moving in and out of these relationships could be given a unified dimension through the concept of hospitality. That is, that the basic human situation is one of loneliness and pain which can be altered by reaching out and creating a friendly space (King, 1995; Patten, 1994).

### **Public hospitality**

The growth in travel in the 19<sup>th</sup> century led to the need for more extensive accommodation to be provided and the origin of the modern hotel can be traced back to this era where the traveller needed to find shelter, beyond the provision offered by individual hosts and religious orders. Although the monasteries were early providers of shelter for the traveller in the Middle Ages this was not for financial gain but to serve God by meeting a human need and give “balance and wholeness to the guest” (Lashley & Morrison, 2003, p. 33). Commercial hospitality began to develop throughout the world as a response to advances in travel as well as the need for travel not just for pilgrimages but for trade. Until the 16<sup>th</sup> century travel was endured rather than enjoyed because of the threat of danger and the basic accommodation which was offered which may involve sharing beds or sleeping on straw floors (Walker, 2013). An inn served as a

store, bar and a brothel as well as somewhere to sleep but was often a dangerous place to stay during Roman times as innkeepers would rob their guest whenever the opportunity arose (King, 1995).

As better roads were built in Europe, inns were built alongside them to accommodate the increasing number of travellers in private carriages and stagecoaches. There were different classes of traveller and the wealthy were given a much better class of accommodation and food than the poorer traveller. The building of the railways enabled affordable travel for the ordinary person, as well as making it faster and more pleasurable for the wealthy (Walker, 2013). The aristocrats in Europe began to travel for leisure and there was a demand for high quality accommodation (King, 1995). The nobility in Europe would rent luxury apartments known as 'hotel garni', which became the foundation of the modern hotels of today (Nailon, 1982). This led to the building of grand hotels, which were also used by the new rich industrialists of Europe who were keen to emulate the lives of the nobility.

In America travel had also developed and inns and luxury hotels were also being built, although there was a clear distinction between the type of accommodation offered to the rich and the poor in both Europe and North America. As more hotels were built there was a very different approach to the way the European and the American hotelier managed their businesses. The American hotel was a place that would be used by an ordinary person, who could relate to the person who served them, whereas the European hotel adopted a servant and master relationship with their guests, emulating the class system which had been entrenched within Europe for centuries (King, 1995; Nailon, 1982). The American hotelier Statler was quick to recognise the importance of the customer and he led the way in his approach towards customer service, believing that all guests should be given polite service regardless of who they were (Nailon, 1982). The American approach to running a hotel was very much as a commercial hospitality

business , as highlighted by Ernest Henderson who marketed Sheraton with the slogan “a room with a bath for a dollar and a half” (Nailon, 1982, p. 136). In contrast the European hotel was run very much like a noble household, except it had transient visitors and not a household to look after who would have guided them in their role. Consequently staff received little training in how to adapt and their behaviour was based on ritual and rules, which often led to pretention and a lack of understanding of the customer’s needs (Nailon, 1982).

This review of the literature surrounding the history of hospitality indicates that private hospitality has a rich history which is entrenched with social significance, politeness and social rules (Derrida, 2000; King, 1995; Nouwen, 1976; O'Connor, 2005). Much of the hospitality found within the private domain and within religious orders has formed the basis for the commercial hospitality in existence today. Thus the roots of commercial hospitality, the provision of food, beverage and accommodation in a business sense has been in existence for over 4,000 years (O'Gorman, 2009).

This discussion has highlighted that historically hospitals were linked to religious orders and that caring for the sick was synonymous with hospitality. Hospitality and hospitals had an early affiliation; this study will explore the relationship between hospitality in hospitals in the twenty first century. It will endeavour to uncover a deeper understanding to the significance of hospitality surrounding the hospital experience. In order to do this, some discussion surrounding the definitions and interpretations of hospitality will be explored.

### **Defining hospitality**

The historical development of hospitality discussed above indicates that it involves some common themes and characteristics and these will be further explored. Hospitality tends to be associated with offering food, drink and accommodation between the guest

and host in a hospitable manner (Brotherton, 1999; Hepple et al., 1990; King, 1995; Lashley et al., 2007). This definition has been explored by academics in recent years who have differed in their interpretation of the meaning of hospitality which has led to increasing debates and confusion (Brotherton, 1999; Hepple et al., 1990; Lashley, 2000). Hospitality is subjective and not a “matter of objective knowledge” (O’Gorman, 2007a, p. 201) and for this reason there are many different interpretations of hospitality.

Lashley (2000) has suggested that there is a need to define hospitality so that it can be better analysed and he developed a model of hospitality activities which illustrates the social, private and commercial domains. The model indicates that each domain of hospitality is independent, but does overlap to some extent. The social domain is an illustration of where social interaction takes place together with the social forces of the production of food, drink and accommodation. The private domain is concerned with hospitality within the home and the relationship between the guest and host whilst the commercial domain refers to hospitality as an economic activity which may be in the private or public sector (Lashley & Morrison, 2000).

Defining hospitality falls under two broad approaches: semantic and evidential; where the semantic approach is based upon dictionary definitions, informed commentators and academics involved in the research and teaching of hospitality management in higher education (Brotherton & Wood, 2000). The evidential approach is concerned with “locating and defining hospitality within the real world of evidence” (p. 136) and it is based upon secondary literature sources and is generally theoretical and conceptual. At the time of suggesting these approaches Brotherton and Wood (2000) noted that the evidential approach was under developed but there is evidence to suggest that this is no longer the case. Lashley et al. (2007) suggest that there is now a growing interest into the study of hospitality by academics from many fields of study whose perspectives are

not solely concerned with the management of commercial hospitality operations but who see value in its application to other areas of society.

Hospitality has been defined as being:

A harmonious mixture of food, beverage and/or shelter, a physical environment and the behaviour and attitude of people. This produces a feeling of being at home, an at-ease feeling in people who do not belong to the group of people who 'produce' hospitality, but stay under their roof. (Cassie & Reuland, 1983, p. 144)

A slightly later definition refined this a little by theorising hospitality as having four distinct characteristics:

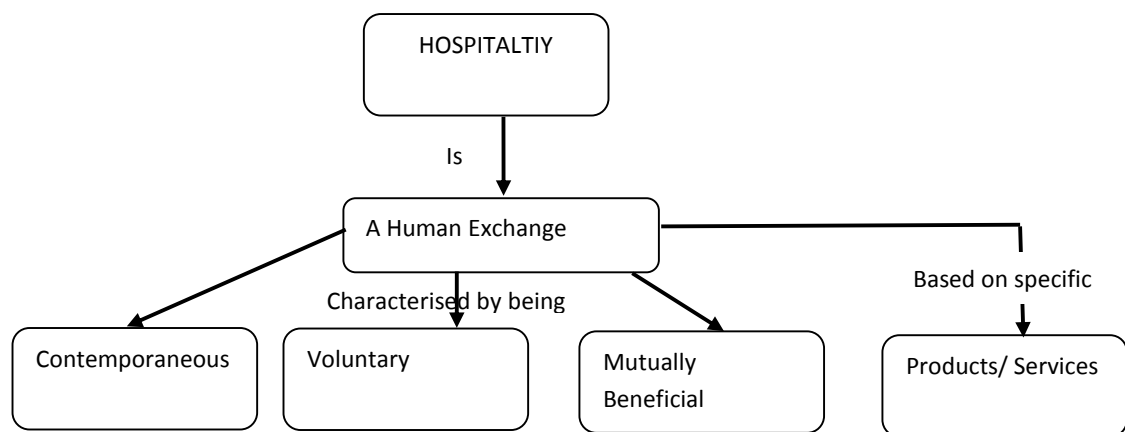
1. It is conferred on a guest who is away from home.
2. It is interactive, involving the coming together of a provider and receiver.
3. It is comprised of a blend of tangible and intangible factors.
4. The host provides for the guest's security, psychological and physiological comfort.

(Hepple et al., 1990, p. 308)

It may be concluded that the relationship between the guest and host is often characterized by hospitableness between the two and incorporates a welcoming environment and attitude (Severt et al., 2008).

However, it is suggested by Brotherton (1999) that these definitions confuse hospitality with hospitable behaviour and that hospitality is more than this. Although the human interaction is important hospitality also includes a motive and product, that being accommodation, food and drink, which he describes as a "holy trinity" (p.169), which

sets hospitality apart from other service industries. This is illustrated in his model (see Figure 1). He emphasises that accommodation is not only used to describe public and private accommodation for example in the form of a bed in a hotel or private dwelling but any space where hospitality is offered, for example a restaurant and bar. Nouwen (1976) proposes that hospitality should encompass a free and friendly space offering physical, emotional and spiritual space.



**Figure 1:** The dimensions of hospitality. (Reprinted from Brotherton, B. (1999). Towards a definitive view of the nature of hospitality and hospitality management. *International Journal of Contemporary Hospitality Management*, 11(4), 165-173. Permission granted by Emerald Group Publishing Limited).

Thus the concept of hospitality is not created by simply offering goods and services to the guest but involves interaction between the host and guest which will create either hostility or hospitality (Hepple et al., 1990; O'Connor, 2005; O'Gorman, 2007a). This model may be useful when discussing commercial and private forms of hospitality where there is an economic exchange. Indeed the primary focus of defining hospitality has tended to centre around hospitality in a commercial context with academic research focusing upon management of the hospitality industry as a series of organisational functions and service transactions (Lugosi, 2008).

The term hospitality management emerged as a label used to describe commercial hotel and catering activities in America in the 1970s. Lashley (2007) observes that this is an interesting way of using language to alter a person's perception of this industry, as the

UK used the term ‘hotel and catering management’. He argues that the use of the term ‘hospitality industry’ suggests that the traditional benefits of hospitality will be on offer for example, to be welcoming and meeting the needs of the sacred guest, yet hotels and restaurants are commercial businesses which offer goods and services at a price.

Commercial hospitality may be defined as a relationship between the guest and host, where the host’s aim is to provide a product and service in a generous manner. The aim of commercial hospitality is to please the guest, to the extent in which they are satisfied enough to return again, which often utilise specific management principles for example a service delivery system (King, 1995).

Thus hospitality is framed in distinctly different ways depending upon disciplines and sectors (Lynch et al., 2011); it encompasses a description of the commercial hospitality sector with an emphasis on organisational, management and service functions pertaining to the guest and host with financial implications (Brotherton, 1999; King, 1995). It is used to describe the study of hospitality which takes the form of different elements and approaches. The more traditional approach encompasses hospitality management education with application to the industry which is sometimes considered closed and unthinking in its approach (Lashley, 2007). A more emerging approach by academics interprets hospitality in different social and cultural contexts moving away from a simple application of management theory related to industrial application, to embrace a more philosophical approach, one which allows for a broad spectrum of enquiry and critical analysis (Lashley, 2007; Lugosi, 2008; O’Gorman, 2007a). The study of the phenomenon of hospitality is no longer synonymous with the hospitality industry but is a recognised field of study by academics from a broad range of disciplines including philosophy, healthcare and social sciences (Lynch et al., 2011; O’Gorman, 2007a). Within the social sciences the meaning of hospitality has been defined as “hospitality as a means of social control and hospitality as a form of social and economic exchange”



(Brotherton & Wood as cited in Lynch et al., 2011, p. 5). This definition has shifted the thinking of hospitality from its functional form to applying it as an influential tool in the study of social analysis and in particular within the area of social control. This ideology has evolved essentially from the way hospitality (the host) exerts control over the stranger, or person who is often within an unfamiliar environment (Lynch et al., 2011) . Thus hospitality has wide application and relevance to different organisations including within a hospital setting (Hepple et al., 1990).

### **Hospitableness**

This brings to the fore the discussion surrounding the act of being hospitable and whether being hospitable is synonymous with offering ‘true’ hospitality (Telfer, 2000). It has been suggested by Telfer (2000) that genuine hospitable behaviour requires a motive, and these motives include a concern for the welfare and pleasure of the guest. That pleasure may be in knowing that one is making the guest happy. The motive could be out of a sense of duty and concern for the guest. She further suggests that a truly hospitable person will not only possess a motive but should also display these characteristics on a regular basis.

The ‘truly’ hospitable person will pursue the virtues of hospitableness and is naturally attracted to the ideal of hospitality in all aspects of their life, not simply in a situation where it is expected, for example at work - in that instance it becomes onerous and Telfer (2000) argues it should always be joyful. She also discusses three motives which are: those in a relationship to the host, friends of the host and lastly those in need. It is this group which she also terms as “good Samaritan hospitality” (p. 47) which has most relevance to this study. It is the individual in need, who may be lonely or yearning to feel valued as an individual, that is particularly well served by hospitality.

Telfer's (2000) view is that truly hospitable behaviour is motivated by a genuine desire to please and not to impress the guest or with an expectation of any repayment. Derrida (2000), argues that pure hospitality is unachievable because of the power distance relationship in existence between the guest and host which creates what he calls 'hostipitality'. Ritzer (2007) would agree that acts of hospitableness require a desire to be genuine, yet this is never possible because there is always an ulterior motive behind the action of the host.

### **Hospitality experience**

The study and application of hospitality is varied as discussion in this chapter has highlighted and another aspect to hospitality is the impact and significance of the hospitality experience. It is argued that there is a "failure to understand the phenomenon of commercial hospitality" (Hemmington, 2007, p. 747). He suggests that an emphasis on the solely commercial and economic activity of the hospitality industry is too narrow and he cites the 'holy trinity' approach by Brotherton (1999) as being too concerned with "the paraphernalia of hospitableness centred around food, drink and accommodation" (Hemmington, 2007, p. 749). This is supported by Lugosi (2008), who suggests that the provision of hospitality continues to focus on a rather narrow set of transactions, involving food, drink and accommodation often ignoring the significance of both entertainment and social interactions. The emphasis on service delivery and service quality fails to capture any of the excitement or vibrancies of the commercial hospitality industry (Hemmington, 2007). This is supported by Lynch et al. (2011) and O'Gorman (2008) who agree that much of the 'essence' of hospitality found in its earliest forms has been replaced by the public sphere of hospitality found in hotels and restaurants, which is impersonal and with an emphasis on financial exchange. It fails to acknowledge the consumer experience or demand perspective, which is essential for the successful delivery of hospitality products (Hemmington, 2007; Nailon, 1982).

Hemmington (2007) attempts to redefine hospitality as behaviour and experience by identifying five key dimensions of hospitality in a commercial setting as host guest relationship, generosity, theatre and performance, lots of little surprises and safety and security.

He introduces the concept of a 'memorable experience' in his definition of hospitality, as he argues that "customers buy experiences not services, they buy memories not products and they buy meal experiences not food and drink" (Hemmington, 2007, p. 749). Pine and Gilmore (1998) agree along similar lines with their discussion of an emerging 'experience economy', where a customer expects to buy more than goods and services but a memorable event and experience. The hospitality experience also incorporates the physical environment, and Bitner (1992) explains that the customer's overall satisfaction with a service is impacted by the physical setting in which it is received.

The interaction between front line staff and guests as well as a hotel setting combine to create an emotional value and memorable experience for the customer (Ariffin & Maghzi, 2012). It is often the emotional aspects of a meal experience which are remembered and regarded as being more important than the meal itself (Lashley et al., 2005 as cited by Ariffin & Maghzi, 2012). It is also regarded as important that the authenticity of the service encounter toward the guest should be genuine as contrived behaviour is easily identified by the guest (Ariffin & Maghzi, 2012).

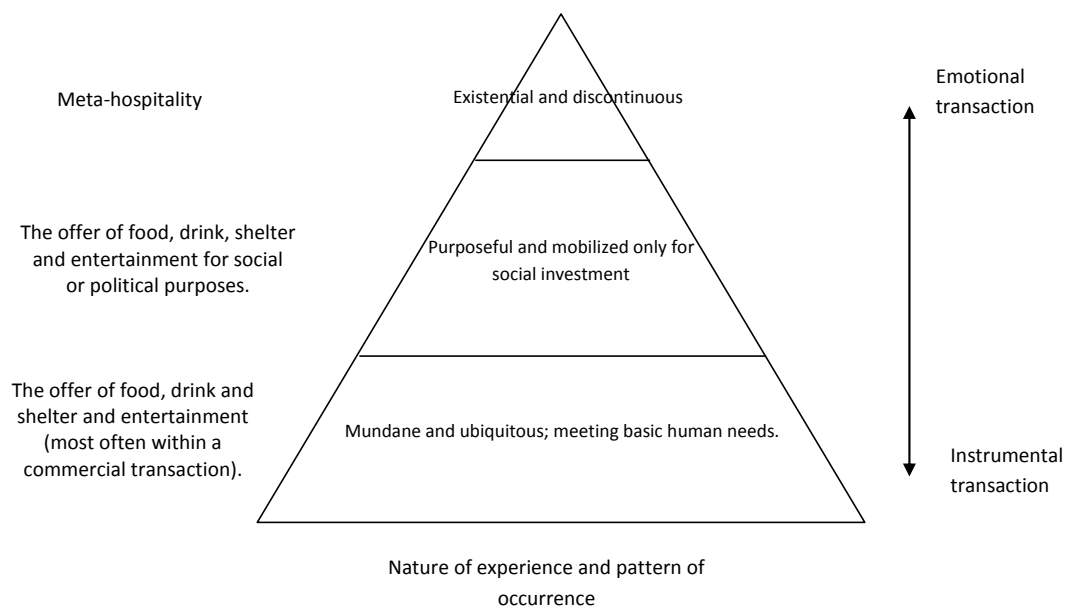
### **Emotional connection**

The emotional and social aspects of hospitality should be considered when discussing definitions of hospitality and in particular how they relate to the guest experience.

Lashley et al. (2007) discuss the significance of the guest in terms of the guest relationship in a hospitality exchange and Lugosi (2008) recognises that other guests

within a commercial setting help to create and shape another guest experience in much the same way the host will impact the hospitality experience.

Lugosi (2008) emphasises the significance of the relationship between entertainment and the hospitality exchange and, like Telfer (2000) and King (1995), the word entertainment is used interchangeably with providing hospitality and is often seen in the context of offering food, drink and accommodation. Lugosi (2008) describes the significance of including entertainment as part of the hospitality concept because it enables a distinction to be made between different forms of hospitality transactions and hospitable behaviour. He created a model which describes three manifestations of hospitality, (see Figure 2):



**Figure 2:** Forms and manifestations of hospitality. (Reprinted from Lugosi, P. (2008). Hospitality spaces, hospitable moments: Consumer encounters and affective experiences in commercial settings. *Journal of Foodservice*, 19, 139-149. Permission granted by John Wiley & Sons).

Working through this model at the first level he describes a mundane functional form of hospitality where food, drink and accommodation may be offered, to fulfil basic needs relating to hunger and thirst. This is often found within a commercial transaction but limited social connection is made in this very instrumental transaction. At the second

manifestation the same basic provisions are offered but added to this is a social intercourse which establishes or builds upon existing relationships, it is more purposeful and may contain a more emotional element.

At this level it may be argued that the functional forms of hospitality can still be managed within a service encounter, as it is within many commercial operations for example McDonald's. This may result in the encounter becoming so prescribed that the social interaction between the host and guest lacks any genuine form of social connection to the point of becoming inhospitable (Ritzer, 2007). Within a commercial context, Ritzer (2007) argues that it is difficult to ever offer true hospitality when an ulterior motive is at the heart of any exchange. He suggests that whilst a customer enjoys the predictability of standardisation within large branded hotels like Hilton and restaurants like McDonald's they also want to be treated as individuals, thus the concept of genuine hospitality is at odds with a service model that emphasise efficiency. Arguably, the two do not go together.

Based upon Ritzer's (2007) ideas, genuine hospitality cannot be found within a commercial organisation, because it does not make good financial sense. Hemmington (2007) agrees that within a commercial context there is a dilemma between generosity and the economics of business, but that it can be achieved by redesigning the hospitality experience. The financial aspect of the relationship should be controlled in such a way that a guest is not constantly reminded of it by factoring it in to the overall price of the experience.

At the last stage of the model Lugosi (2008) admits that the third manifestation of hospitality, known as meta-hospitality is often infrequent, but at the centre of the encounter is an emotional experience. This approach is supported by Hemmington (2007) who suggests that hospitality is about behaviour and experience where customers

buy experiences and memories. Meta hospitality requires those involved to dispel preconceived ideas and judgments with regard to the other so that mutual wellbeing and joy is created in a shared experiential space. The emotional bond is acknowledged as being temporary, but the key here is that hospitality is not seen as the means to an end rather hospitableness is the end itself. By this Lugosi (2008) is suggesting that hospitality transactions may provide the basic economic, social or political needs for a guests, but, “ a hospitable interaction is an acknowledgment of the other” (p. 141). This third approach would be supported by healthcare academics, who advocate the importance of encouraging a more emotional, socially connecting form of hospitality as being very beneficial (Bunkers, 2003; Patten, 1994). It is this emotional connectedness, a deeper sense of knowing the other person which, it is argued, forms the basis of caring in healthcare. “When attuned to a client you feel it in your heart, not just the head. You are drawn to caring. This level of caring is somehow related to having a holistic perspective and seeing the whole person” (Wright-St Clair, 2001, p. 189).

### **Parallels between the hospitality industry and hospitals**

It is this construct of hospitality which appears to lend itself to this study, where the host is engaged with the guest displaying a sincere and emotional connection during the experience. This enables the guest to feel relaxed and respected with the barriers of power, social status and technology (which are often believed to be very prevalent within a hospital setting) temporarily removed (Hepple et al., 1990).

With specific reference to this study it is important to decide if a hospital should be considered to be a commercial hospitality space and if the exchange between patient and nurse or carer fits within a recognised definition of hospitality. In terms of the host /guest exchange and the functional amenities which are offered within a hospital comparisons have been made to the hotel industry. There are parallels in terms of twenty four hour operation, accommodation and bed management, security and the

delivery of food service. In addition both sectors have to cope with fluctuations in demand which may be planned or unplanned (Severt et al., 2008). The key difference between the two, perhaps, is that the 'guest' is sick.

Commercial hospitality encompasses a focus on meeting the needs of the guest, through a host guest relationship, further characterised by offering hospitableness in the form of a welcoming attitude and environment (Brotherton, 1999; Lashley, 2000; Severt et al., 2008). From both the historical perspective and with regard to recent definitions of hospitality it would seem appropriate that a hospital can be considered part of the hospitality industry. Recently some hospitals in Europe and America have approached hospitality academics to advise them as to how they can make their hospitals more like a hotel for people who are sick (Pizam, 2007). It is suggested by some that hospitals within the National Health Service in the UK should implement service quality systems which are used in the hotel industry to improve levels of patient satisfaction (Descombe & Eccles, 1998). Pizam (2007) explains that the difference between hospitals and hospitality is "ity" (p. 500) which can make a substantial difference to the recovery of a patient. Pizam (2007) describes the "ity" factor as a philosophy of ultimate service where employees show dedication to the needs of the customer. Staff are coached and stimulated to be caring and compassionate. However the "ity" factor is not created unless an organization creates an environment with "the right feel" (Pizam, 2007, p. 500). This is supported by Wright-St Clair (2001) who suggests that empathy can be taught but caring cannot, as caring is something which "grows from within" (p.189). She proposes that caring may be described as a willingness to go the extra mile.

The term 'going the extra mile' is also used in the hospitality industry, for example in the Wyndham Hotel group, which encourages employees to really connect with the guest. This is illustrated with the story of a server who overheard his guest telling his companions at lunch that during a recent stay in a Wyndham hotel he had purchased

some sauces at a barbeque, which he subsequently misplaced at the hotel. Upon hearing this the server went ‘the extra mile’ and purchased some more sauces from the hotel shop with his own money and gave them to the guest (Kropf, 2002). This demonstrated a willingness by the host to do more than perform a prescribed commercial transaction, and in so doing he created a memory and an unforgettable experience for the guest (Hemmington, 2007).

The sick patient in hospital provides an extreme illustration of a guest/host exchange as in most cases the patient is an unwilling guest (Severt et al., 2008). Thus “the importance of the hospitality surrounding the service experience of medicine may be magnified” (Severt et al., 2008, p. 665). Applying the idea of hospitality to a hospital setting was examined by Hepple et al. (1990) who determined that the patient hospitality experience centred around the idea of “feeling as at home as possible” (p.309) during their hospital stay. Gilje (2004) refers to a “relationship between hospitality and at homeness” (p. 37), when discussing experiences of hospice patients who described how the way they were received by nurses made them feel relaxed and welcomed, as if returning home. When applying this notion of feeling ‘at home’ to their study in a hospital setting, Hepple et al. (1990) recognised this term may be misconstrued and clarified it to mean ‘feeling at ease’ and encompassing the essence of a hospitality concept within a hospital. This concept comprises of the hospitality factors, physical comfort, security and psychological comfort and security, being blended together and that the feeling created in the consumer is of great importance (Cassie & Reuland, 1983).

From this discussion it would seem appropriate that hospitals sit within a commercial hospitality context and that definitions of hospitality which have been considered thus far can be applied.



## **Hospitality in healthcare**

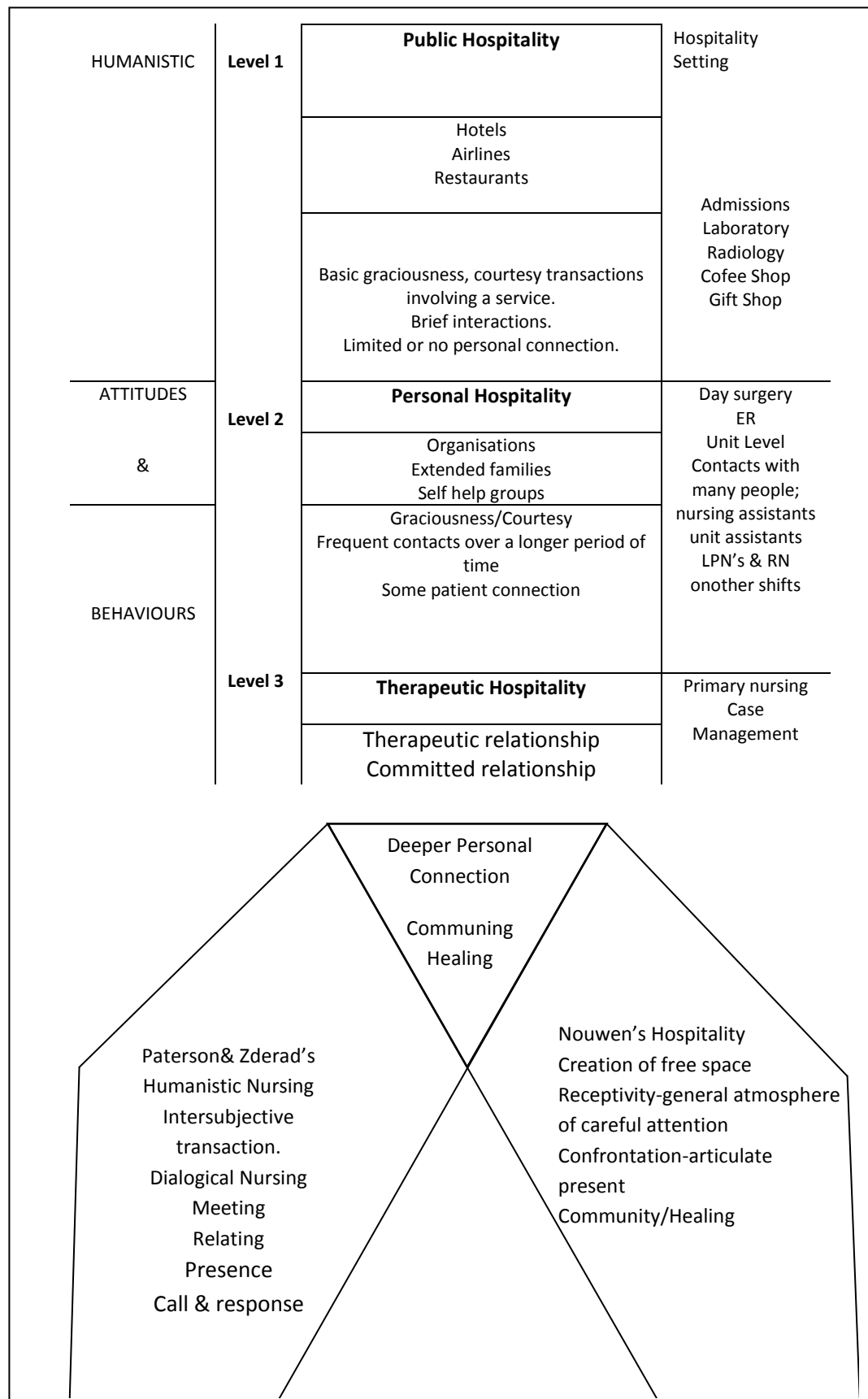
Within healthcare and nursing literature the concept of hospitality may be seen as an emerging one (Bunkers, 2003; Gilje, 2004). Interestingly, several investigations of hospitality in a hospital setting over the last 25 years fail to critically examine the social and dimensional forms of hospitality (Hepple et al., 1990; Severt et al., 2008).

According to Patten (1994) “hospitality issues must become a greater part of today’s nursing management” (p. 80a). It has also been suggested that the way the stranger is treated should be incorporated into the education of nursing professionals (Bunkers, 2003). “The hospital is seen as a place where a stranger may find rest care and protection and the word ‘hospice’ is defined as stranger and host and ‘pito’ means powerful one” (Bunkers, 2003, p. 306). Within healthcare the stranger or other is not just seen as the person but also as the disease, the idea or the experience. The healthcare worker is sometimes described as the powerful one (Bunkers, 2003).

## **Hospitality model in healthcare**

Purportedly, patients and their families are far more concerned with what is said and how it is said rather than the clinical aspects of their care (Patten, 1994). The service quality in hospital environments comprises of three elements; technical care, interpersonal relationships and the quality of hospital amenities and environment. It is the supportive dimensions which are now recognised as being critical to meet patients’ expectations. An understanding of their significance assists in the delivery of support services which promote patient safety, treatment, recovery and sense of wellbeing (Jenkins et al., 2011).

Patten (1994) introduces a nursing framework identifying different levels of hospitality: these are public, personal and therapeutic which are applied differently depending upon the situation (see Figure 3).



**Figure 3:** Steps to therapeutic hospitality. (Reprinted from Patten, C. S. (1994). Understanding hospitality. *Nursing Management*, 25(3), 80A-80H. Permission granted by Wolters Kluwer Health).

Working through the model, public hospitality is a brief personal exchange, involving politeness - between the hotel guest and the receptionist during check in for example. Within the hospital context it would include the admittance procedure for the patient. The nature of this exchange generally gives an important and lasting impression for the stay as it is the initial welcome.

Personal hospitality goes further than a brief exchange to include a personal invitation and sharing of interests and opinions between the hospital professional (host) and patient (guest). The encounter has some emotional involvement from both parties and would occur in day surgery for example where the patient may have an intense but short involvement with medical staff.

Personal hospitality may evolve into a more in-depth therapeutic level of hospitality and this encompasses a more ethical and moral dimension which may form the basis for professional caring practice. Wright-St Clair (2001) describes caring as being attuned to another person, which provides a greater depth of knowing about that person. In so doing it creates a holistic perspective enabling the carer to see the whole person. It is when a carer shows compassion, sometimes in the smallest of acts, that not only does the patient feel cared for but the health care professional may also feel more positive within themselves (Youngson, 2012).

A more intense and intimate relationship is formed between patient and carer which may form the basis for healing, and includes the therapeutic use of self (Patten, 1994). Patten relates this to Nouwen's concept of hospitality where he discusses the human situation as being one of pain and loneliness, which may be altered when a friendly space is created by others, enabling them to reach out and tell their own stories.

The opposite may occur when the host is confrontational and the guest is made to feel unwelcome, and this approach is one of hostility. Patten (1994) also discusses Paterson

and Zderad's theory of humanistic nursing who describe nursing as the lived experience between individuals which encompasses far more than one-way technical communication. This approach is characterized by concepts such as holistic, individual, empathy, intimacy, coping, caring and choice to create a humanistic rather than dehumanizing experience. A patient may feel vulnerable and Patten (1994) suggests that when a nurse shows real presence to listen, a patient will tell their story which may enhance their wellbeing and therapeutic progress. The models of hospitality presented by Patten (1994) and Lugosi (2008) would seem to show similarities in their interpretation of hospitality, in that it involves a significant emotional connection between the host and the guest. It is the emotional experience which is at the centre of the encounter, a hospitable act which abandons rational judgement to offer complete acceptance of the other which creates mutual wellbeing for both parties. It is this openness, recognised by being only a 'moment', a temporary exchange, which is regarded as hospitality (Lugosi, 2008; Patten, 1994). This idea of pure hospitality may be compared to the concept of true presence which is discussed in the healthcare literature (Bunkers, 2003; Stanley, 2002).

### **True presence and the lived experience**

The idea of attending to others by being truly present and acting with a spirit of hospitality is discussed by Bunkers (2003), who theorise a healthcare provider as being both guest and host in the lives of strangers. A spirit of hospitality involves opening up to the stranger, to have regard for differences and seek to understand their lived experience (Bunkers, 2003). To give the best care to the patient involves getting to know them and not making presumptions about them and what is best for them as each person is unique (Parse, 1992). True presence requires a connection with another person, developing a relationship to enable a knowing and understanding of another person's situation. True presence requires an intention to actively listen to the patient's

stories of their experiences, to be respectful, non-judgemental and perhaps to be silent. The sometimes painful or awkward situation faced by the patient can result in the nurse being exposed to personal anguish and difficulty in a lived experience which would not normally occur between two strangers. It is the nurses' ability to react in the moment with their full attention which demonstrates true presence, and the human becoming school of thought believe that acting with a spirit of hospitality and true presence are a unity, which foster a quality of care (Bunkers, 2003). Nurses may stress that they do not have time to care, yet Youngson (2012) suggests that many aspects of caring such as listening and providing information can occur simultaneously with physical caring and actually take no extra time.

'Presence' emerged in the nursing literature in the 1960s, and it was conceptualized as a philosophical model which was derived from the existentialism of Gabriel Marcel and Martin Heidegger (Stanley, 2002). Presence has been described as a 'gift of self' characterized by availability and openness (Paterson & Zderad, 1976). Stanley (2002) regards the paradigm of nursing presence as crucial in order to enhance the patient lived experience. It is not a passive concept but one she describes as powerful, requiring strength courage and doing, I have developed a table based upon the nursing assumptions which Stanley (2002) discussed in her article and these are illustrated in Table 1.

**Table 1:** Stanley’s assumptions of nursing presence (Stanley, 2002).

Assumptions of nursing presence:
Presence is a mode of being
Presence requires knowing and being comfortable with oneself
Presence requires knowing the other person
Presence requires a connection
Presence requires affirmation and valuing
Presence requires vulnerability
Presence requires intuition
Presence requires empathy
Presence requires being in the moment
Presence requires serenity and silence
Presence can be transcendent

Nurses have described experiences of presence as being both meaningful for them as well as the patient, provoking feelings of comfort and peacefulness whilst diminishing anxiety and vulnerability often when no words exist (Stanley, 2002).

Renzenbrink (2011) discusses how patients described staff as having absolutely no interest in their lived experiences and all that the patient wanted was for someone to show some interest in them as human beings and not as an object for analysis. She describes how patients felt alienated from the staff because no one cared about them on an emotional level, and there was no interest in how the illness or situation of being in hospital was impacting on their lives. Renzenbrink (2011) stresses that staff were not unkind, they were just focused on the tasks that needed to be done, and this perhaps illustrates the ‘public level’ of hospitality discussed in Patten’s (1994) model (Figure 3) where a transaction is taking place but there is no human connection other than what has to be said to get the task done. This caused patients to feel completely detached, with one patient articulating that it is often the small things that make such a difference like someone saying “goodnight” (Renzenbrink, 2011, p. 37).

## **Patient experience**

Previous studies with regard to the patient experience would suggest that patients expressed satisfaction with their treatment and care, yet talked about factors which although not essential to meet their needs were often compromised, for example their “reflections and existential thoughts” (Sørli, Torjuul, Ross, & Kihlgren, 2006, p. 1240). The researchers argue that these should be recognised as vital to a patient’s experience. The traditional view of hospital service quality centred upon the quality of technical care. A recent report commissioned in Australia suggests that this is outdated and understates the significance of interpersonal relationships and the impact of hospital amenities including the environment upon the patient experience (Jenkins et al., 2011). This would support Stanley’s (2002) philosophical model of nursing presence of acting with a spirit of hospitality (Bunkers, 2003) and Patten’s (1994), therapeutic model emphasising the significance of human involvement in the patient experience, as well as those of Hemmington (2007) and O’Connor (2005) from a hospitality perspective.

An earlier study considering the importance of hospitality within a hospital setting revealed that patients were concerned with feelings associated with “at homeness” (Hepple et al., 1990, p. 309). Gilje (2004) emphasises that the patient wants to feel welcomed and connected to nurses and other staff, which creates a sense of feeling at ease with oneself and others in their surroundings. Within a residential mental health facility in London patients are referred to as guests to promote the idea of hospitality and move away from the concept of treatment, with the aim of enhancing the perception of the ‘patient’ experience (Leason, 2004). It has also been acknowledged that communication from medical staff, discharge information and staff responsiveness is rated highly by patients as an important part of their hospital experience (Elliott et al., 2010).

In addition to staff responsiveness the patient experience encompasses food and menus (Johns, Hartwell, & Morgan, 2010), and whilst many patients are satisfied with hospital food, the researchers identify factors which affect their meal experience. They include organisational barriers where menus lack sufficient information for patients to make suitable choices about the right food to order, and difficulties in food ordering systems. The physical barriers faced by a patient were described as being placed in an uncomfortable position in bed which made eating difficult and an inability to eat food because it was placed out of reach.

The environmental factors which affected patients' stay involved interruption by medical staff, the disruptive and noisy behaviour of other patients or visitors and unpleasant smells (Naithani, Whelan, Thomas, Gulliford, & Morgan, 2008). The ability of the physical surroundings to impact behaviours and create images for customers and employees in hotels, restaurants and hospitals is evident (Bitner, 1992). This is particularly significant in the hospitality industry because the consumer is "in the factory" (p. 57), experiencing the product and service as it is happening (Bitner, 1992), and it is easy to see how this could be experienced in a hospital environment.

Enhancing the physical surroundings using hospitality inspired designs is seen as crucial by Wu, Robson and Hollis (2013) in order to appeal to and reassure patients. Patient centred hospitals with a "hospitality –inspired environment" (Annunziato, 2000, p. 58) and hotel five star accommodation and concierge style services (Mader, 2004) are being built in order to allow patients to be "treated with dignity and respect" (Annunziato, 2000, p. 55). The stated aim of these philosophies is to reduce patient stress. These studies were conducted in private hospitals but the essence of what they are aiming to achieve could also be applied to public hospitals. Elements of the servicescape have been recognised as affecting the emotional, cognitive and psychological states of



patients and staff within the emergency department of hospitals in New South Wales, Australia (Jenkins et al., 2011).

Similarly a project in the UK funded by the Kings Fund has transformed over 120 healthcare environments which has enhanced wellbeing for both patients and staff. Upon launching the project in 2004 HRH The Prince of Wales commented “It could not be easy to be healed in a soulless concrete box with characterless windows, inhospitable corridors and purely functional wards” (Renzenbrink, 2011, p. 35).

### **Identifying the gap in knowledge**

There are many studies which focus upon delivery of customer service in hospitals with analysis through customer satisfaction surveys (Descombe & Eccles, 1998; Fottler, Dickson, Ford, Bradley, & Johnson, 2006; Randall & Senior, 1994). However, this tends to focus on implementation of service delivery systems, “hospitality centric philosophy” (Severt et al., 2008, p. 664) or SERVQUAL (Randall & Senior, 1994) to measure levels of quality which are implemented to increase a hospital’s strategic advantage or improve their marketing potential (Pizam, 2007). They concentrate on the application of different management service models in an attempt to improve service delivery and service quality for patients and operational efficiency.

It may be argued that this approach fails to meet the needs of the customer because it is too prescriptive. The hospitality centric philosophy suggested by Severt et al. (2008) is a service excellence model which aims to customize service design and increase efficiency, but Hemmington (2007) suggests hospitality is much more than a series of service transactions as it incorporates experiences and memories. All customers are different and trying to apply a ‘one size fits all’ approach does not allow for a patient’s individual and emotional needs to be understood and as such the patient may often be left feeling disconnected (Bunkers, 2003; Patten, 1994; Renzenbrink, 2011).

The interaction between patient and staff should not be underestimated because it is usually rated more highly in patient satisfaction surveys than technical skills (Patten, 1994). Much of the research surrounding the patient experience has consisted of prescribed questionnaires in a quantitative style which has asked a patient to rate aspects of the service they received using a scoring system (Elliott et al., 2010). This has resulted in the patient experience being measured as satisfactory or not based on functional and technical criteria, rather than investigating the emotional or lived experience of the patient. Yet research surrounding the delivery of patient meals in hospitals, for instance, suggests that the attitude of staff who deliver the meals can affect the satisfaction and the perception of the meal quality (Edwards, Edwards, & Salmon, 2000). This suggests that despite studies relating to hospitals and customer service there is a gap in the literature surrounding the significance of hospitality in relation to inpatient care (Gilje, 2004; Paraschivescu, Cotârlet, & Puiu, 2011; Severt et al., 2008). Relatively few studies have explored hospitality in a nursing and hospital context (Gilje, 2004; Paraschivescu et al., 2011), despite suggestions from Patten (1994) that hospitality issues in healthcare “must become a greater part of today’s nursing management” (p. 80h). Therefore this study sets out to answer the question “What is the lived experience of hospitality for adults during their hospital stay?”

## **Summary**

This comprehensive scoping review of the literature explored what is already known or understood about hospitality and how it might play out in the hospital setting. Evidence from the existing theoretical and research literature retrieved suggest many factors contribute to the inpatient experience which is further complicated by its subjectivity, similar to the guest experience in a more traditional commercial hospitality situation, which is described by O’Gorman (2007a) as “existing within the lived experience” (p. 201).

It is through the diversity of interpretation within numerous social, cultural, commercial and academic frameworks, that hospitality is open to wide application in the modern world. Hospitality does not need to sit within specific contexts or incorporate precise objects, or involve certain actors, it should instead be envisaged as a “condition and an effect of social relations, spatial configurations and power structures” (Lynch et al., 2011, p. 14). All of these are encountered within a hospital environment, and this study is not intended to research the medical care of the patient but to investigate the impact of social interactions and power relationships between hospital staff, other patients and visitors and the effect upon the hospital patient.

The link between hospitality and hospitals is identified in the literature review with specific reference to the models of Lugosi (2008) and Patten (1994) which were discussed in some depth. The literature also discussed the idea of attending to others in true presence and acting with a spirit of hospitality in healthcare (Bunkers, 2003; Stanley, 2002). This links with the hospitality literature where Telfer (2000) describes hospitable behaviour to be motivated by a genuine desire to please the guest, to enable them to feel valued and respected. It is significant that hospitableness and hospitable behaviour should be genuine as it counts for nothing if interpreted by the guest as insincere, and this is so historically as well as in the present day (O’Gorman, 2006; Telfer, 2000). The difference between hospitality and hospitals is the ‘ity’ factor, which is created when a hospital creates an environment with ‘the right feel’ which will make a difference to the recovery of a patient (Pizam, 2007).

Furthermore, there are many factors which affect the patient experience within a hospital setting and that it may be useful to understand the many dimensions of hospitality and its potential application when caring for patients (Annunziato, 2000; Bunkers, 2003; Descombe & Eccles, 1998; Nouwen, 1976; Paraschivescu et al., 2011; Patten, 1994; Renzenbrink, 2011; Reuland, Choudry, & Fagel, 1985; Wu et al., 2013).

Hence, this study seeks to assess the significance of the space and environment surrounding the patient and whether it is hospitable or welcoming. This does not necessarily apply just to the servicescape like the temperature, colour of the walls and the comfort of a chair but may encompass a friendly space which is created in the hospitality transaction (Bitner, 1992; Lugosi, 2008; Lynch et al., 2011; Nouwen, 1976).

In the healthcare domain much emphasis is placed upon medical treatment for patients but there is evidence to suggest that other factors also play a significant part in the treatment plan and care of patients. This study, therefore, uses an interpretive phenomenological approach to explore the lived experiences of hospitality for adult elective surgical patients, opening the way for participants to identify what is meaningful to them.

The next chapter will introduce and discuss the methodology and methods used to complete this research.

## Chapter Three: Methodology

*“Thinking is lived, breathed, and dreamt, felt, run-with, laughed, and cried. It arises from all that has come before in one’s life, both the remembered and that which is known without knowing. Thinking reveals itself in the ‘ah ha’ of words jumping off a page.” (Smythe et al., 2008, p. 1390)*

### Introduction

This chapter introduces the philosophical understandings which guided the methodology and methods used for this study. This study asks the question, “What is the lived experience of hospitality for adults during their hospital stay?” In order to have a better understanding of this experience it was necessary to choose a research approach that would stay close to the participants’ experiences; to provoke thinking and point to a closer understanding of what is lived. It was believed that to use a quantitative research approach which focuses on prediction, control and measurement as outcomes would limit the ability of this study to gain an in depth insight into an understanding of the patient experience. It was essential that a methodology was chosen that would enable me to gain a deeper understanding of what it is like to be an elective surgical patient and what the impact of hospitality was during that experience. When trying to understand more about the nature and meaning of the lived experience it is suggested that a method of inquiry that uses phenomenology is adopted (Laverty, 2003).

### Two academic fields

Two very different fields of academic study, hospitality and healthcare, are broached within this study. As evident in the literature review, although there are studies which investigate hospitality in hospitals there are only a few, and those that do, have used a quantitative method for investigation and analysis (Hepple et al., 1990; Severt et al.,

2008). I was keen that this study would provoke more insight into the relevance of hospitality within the hospital setting and to do this would require participants to describe their actual experiences within an in depth interview. So I turned to the research literature within healthcare and discovered that within the field of nursing research phenomenology is widely used because it focuses on the human lived experience (Smith, 1998).

### **A winding path**

Through the research journey of my thesis, which has been long and winding, certainly not linear, I have been guided by what I have read and who I have spoken with. Many times I have questioned why and how I am knowing and understanding something but gradually the path has taken me to a place of understanding. This has also involved my reflections which I have written along the way in my journal which I continue to refer back to, to help me with my thinking. It is through this process that I decided to adopt the philosophical approaches of Heidegger (1927/1962) and Gadamer (1993) using a hermeneutic phenomenological methodology. Phenomenology does not seek to solve problems - it asks meaning questions, so that a situation may be better understood (van Manen, 2001). This is why it was justified as the most appropriate methodology to use for this study. There is a place for scientific, objective concepts of truth using a positivist approach for some studies, but this study does not make claims to do that. That style of research does not enable the researcher to uncover what it is to be human, 'what it is to be' to uncover the what 'is' (Smythe et al., 2008).

I wanted to understand 'what is' the meaning of hospitality for a patient, how did it make 'them feel' and what was 'the experience' for them. For instance when a nurse took the time to show an interest in a book they were reading, or when a health care assistant asked them when they would like to be taken for a wash, when was the best time for them? These types of questions can best be answered and understood from

listening to the stories told by patients of their lived experience and through interpreting the meanings of those stories.

## **Phenomenology**

“Phenomenology asks for the very nature of a phenomenon, for that which makes a some ‘thing’ what it is and without which it could not be what it is” (van Manen, 2001, p. 10). Therefore, experiencing hospitality was the phenomenon of interest in this study. Phenomenology was originally developed by the philosopher Husserl who aimed to understand more about the lived experience or life world. From Husserl’s perspective this type of inquiry asks; “What is the experience like?” Attempting to unfold meanings as they are lived in everyday life (Lavery, 2003). Such experiences may be regarded as very ordinary, as they occur in our everyday life and are often taken for granted. Phenomenology attempts to uncover the essence of a phenomenon by using descriptive language in such a way that it uncovers new and deeper meanings of a particular experience (van Manen, 2001).

Husserl achieved this through phenomenological reduction, bracketing out the researcher’s own underpinnings to write descriptive interpretations to understand the essence of an inquiry (Koch, 1996). Although Husserl explores the lived experience his focus was on understanding beings, while Heidegger (1927/1962) focused on ‘Dasein’, or ‘being-there’ to signify human existence as always situated in a mode of “Being- in-the -world” (p. 65). Heidegger firmly believed that consciousness is not separate from the world but it is part of our historical lived experience (Lavery, 2003). To illustrate this a person who is going into hospital for surgery will have an expectation of what the experience will entail within their own consciousness, and this may be based upon a previous stay or from what others may have spoken about. This person’s being or ‘Dasein’ is part of who they are and what makes them human.

## **Hermeneutic phenomenology**

Hermeneutic phenomenology sits within the interpretive paradigm and is aligned to the social sciences (Grant & Giddings, 2002). Hermeneutics studies language within text, and using an interpretive process of writing rich descriptions it aims to evoke being in moments as they were lived to get closer to an understanding. Both Heidegger and Gadamer believed that “language and understanding are inseparable structural aspects of being-in-the-world” (Lavery, 2003, p. 25). Heidegger was concerned with the ontological-existential questions of thinking, understanding and experiencing which he uncovered through engaging with language and interpreting texts (Pernecky & Jamal, 2010).

In this study it was crucial to decide upon the meaning of the word hospitality in the context of a hospital setting, in order that a deeper meaning and understanding of the phenomenon could be understood. That is the ‘being’ of the hospitality lived experience for the surgical patient. Hospitality has been defined in chapter two as attending to others in ‘true presence’, acting with a spirit of hospitality, to establish a genuine human connection with a patient for a limited time, to create a friendly space.

## **The fusion of horizons**

Whereas Husserl believed that pre-understandings should be acknowledged but then bracketed out when interpreting, Heidegger contended that “interpretations are grounded in something we have in advance, a ‘fore-having’ a ‘fore-sight’” (Pernecky & Jamal, 2010, p. 1065). Put simply, what I as a researcher bring to this study, in terms of my work experiences, my culture and my history, will shape my experiences and interpretations and as such will impact the findings. Gadamer suggests that these pre-understandings may be described metaphorically as a fusion of horizons. Understanding comes from interpreting and it is the willingness of the researcher to recognise their own pre-understandings which will enhance this process.



Gadamer describes a horizon as a vision from a particular vantage point, it allows for the seeing far beyond what is close at hand (Lavery, 2003). It enables me as a researcher to be challenged by what is new and unfamiliar to me, it is as I move backward and forward in my thinking and allow the horizons to move with me that understanding occurs. Through interpretation the horizons of me as the inquirer and the horizons of the participant fuse together to uncover a deeper understanding of a lived experience (Koch, 1999).

During this study I was conscious of the potential impact of my viewpoint, aware that my present horizon may dominate my interviewing and steer the interview in a particular direction almost to a preset conclusion. So I was mindful to self-reflect. After a pilot interview I observed from the tape that I had sometimes led the participant toward an answer, because of how I had phrased a question. Smythe et al. (2008) call this freezing the phenomenological spirit. On another occasion because I was new to this field of inquiry I had not respected the patient's silence, and I was quick to interject with another question - yet I have learnt that a pause or a silence has significant meaning and should be interpreted in the same way as text (van Manen, 2001).

I continued to self-reflect throughout the study, particularly when drawing coherent stories from the interview transcripts and then through interpreting those stories that expressed what it was to experience hospitality. As I moved amongst the text, sometimes stepping away from the text then looking back I aimed to deepen my understanding of what it was that it all meant. This process occurs through being within the 'hermeneutic circle'.

### **The hermeneutic circle**

The aim of hermeneutic inquiry is to gain more understanding not to gain more knowledge (Koch, 1999), this is achieved through interpretation of the text. To gain

insight into the meaning of the text the interpreter immerses him or herself within their text. To engage and uncover meaning I looked at the text, then moved away from the text, then back again. By re-reading and re writing, by acknowledging my own historicity I continued to move in and out of the text until a “place of sensible meaning” (Lavery, 2003, p. 30) was found. This process of moving in and out of the text is described by Gadamer as being within the hermeneutic circle (Lavery, 2003). It is understood that when a ‘sensible meaning’ is found that this is not fixed and that this construction will alter if a better understanding comes along (Koch, 1999).

Interpretation is far from being an easy process and when conducting this study I was at times overwhelmed and at times lost as I tried to navigate my way through the data. As Smythe et al. (2008) explain one has to put trust in oneself that through being within the hermeneutic circle that understanding of the text will come. I persisted in my endeavour and then without warning the text would jump from the page and proclaim itself to me in a ‘wow’ moment. Let me illustrate this from one of the stories I was told; Beth is describing how she felt when the staff in her ward went out of their way to organise for her to go to chapel.

*They got me there in my bed! Well I was like, you are kidding me you are taking me to church in a bed, this will be a first. I was prepared to jump into a wheel chair, and put my foot up, but they said absolutely categorically not, you have to stay in bed. So a volunteer came and took me in the bed, the entire bed, to the chapel! I don't often go to church in a bed. It was such an adventure. It was fun! My legs were extended up there, clothes and plaster everywhere and I was the only one in the chapel in a bed the others were sitting on chairs or on walkers.*

*That was really lovely, I felt really special that was such a nice thing  
for them to do! (Beth)*

Something very memorable happened to Beth in hospital which she will probably never forget and it had nothing to do with her medical care. To me this demonstrates a human connection shown towards Beth, which is not contrived, or based on protocol. It is an example of several people going out of their way to do something which is not part of their normal job routine. This shows an act of hospitableness involving others being hospitable for genuine motives, showing a genuine desire to please others and give pleasure. The staff did not have to do this but the fact that they did showed Beth a true example of hospitality and the impact it had on her was considerable, and perhaps this is why hospitality needs to be thought about when caring for patients in a hospital setting.

This interpretation was by no means a quick or easy process for me but gradually it enabled me to uncover a deeper meaning and understanding of the hospitality experience for the patient.

### **Pre-understandings**

In order to move between the research question and understanding when doing interpretive inquiry in a hermeneutic phenomenological mode, it is necessary to address the history of my pre-understandings, to reflect upon my experiences and to discover how my own knowledge has been shaped.

Who one is as a researcher is fundamental to the research. It is because of who I am that I have posed the question that I have. It is my thinking and my knowledge that will lead me and have led me to the very journey of discovery that I am on. Thinking does not occur in a vacuum, separate from the world in which we live but it is very much part of our lived experience (Smythe et al., 2008). Within the interpretive ontological perspective, existence is not one reality but a construction of multiple realities by the

knower, thus the knowledge I already have will influence my understanding (Lavery, 2003).

The idea of value-free research has been much debated, whether a researcher can actually achieve this is questionable and whether in doing so would in fact be useful. It has been suggested that researchers who have attempted to be value free has resulted in the loss of certain kinds of knowledge about the human experience (Lavery, 2003).

Within interpretive phenomenology, the researcher and participant are regarded as interactively linked in the creation of findings and the researcher is often regarded as a passionate participant in this process.

It is suggested that through hermeneutics we are able to locate ourselves historically and culturally enabling us to relate to others and the world in general (Koch, 1999). It was Heidegger (1927/1962) who declared that every interpretation of an encounter is based upon a person's background in its 'historicality'. Whereas Husserl believed that a researcher's own experiences should be bracketed out, Heidegger and Gadamer believe that:

We are neither inside or out, rather we are in our culture as it is in us. We are the same coin. It is a world that we live and as we live it, it is a world that we are (Koch, 1999, p. 24).

Gadamer refers to these pre- understandings as prejudices, and he suggests that it is these very biases that inform us of who we are, of our 'being'. It is from our prejudices that we are able to experience the world, they form our knowledge, it is our prejudices which help us to understand when we research (Koch, 1996). For this reason it was a good idea for me to acknowledge my pre-understandings so that it may be clearer to understand why I have chosen this particular research journey.

It is a common feature of hermeneutic research to have a pre-supposition interview to identify pre-understandings, biases and previous knowledge which will be brought to the research. I was interviewed by both of my supervisors early in the research process. I found the interview to be an enlightening experience, it drew from me past history which I had long forgotten but it was also emotionally draining. I took from this two things, firstly that I had a far deeper history of hospitality and of hospitals than I had remembered and it was from this interview that I began to realise why I was asking this research question. It was indeed my fore-havings which had led me here, as Gadamer (1993) asserts in order for an interpreter to better understand something they need to have a bond with their subject. A detailed explanation for my pre-understandings and why I choose this topic are discussed in chapter one. The second thing I learned from the pre-supposition interview was that I should be mindful of the emotional and mental tiredness that an interview may have upon my participants, as I found the experience of being interviewed far more draining and emotional than I was expecting.

### **Reflexive journal**

In order to completely immerse myself within the hermeneutic circle I kept a reflexive journal throughout my research journey, and it enabled me to record my experiences, my thoughts, my feelings and my understandings. I completed this journal when something significant occurred for me (often this would occur after I had completed an interview). I would immediately feel the need to write down my thoughts; I referred back to the journal and continue to complete it throughout my transcribing and interpreting of the data. Koch (1996) suggests that the reflexive journal aids the researcher to recognise how his or her horizons are working and it also gives credibility to the research through an interpretation of the researcher's own experiences.

## **Research methods**

Within this section I will outline the methods which were used to complete this hermeneutic phenomenology study, using methods guided by van Manen (2001) which is appropriate at Masters degree level.

## **Ethics approval**

In order to commence, research ethics approval was sought through Auckland University of Technology Ethics Committee (AUTEC). A copy of the initial approval letter dated 9<sup>th</sup> August 2013 can be seen in Appendix A and was given the approval number 13/193. However, this approval was subject to a few amendments of the information sheet and indicative questions. After consultation with supervisors, each amendment was addressed individually and the responses and changes may be seen on a letter sent to AUTEC on 14<sup>th</sup> August 2013, also in Appendix A. It should perhaps be noted that a suggestion was made by AUTEC to change the style of the indicative questions; however both supervisors made a case that they were in keeping with the methodology and should remain unaltered. Final approval was received on 14<sup>th</sup> August 2013 (Appendix A).

In the original application a clause was put in to allow participants to receive counselling should they become upset after retelling their stories - this was included after discussing the proposal with members of staff and supervisors. The AUTEC did not feel there was a need for this to be included so it was withdrawn. So that risks were minimised to participants they were advised in the information sheet that they could bring a support person with them to the interview, or stop the interview at any time. The participant information sheet can be seen in Appendix B.

Before commencement of the interview participants were fully informed of the research and its implications for them through the participant information sheet. They were invited to read the information sheet and sign the consent form (see Appendix C).

Privacy of participants would be protected, and they were also informed that the interview would be audio taped upon their agreement and consent. Any information provided would only be accessible to me and my supervisors and reference made to them in the study would always use a pseudonym. This is detailed in the information sheet. Participants had the right to withdraw from the study at any time. All data will be kept for a maximum of six years and stored in a locked cabinet on AUT premises in WH building office number 507. After this period all data will be shredded at AUT.

There was some concern from the AUTECH with regard to the safety of the researcher as I would be interviewing participants in their own home, and this was requested by them as an amendment after the initial application was made. A researcher safety protocol was duly completed and is displayed in Appendix D. This was an excellent idea and ensured that when I conducted an interview that my supervisor was aware of where I was.

### **Treaty of Waitangi**

The Treaty of Waitangi (1840) sets out to protect the rights of people within New Zealand. Researchers in New Zealand are expected to adhere to the principles of the Treaty in terms of respect, partnership and participation. This research at all times respected and acknowledged the Treaty of Waitangi although this research did not aim to address any particular Treaty obligations. All participants were treated with respect regardless of their culture or social group.

## **Inclusion criteria**

This study is all about the hospitality lived experience of a hospital patient, and it was decided that in order to have had enough experience of being in hospital participants should have been admitted to hospital for a minimum of three days. Any less time might be considered too short for participants to have really lived the hospital experience. It was decided that the inclusion criteria would stipulate that all participants must be adults between the ages of 25-55; they must have stayed in hospital for a minimum of three days and have been admitted to an Auckland hospital for elective surgery in the past year.

The inclusion criteria are very specific and this is for several reasons. The focus of the study was to be on adults as it was assumed that the experiences of teenagers, young children and elderly people would all be so different that it may not lead the research question to any deeper meaning of the experience. As this is such a small study it was further decided to focus on a particular group of patients who had had elective surgery. It was crucial that all the participants had elective rather than emergency surgery because it was assumed that each may result in a very different type of hospital hospitality experience. A planned surgery is expected and the patient has had time to prepare mentally and emotionally whereas emergency surgery is unplanned and the patient is likely in a very different emotional and physical state. I wanted to know what the experience for planned arrival was; what was the hospitality like that they received? The reason that Auckland hospitals were chosen was primarily because I live in the Auckland region and it would be easier for me to meet with an interview participants. Another reason why Auckland was chosen was because the Auckland District Health Board had shown some interest in the findings of this study so it would be necessary to ensure that only hospitals within this region were used.



The last inclusion clause was that all participants had good conversational English as this is the only language that I speak fluently and it was assumed it would be difficult to conduct an interview through an interpreter for this methodology. A final exclusion was that I would not interview anyone who was previously known to me before I commenced this research; this was because my pre-assumptions and theirs may affect the outcome of the interview and create biases toward coercion or non-disclosure.

## **Recruitment**

Initially potential participants were to be purposively recruited by way of an advertisement which I placed (with permission) at various locations in the West Auckland area - this included community centres, libraries, doctors surgeries and community notice boards. The advert was very specific in order to promote potential participants matching the inclusion criteria. The advert was approved by the AUTECH and a copy can be seen in Appendix E. The advertisement invited respondents to phone, email or text me with their name and contact details if they were interested in receiving more information about the study; or to ask further questions.

In addition to the advert being placed in various centres I began to talk to colleagues at work and to other postgraduate students about my study. On many occasions they would ask me to send them the advert because they thought that they knew a person who may be interested in participating. Sometimes I heard no more but on more than one occasion this is how I recruited my volunteers. Once they had expressed an interest in my research I made contact with them either by phone or email, depending upon their preference, to ascertain if they met the inclusion criteria and to tell them more about what was involved. Having made initial contact, if potential participants were keen to take part, I sent them a consent form and participant information sheet and set up a date for an interview once consent was indicated. Unfortunately when I spoke with a few volunteers I discovered that for one reason or another they did not exactly fit the criteria

and I was unable to interview them. This was a shame as on these occasions I sensed that the person was very disappointed as they really wanted to share their stories and experiences.

The recruitment continued to snowball in this way so even though I had initially planned to place an advert in a free local paper I never needed to do so.

## **Participants**

In total I interviewed seven participants for this study. All the participants were women, not through my choice but simply because no men volunteered for the study. The women were all admitted to Auckland hospitals - some went to private hospitals whilst others were admitted to public hospitals. The participants were from a broad age range within the specified criteria, were from different cultures and had all been admitted for very different kinds of surgical procedures.

## **Interviewing**

For this hermeneutic phenomenological research the interview was used for a very specific purpose; to explore and gather experiential information which was to be used to develop richer and deeper understanding of the hospitality lived experience of the hospital patient (van Manen, 2001). I conducted a pilot interview using the indicative questions which were approved by AUTECH; a copy may be seen in Appendix F. As a novice phenomenological researcher I was keen to improve my technique of this style of interviewing, as conducting unstructured interviews may have resulted in gathering data which had little relevance to my research question if not carefully framed. van Manen (2001) explains that an inexperienced researcher may gather insufficient 'quality' material if questions are leading because answers are too short, or the opposite may occur when far too much data from poorly managed interviews leads to confusion in how to gather any meaning from the data.

Although AUTECH initially questioned the submitted questions both supervisors believed that they were congruent with this methodology, being designed to gently probe participants in order to elicit stories of their experiences. For example “Tell me about being a patient in hospital”; this may be followed by a prompt question for instance “Tell me about what happened when you first arrived”. When resubmitting the ethics my supervisors suggested that these questions would be revised if they failed to draw out from the participant’s relevant responses, and this approach was accepted by AUTECH.

The pilot was conducted with a postgraduate student who I had met briefly at a workshop at AUT, as she was a keen volunteer. The data from this pilot interview was not included in my findings and analysis. I had met her only twice so she was familiar to me but I knew nothing of her hospital stay prior to the interview. She had recently had surgery and had stayed in hospital for more than three days, and I interviewed her in her own home. Following the interview I turned to my journal to write down my thoughts. Reading from my journal I expressed great excitement at finally beginning my research journey, and I commented that some of the questions needed to be altered slightly in order to elicit relevant responses. After I played the tape back and began to transcribe I realised that I sometimes found myself leading the participant and also interpreting with her during the interview why a particular thing may have occurred.

The pilot interview enabled me to re-examine myself in terms of my technique and I was very mindful of this when I conducted my subsequent interviews. All the interviews were conducted in the participant’s own home or work environment and lasted from between 50-90 minutes. Each interview was recorded and then transcribed verbatim by myself.

## **Analysis of data**

From the transcriptions I immersed myself within the text; I read and re read the dialogue in order to identify and draw coherent stories of the ‘ah ha’ moments, of our conversation (Smythe et al., 2008). These are the stories which made me hesitate in my reading, which made me stop and think, because they expressed a significant moment of an experience which related so beautifully to my research question.

The coherent stories were returned via email to each participant in order that they could confirm that this was a true account of what had been discussed in our conversation.

This provided validation and rigour for my research. Participants were asked to comment on how it felt to read these stories and at this point I invited them to choose their own pseudonym to provide confidentiality in the thesis. Many participants expressed great delight in reading their stories in the way in which their experience had been recreated, and there were quite a number of ‘phenomenological nods’ where the participants responded that I had captured their stories of experiences the way they had experienced them.

I then set about the task of interpreting the data through immersion in the hermeneutic circle. I read and read the stories to decide which stories were the most significant in terms of their deeper meaning in the context of the research question. I set about to identify themes within the stories of those stories which really captured the meaning of the hospitality experience, which moments reveal the ‘what it is’ of this phenomenon. van Manen (2001) suggests that a good theme is one that captures the ‘core’ of the notion we are trying to understand. I needed to decide what it was about a particular story, or sentence or pause that revealed a deeper meaning and understanding for me about the impact of the hospitality experience for the hospital patient.

I returned to the coherent stories after a period of reflection. I needed to decide which were the most poignant stories, to uncover if several stories had similar themes so that I could begin to interpret just those stories that were most significant to this study, which made the clearest or most illuminating contribution. This proved to be an agonisingly difficult process because I wanted all the stories to feature; this of course was a ridiculous notion as there were far too many stories. Gradually I began to select those stories which were the most powerful to me in expressing the impact of hospitality, just what was it that made the difference to their stay?

To interpret hermeneutically I had to believe the stories that were told to me were real, and many times I could feel just how real they were by the tone of the voice, or a tear in the eye as a story was retold to me. When I interpreted the data, I expressed a meaning of what I thought the text or the story was getting at, what it meant to that person, and this was based on a method suggested by Koch (1999). She details a method for interpreting data, some (not all) of which I found to be a useful guide to follow as a starting point. This involved reading the text in a literal way to begin with - put simply what did this story tell me? Then I began to see if other stories told me a similar notion, in which case I began to cluster stories together and develop some common themes. When interpreting I am always aware that my experience and history are influencing and shaping my understandings of the text, and this is a valuable part of being within the hermeneutic circle.

With hermeneutic research it should be remembered that although a particular theme is reoccurring and another theme appears only once it does not make one more significant than the other. A theme has shown me something which I want to point the reader towards, it is the 'ah-ha' of my research that I hope will provoke more thinking and discussion (Smythe et al., 2008). The themes are presented in separate findings chapters yet, in reality, they are interconnected and inseparable. Sometimes, to get to the core

meaning of the stories, when I interpreted I followed a more critical approach suggested by Koch (1999) and referred to as 'hermeneutic of suspicion'. I looked for deeper meaning, sometimes an underlying meaning of the text; I attempted to work out what the implications are of what the conversation really meant to the participant. I continued with this interpretive process until I had reached a moment of sensible meanings, a tentative understanding of what hospitality meant within the stories for my participants at this time. I understand that this place of understanding, is temporary and within hermeneutic phenomenology it is always changing it is just as it is for now, up to this point (Lavery, 2003). These notions which I uncovered through this process are discussed in detail within the findings chapters that follow. Highly illustrative stories are presented in the findings chapters, followed by my interpretation of what the story is saying and the meaning behind the text. The stories are drawn from across the whole of the research data to ensure that all the participants' voices are represented. The storied data are presented in italics, and where participant words are quoted in the interpretive text they are also presented in italics.

### **Trustworthiness**

There is a lack of consensus in the literature as to what makes a qualitative research study legitimate and valid (Koch, 1996), which can be a challenge for me as researcher. It is suggested that in explaining the philosophical approach which I have adopted for this study that it will have more credibility because different philosophical positions inform the research process (Koch, 1996; Lavery, 2003). This chapter has outlined the methodological approach of hermeneutic phenomenology and discussed why it has been chosen as appropriate for this particular research question.

### **Credibility**

Rigour is an important part of academic research, and this can be demonstrated as throughout the research process, I have maintained strong links with my supervisors. At

the commencement of the project we completed a supervisory agreement agreeing to terms and conditions of how the project would be undertaken. Regular meetings were arranged throughout the process which enabled me to ask questions which I had noted in my reflexive journal. I would bring copies of transcripts, coherent stories and interpretations which were discussed to assist me in my quest to research in a way which was appropriate to this methodology. Minutes of meetings would be taken and I would also make notes in my journal, and this enabled a trail of the decisions that were made throughout the process to be recorded, which supports the credibility of this study (Koch, 1999). Credibility was established further by returning coherent stories to participants so that they could validate them as being a true account of our conversation.

### **Dependability**

Trustworthiness was required for my participants, for several reasons. In keeping with this methodology I needed my participants to have trust in me so that they were comfortable during interviews and be open with me. It was necessary to develop an embodied relationship with each other for participants to share their stories. Openness is crucial in this methodology to enable me as the researcher to stay close to the lived experience which would not happen if we were unable to trust each other (Koch, 1999; Lavery, 2003). I established trust from the outset by being honest and open about what this study involved by way of giving accurate information in the advertisement and the participant information sheet and consent forms. I was honest and at no time pressurized any participant to take part in the research if they wanted to withdraw. In the ethics section of this chapter I gave clear guidelines as to how I would collect data and use data to ensure it was safe, how it would be used and how it would be discarded after the appropriate time period. All of these processes enabled me to gain trust and dependability with each participant.

In line with Gadamer's view on prejudices (Koch, 1999) that I have brought to this study, I have acknowledged that they will play a significant part in how I interpret text and how I have addressed the research question. To identify my prejudices I took part in a pre-supposition interview as already discussed where I began to explore my pre-understandings more deeply. This began my journey of being within 'the hermeneutic circle' (Koch, 1999) going back and forth to eventually complete my interpretations. The reader should be able to follow the process of how I interpreted my data and how this relates to the research question in the way I have discussed this process within this chapter and throughout the thesis.

## **Conclusion**

The aim of this chapter was to introduce the reader to the methodology and methods that have been used to address the research question. It has explained why the philosophical underpinnings of Heidegger and Gadamer have been chosen as the most suitable guidance for this study. I have also explained the methods which using the approach of van Manen have been followed in the gathering and interpreting of data, to ensure it is in the style of hermeneutic phenomenology. The next chapters will present my findings.



## Chapter Four: Hospitality just is

*“We do not know what hospitality is.*

*Not yet.*

*Not yet, but will we ever know?” (Derrida, 2000, p. 6)*

### Introduction

True hospitality appears to be a mystery, not because of any philosophical challenge but because of its subjectivity, quite simply it is not a “matter of objective knowledge” (O’Gorman, 2007a, p. 201). This thesis poses the question “What is the lived experience of hospitality, for adults during their hospital stay?” The literature chapter discussed in some depth the meanings and definitions of hospitality although as the quote from Derrida (2000b) implies there is still much to know while accepting it may never be revealed in its entirety.

Nonetheless, accepting that I can work to come closer to understanding what it is, I have drawn from the hospitality, healthcare and methodology literature to deepen my interpretations of what it appears within the participants’ stories. I understand that hospitality in the context of this study is very much about the ‘being’ or existence of the hospitality lived experience. O’Gorman (2007a) suggests that hospitality may be described as existing within the lived experience. It is the phenomenon of experiencing hospitality as it happens which this chapter will uncover. Through probing and unwrapping the rich illustrative text within the participants’ stories I will reveal the significance of ‘hospitality just is’ for these elective surgical patients.

Each story in this chapter has been chosen because it shows something of how the participants experience and frame their notions of hospitality and what hospitality means to them. It is not suggested that one story is more significant than another by the understanding that it reveals, for each individual has their own perspective of hospitality

just as it 'is' and what that means to them. The stories are carefully selected, through my submersion in the hermeneutic circle, where I thrust myself in and out of the text to uncover some deeper meaning of how the phenomenon of "hospitality just is" showed itself to these participants.

Although hospitality is a subjective notion, it should not be regarded that by the uncovering through my interpretations a deeper understanding of this phenomenon, that it should be regarded as unimportant to any other hospital patient. What begins to show itself in this chapter is of how it is experienced in the lives of these patients and how it brings to the fore the ways hospitality plays out within a hospital setting. In the retelling of these stories to uncover the participants' experiences and my understandings, the reader may find the text is at times familiar to them; this is the very character of phenomenological research. To sometimes point the reader to what they may already know but perhaps had not dwelled to think more deeply about. This is a very Heideggerian notion - "What Heidegger notices, and presents in conceptual garb, is in a way obvious to anyone once it is pointed out to them" (Inwood, 1997, p. 37).

At times during the stories participants spoke of moments, of occasions when they were overwhelmed by the attentiveness of a healthcare professional. These were occasions when something occurred, which was beyond what the person, as 'a patient', would reasonably expect within a hospital environment. Such experiences led to memorable moments, which would be told and retold. Beth's story speaks of such an 'ah ha' moment:

*On Saturday morning I mentioned to the staff that I would quite like to go to the chapel service on the Sunday if it could it be arranged, if you can't arrange it then it's no big deal. But they did! I must say they were really, really good about arranging it. Which I thought was really sweet of them. Each time there was a change of staff, the staff*

*member would say we will take you to the chapel tomorrow. In fact I nearly said to them you are taking this way more seriously than I am ha ha.*

*They got me there in my bed! Well I was like, you are kidding me; you are taking me to church in a bed? This will be a first. I was prepared to jump into a wheel chair, and put my foot up, but the nurses said absolutely categorically not, you have to stay in bed. So a volunteer came and took me in the bed, the entire bed, to the chapel! I don't often go to church in a bed. It was such an adventure. It was fun! My legs were extended up there, clothes and plaster everywhere and I was the only one in the chapel in a bed the others were sitting on chairs or on walkers. That was really lovely, I felt really special that it was such a nice thing for them to do. (Beth)*

Something very memorable happened to Beth in hospital. The way she tells this story suggests the memory will linger even though it had nothing to do with her treatment or medical care. In her recounting this story of asking to go to the chapel service on Sunday, Beth's words suggest she is not too concerned if it did not eventuate; her words reveal some hesitancy at asking if it can be arranged. Yet when she exclaims *But they did!* We can hear her experience of being overwhelmed; her disbelieving it would come about. And as she emphasises how the staff *were really, really good about arranging it*, it suggests Beth's hesitancy at asking; of her feeling some guilt just for asking for something beyond her usual care. Further, her words point to the unexpected specialness of it happening.

As Beth talks about offering to jump into a wheelchair, the text points to her wanting to make it easy for the staff as if her request of going to the chapel service is beyond what

she should reasonably expect. As she recalls the staff member saying she *absolutely categorically will not* go in a wheelchair Beth reveals the definitive nature of how her health needs were looked after. Her surprise at the attentiveness towards her wish shows in her response, *you are kidding me!*

This story points towards the notion of hospitality as generosity, the way in which Beth continually talks about this moment, referring back to it repeatedly, as she retells this story may be regarded as an example of the ‘hermeneutic as’ in play. Heidegger (1927/1962) describes such harking back to one moment as pointing to something which has greater meaning and it “lets something be seen as something” (p. 57) else. It is the actions by the staff which Beth is describing which are revealing themselves ‘as something else’, as unexpectedness, when she exclaims *but they did*. Beth experiences a genuine desire from others to please her, by their attentiveness. Telfer (2000) describes this as Good Samaritan hospitality, to look after those in need, who are vulnerable without any expectation of reciprocity, just a genuine desire from the host to please and give pleasure. How does this make Beth feel? Well, she is quite simply aghast at how much attention and time has been given to her to make this visit to the chapel become a reality. Although it is argued that truly hospitable behaviour does not exist because there is always an ulterior motive from the host (Ritzer, 2007), this story would indicate that it can. The text illustrates the effect this had upon Beth, *It was really lovely, I felt really special*. Beth’s words point to a deep happiness, she is feeling so good, so happy, she has been made a fuss of she has been entertained.

Historically, dating back to the 15<sup>th</sup> century, being entertained formed part of a social ritual between the guest and host and is now synonymous with the way hospitality is viewed today (King, 1995). So it seems appropriate for Beth to be entertained and as such she is able to be who she is as a person and can forget that she is Beth the patient in the technical medical sense, but that the people around her have gone way beyond

that; beyond what she anticipated. Having this opportunity to go to chapel took Beth away from the ward, from that sterile environment and allowed her to do something that she would do in her ordinary 'normal world'. When she is not in hospital, it enabled her to be who she is, she was treated as though she was Beth, who is not just a woman with a bad leg but a woman that likes to attend chapel in her normal life.

This story highlights one particular facet of the lived experience of hospitality as generosity which was just there; it just happened, which is for a host to make an individual feel valued, unconditionally. This was demonstrated in the way that the action of the nurse was spontaneous and not premeditated in any way. When a patient is in an unfamiliar setting they lose their own identity and may feel vulnerable to the healthcare professional who may be perceived as the 'powerful one' (Bunkers, 2003). The literature suggests that patients want staff to be interested in them as human beings who had a life before entering the hospital (Renzenbrink, 2011). When a patient feels valued as Beth's story illustrates they can feel special, more relaxed and happy in their situation. Within this story, it is the generosity of hospitality which shows itself.

This next story reveals another dimension of hospitality which is that the hospitality exchange also encompasses the experience of being 'entertained', which can take several forms. Susan's story illustrates the significance of 'the just knowing' of what is available for self-entertainment and why this is of importance to her as a patient. Not so much that a patient expects to be entertained by hospital staff, more that amenities which create a diversion are needed to occupy the time whilst in hospital.

*The one thing they didn't tell me about was what was available for me to do. For example there is a lounge where you can go and watch TV, but I found that anyway by walking around. I did ask them if there was an exercycle, being a keen cyclist, [slight laugh] and I found one*

*actually; really. Yes, the nurse I asked didn't know but on my walking around I found one. On my ward right at the end of the corridor, quite a nice position actually 'cause it was by a big window and I would have used it except it was very squeaky, so when I turned the peddle, "squeak squeak," very noisy, and I thought no this would not be ok. I thought that was great actually, but they need to make sure it is working. They also needed to let people know about it because the nurse I asked didn't know there was one. (Susan)*

What is quite interesting about this story is that there were things to do, amenities were available for patients but the patients did not know about them and neither did the staff. Susan is an active person and a keen cyclist and this story uncovers her desire to keep active and busy physically and mentally while in hospital. Yet Susan's story suggests that although there may be things available for her to do to occupy her she does not know about them and perhaps what is more frustrating is the not-knowingness demonstrated by the nurses of what is available to her, to occupy her. Susan explains *I did ask them if there was an exercycle* to use but the nurse has no knowledge that there is in fact one available for patients to use. It is unlikely that Susan would have expected that there would be an exercycle available for her as she was in a public rather than a private hospital and she likely already knows that public health funds may be limited for purchasing an item which may be regarded by some as a 'luxury'.

Yet, how unreasonable a request is this? A hospital is a place where a person is to be cured and made well and presumably doing exercise would assist in this process. Yet Susan's story suggests she is not too surprised in the answer she is given to her request, in the way she exclaims in a very astonished manner in her story *I found one actually!* Disappointed but not surprised and she is left to discover for herself just what is

available. Susan proceeds to discover for herself by walking around the ward, what there is for her to do. The text suggests that she is rather disappointed that nobody can tell her: that nobody she asks has any knowledge of what there is for her to be occupied with. This may indicate to Susan that her 'being entertained' is not regarded as a high priority in terms of her overall care while she is in hospital. The focus from staff toward her care is centred on her medical care, but as Susan is otherwise active and can still move around freely she is anxious to be busy, to occupy both her body and mind while on the ward. For Susan to sit around all day in bed is just not who she is, or what she wants to do, it is important for her to continue to do some of the things she likes to do when not in a hospital environment.

Interestingly as Susan begins to discover as she walks around the ward there are in fact several things that could occupy her time. To her amazement she does indeed find what she so desires, the exercycle, it is there, really there for patients' use, for her to use. Her surprise in finding it is expressed by her little laugh as she retells the story in which she exclaims *I found one actually!* Susan is suddenly so excited, as a very keen cyclist she would be able to keep riding and keep busy and it was also in a particularly good position by a big window. This comment from Susan about the *big window* suggests it offered a lovely view not afforded by being other places on the ward, certainly a view of outside maybe of some attractive scenery and some sunshine, it points towards how important it is for Susan have the opportunity to reconnect with the outside, as though she feels trapped, rather constrained by the sterile, closed in environment of the hospital. Her words may suggest that she has a yearning to feel the sun on her back and breathe the fresh air again.

Susan is delighted and very animated when she describes in her story the finding of the bike and its position, everything is suddenly so right; she has found just exactly what she is looking for; how wonderful. But then her hopes are dashed as she tries it out,

although it is there, it is all at once not there in a useable way. As she turns the pedals it *squeaks*, it is really noisy, she is aware that if she uses this bike it is going to be too disruptive to others around her, it is seemingly wrong for her to break the silence of the hospital ward. Her words suggest her disappointment is acute, the tremendous joy in finding the cycle has left her crushed inside because she just knows she is unable to use it, it is just too squeaky. She becomes a little angry, firstly because the nurse she spoke to had no idea that the cycle was available and secondly that the cycle has not been maintained. Susan just knows that if she had been able to use it, she would have enjoyed her stay so much more.

This story indicates not just a lack of knowledge from staff of what facilities and services are available but also a lack of interest as this may not seem to be an important part of Susan's overall care plan. The significance of hospital amenities and the environment in the overall care of a patient is recognised as being critical when meeting patients expectations and can assist in their treatment and overall recovery (Jenkins et al., 2011). The support services that were available were a dimension to Susan's care which was overlooked, there was a TV lounge but nobody told her about it and there was a bike but nobody knew about that either. Thus the bike was not maintained and not fit for use, if it was used more then perhaps it would not squeak, but nobody knew it was there so it was perhaps never used.

The idea that hospitality should involve some entertainment is reinforced by this story from Clare. In the retelling of her story she points to the idea that some kind of diversion is needed for patients when they are confined to a hospital ward.

*There needs to be something to occupy people in hospital because you know a distracted mind is probably better as opposed to someone who*



*is in an emotional state, you don't want to sit in bed and worry and be sad.*

*I don't understand why hospitals don't have music, it makes the atmosphere so much better, I think music to lighten the mood would be good. Some of these private hospitals have their own TV's, so having something to watch that would be good and supplying magazines 'cause not everyone is like me and goes shopping one day before and buys 5 magazines so that I don't get bored and maybe some books would be good too.*

*Having been in hospital before and having nothing to do I thought I would take in a laptop but they usually tell you to keep all your belongings at home just for safety reasons. (Clare)*

Clare's story does not hint in any way that she is unhappy with her care however, it does suggest as Beth's did that she is keen to have something to do, to *occupy* her and to take her mind, her emotional self away from focusing on her medical situation. As Clare so nicely expresses she *didn't want to sit in bed and worry and be sad*, so why is it that she is left to sit in bed without being offered or told about what activities there are for her to do. As with Susan's story, this is another example of not being informed of what is available. Or perhaps it suggests that in her situation, as a 'patient' on the ward that having *something to do* is what matters. Clare tells of being experienced *in hospital*. She has already experienced at firsthand what it is like to have nothing to do day after day. Clare's past comes before her as she points to a time in her past when she had too much time to dwell upon her situation. Gadamer (as cited by Lavery, 2003) suggests that our past is inextricably linked to our present when he talks about the notion of historicity of being. Interpreted in the context of this story, Clare's past hospital experience is always already there in this moment illustrated by her saying she did not want to sit and *worry*

*and be sad*, in a way that she had on a previous occasion. It was during these moments during her stay when her existential thoughts may have begun to affect her psychological wellbeing. It is the existential thoughts and reflections of patients which are recognised as playing a crucial role in the patient hospital experience (Sørli et al., 2006). The researchers suggest that understanding the impact of these for patients is important for healthcare workers, which could be why Clare describes how important it is for her to be occupied.

It is interesting how Clare remembers that she did not *have music* to listen to and that she suggests in having some background music in wards it would somehow change the mood and atmosphere for patients. She is suggesting that the music may affect how she feels, it may indeed allow her mind to wander from its current state and become distracted and less focused on her reason for being where she is. Clare does not suggest the kind of music she would like to hear, or how this may impact or affect others around her. Playing music could make the ward seem noisy yet intuitively it is a nice idea and indeed a simple one which as suggested by Clare could simply *lighten the mood* of the place.

Clare is well prepared for her visit and brings in magazines and her laptop, although her story hints that she has been told not to bring in her laptop for safety reasons, yet she does anyway! The safety of personal belongs appears to be an issue here but Clare is more than happy to ignore this as she desperately does not want to be bored during her stay, she expresses quite clearly that she believes that a distracted mind prevents her from worrying and becoming emotional. It does not seem too much to ask to allow Clare to bring in a laptop, which may allow her to communicate with others, those people who are part of her 'normal' world. Her laptop may also allow her to play games, read and otherwise keep her busy as this is an activity she is likely to do every day when not in hospital. It seems a reasonable request for Clare to bring in her laptop,

after all she is not asking the hospital to provide her with one or to supply her with Internet, all she seems to be hinting at here is that she should have a safe place, a lockable cabinet perhaps by her bed in which to keep it. The story suggests another aspect of the patient lived experience of hospitality is ‘as’ safety and security for the ‘guest’ and their belongings, which should be recognised as being important by hospitals. This is a fundamental part of the responsibility of a hotelier under the 1962 Innkeepers Act in New Zealand.

The significance to patients of occasions when healthcare professionals go beyond the expectations that would reasonably be expected is demonstrated in this next story from Cody. Her story points to a moment when she was in hospital when the hospitality she received made a huge difference to her situation.

*I felt totally respected and actually I had bought tickets to go and see Wicked and I asked them could I go. I really wanted to be allowed to go home. Well, I wasn't able to be discharged but they worked around me so that I could go. It was fantastic, the doctors were prepared to let me go, I think they had assessed me and worked out what sort of person I was, so that was very good. The doctors were awesome they said "We can make it work." I still had this hardware thing coming out of me and so they had to strap that up and then they sent me on my way, I was so lucky. They were fantastic I could not fault them the whole way through and the doctors especially, despite being so busy they listened, explained and talked to me about the whole thing. The hospitality of the medical staff and the support staff networking together made a huge difference to me, just huge because they worked in with me to support me. (Cody)*

Cody speaks of being respected and listened to by the entire medical and support staff who worked together in order that she could leave the hospital for a few hours in the evening to attend a performance of *Wicked* at the theatre. The memory of this event has left a lasting impression upon Cody, rather like the story from Beth of going to the chapel. This had nothing to do with her medical treatment and everything to do with her overall wellbeing of being respected as an individual who wanted very much to continue her life, of being who she is, of doing what she wants to do, despite being in a hospital environment. This story highlights the effect for Cody when a more holistic approach to overall care was offered which took into account Cody as an individual not just an object for analysis and treatment. It has been suggested by Renzenbrink (2011) that when the lived experience of an individual is recognised by a healthcare professional, a patient feels less detached in their situation and more humanised.

Much as Cody expresses her desire to go home, she understands that she is not quite ready to leave and listens to the advice given to her from the staff. Yet, she is completely astounded; she appears overwhelmed that her request to leave and go to the theatre is granted. Her surprise is very apparent, *it was fantastic, the doctors were prepared to let me go*. It may not have been particularly convenient for Cody to leave the hospital but it appears that everything was done in order to meet her needs, it is clear that she is not well enough to be discharged completely and yet this is an example of how the hospital worked very hard to accommodate Cody. It seems that it required a great deal of arranging and discussion and yet the hospital staff put in a great deal of time and effort to coordinate and support Cody's trip out.

Cody felt that she was really *listened to* by the different staff around her, in her mind she may have thought that her request to go to see *Wicked* would have been rejected as it may not fall into the usual routine of hospital life. And yet this was not the case and because she was listened to and her request was granted, she felt well looked after,

cared for and in her own words *respected*. She is being respected for who she is and what she wants to do as a person not just as another patient who is on the ward; *they listened, explained and talked to me about the whole thing*.

Although it would probably have been easier for the staff to have just said no to Cody's request, due to the extra time and effort involved with organising this trip, they did not take that approach. The resulting impact for Cody is phenomenal; her words reveal that she is happy and excited to be able to go, *I was so lucky, it was fantastic*; this seems to be way beyond her expectations of the care she expects to receive in hospital. This story highlights just how many people are involved in the care of Cody and how when they interacted together for a common aim were able to give a unique and very beneficial hospitality experience. As Cody says in her own words, in which she actually uses the word hospitality, *the hospitality of the medical staff and the support staff networking together made a huge difference to me*, she emphasises the word 'huge' by repeating it several times in her recounting of this event. Heidegger, (1927/1962,) suggests that the 'harking back' to the same word to emphasise a point is announcing something which is hidden, to uncover the phenomenon to which this is pointing it must 'be discovered' to reveal the concept of "being true"(p. 56). For Cody the lived experience of hospitality for her when she stayed in hospital will always be this memory of being able to go to the theatre, of being respected totally by those around her so that she was able to leave hospital for a few hours.

Cody felt connected with when she received such special care and attention, Cody feels that she is the centre of attention in this story, *they worked in with me to support me*, it is all about her and how everyone focused on her wellbeing. It is an example of what Bunkers (2003) describes as nurses acting with a spirit of hospitality to connect with a stranger and attend to them with true presence, to understand the lived experience of the other without judgment and labelling. Cody's shock at being able to go to see 'Wicked',

relates well to the notion from Hemmington (2007) that hospitality is very much about having a memorable experience, which may offer ‘lots of little surprises’(p.749) . For Cody there was certainly ‘surprise’ in that she could not quite believe how hard everybody worked together so that she could safely leave the hospital which led to a very memorable and lasting experience.

The next story was retold by Grace who stayed in a private hospital and for her the significance of hospitality during her stay had quite a profound effect. As she explains very poignantly, ‘hospitality just is’ for her made all the difference to her lived experience of being a patient:

*To me hospitality is about the whole other stuff, which is not the medical stuff it's about how comfortable and welcome you are made to feel. I think the people that bring round your tea and food and the people who clean your room are just as important as the others.*

*Everyone was very pleasant; people smiled at me and looked at me when they came in the room.*

*The food is a big part of that too, the way it is presented and how it tastes. The lady who brought the tea in was very nice, I don't think it was a nurse, just a lady bringing in the tea. She smiled quite encouragingly and asked if I wanted something to eat, which on the first couple of days I definitely didn't but afterwards I did and the things looked nice. Instead of just saying, “Do you want something to eat?” she would explain what they had, which was nice.*

*Hospitality is also about the way people interact with you and the way they listen and discuss things with you. So I had no complaints at all, it was really nice; it is like getting room service in a hotel! I do think hospitality makes a huge difference because you have less anxiety and*

*you feel cheerful and nurtured and I think you recover better because you don't have 'dark thoughts' you have 'happy thoughts'.* (Grace)

Grace's story illustrates through her expressive words just how hospitality made her feel and how important she believes it was in making her feel comfortable and less anxious. In the retelling of her story she describes how hospitality to her is about *the whole other stuff*, suggesting Grace is more than happy with her medical care but then something else happens during her stay which really enhances her patient experience, the people around her taking the time to talk to her, listening to her and smiling with her. Grace suggests that the actions from those around her are very sincere which has the effect of making her feel really relaxed and comfortable about where she is.

The sincerity of the hospital staff actions is implied by the way in which the *tea lady* smiled *encouragingly* at her while taking the time to explain at some length and detail what food was available. Whereas she could have just walked into the room and put the food on the table without making any attempt to talk to, or encourage Grace to eat. Seemingly, the tea lady did not perform her task out of a sense of duty toward Grace; it was more than this because as Grace explains she did not rush, she really went out of her way to engage in conversation and to describe in detail the food which was available. Indeed, to the point that Grace compares the experience with that of room service in a hotel.

Interestingly, as Grace tells it, when the tea lady speaks to Grace she does not seem to use scripted words as is sometimes the case of food service staff who are trained to use very prescribed words in the delivery of customer service, which can then seem quite insincere. Grace actually makes a point of mentioning this when retelling the story, *instead of just saying "do you want something to eat?"* the tea lady actually explained it and Grace notices this and the effect upon her was that she felt this was a nice gesture.

For Grace, it was a genuine act of hospitable behaviour. She noticed this and described how this made her feel, and Telfer (2000) describes this action by the host as one which is motivated with a concern for the welfare of the guest.

Suddenly, Grace becomes less emotionally anxious about her situation; it appears that everyone, from the person bringing her food, to the cleaner and the nurses have only one focus which is Grace. She begins to feel important, she is the centre of attention and this is making her feel really *cheerful and nurtured*. It is when the hospitality factors, physical comfort, security and psychological comfort and security are blended together that a feeling of great importance is created for the patient (Cassie & Reuland, 1983). Grace is made to feel important due to the acts of kindness shown towards her by the different people working on her ward.

She explains that it is hospitality which made the biggest difference to her stay in hospital, not her surgery, not her medical care but hospitality. For Grace, hospitality is about how the people around her made time for her, they would make every effort to check that she was alright and they would smile encouragingly at her. It was because of the hospitality she received that she had *less anxiety* and she believed it helped her to *recover because you don't have 'dark thoughts' you have 'happy thoughts'*. This suggests that if Grace had not received as much attention from the various people who were working on the ward that she may have begun to dwell mentally on her situation, to become self absorbed in herself which may in turn have led to her feeling a little sad and depressed, to have *dark thoughts*.

Grace's story is a good illustration of the impact of hospitality surrounding the patient experience and when it is present it can lead to a reaction within the patient of feeling at ease and relaxed within their environment (Hepple et al., 1990). Being welcomed, being listened to and people showing an interest in Grace created this blend of intangible



factors which resulted in her feeling cheerful, comfortable and less anxious. For Grace, hospitality is about the *whole other stuff*, that goes on around the being in hospital and it made all the difference to her patient lived experience.

The last story in this chapter points towards the notion of hospitality ‘just is’, as being made to feel welcomed and genuinely cared about. This story was retold by Christie who appears to be suffering with a large amount of anxiety and fear as she anticipates her arrival to the hospital.

*I was excited you know, but very nervous because of a previous experience I'd had and also because my operation had been postponed before. So I was very anxious as to what is going to happen, whether I am going to have the surgery or not. So this was the scenario before I got to the hospital!*

*But after I arrived at the hospital I didn't feel anything like that, they welcomed me. As soon as I entered the reception I was so happy, they said they were waiting for me “Oh we are waiting for you!” They were so nice in the way they talked to me, it really changed my anxiety and all the fear I had before I arrived. It made me comfortable. She made me comfortable actually, in the reception itself, she said we have been waiting for you.*

*It was a private hospital and I didn't get the letter from the insurance company but she made me comfortable, it wasn't an issue, even though it is the main thing. I should have the letter otherwise they didn't have the guarantee that I would pay, but they didn't make it a big thing. She said “Just give me the number, that is fine,” she trusted me, she asked me to wait for a little while and then they came immediately to take me.*

*The nurse came to take me and she was lovely too, she said I shouldn't feel uncomfortable and she joked with me about my bag and she was making fun of me to make me feel at ease. I was shocked how much they noticed the little things. She said she can look after my bag for me, she was happy to look after it. Even my shoes, she looked at me and said "Are you comfortable to wear those heels here? I can give you another pair." I was shocked, I mean, even my shoes they take care of, even the simple thing, the little things. I was shocked actually, how much they are noticing me and they are caring about me.*

*(Christie)*

Christie's story implies that this is not her first visit to hospital to have this surgery, with the previous attempt ending in a postponement. The cancellation of her operation has led to a heightened anxiety for Christie, *I was anxious of what is going to happen*, she is experiencing a nervousness on two counts; about having the operation, which she understands she should have, but she is also feeling stressed that it may be cancelled again *this was the scenario*. Christie is speaking quickly as she recounts the story, her voice has an excited, yet nervousness to it, it is as if she is reliving that moment again as she is speaking to me. As she is retelling this story, I feel as though she is taking me with her to the hospital and I get a real sense of how it must have been for her.

Then something interesting happens after Christie arrives in the hospital reception area, her whole emotional state turns from nervous anxiety to complete calm and happiness. She experiences being welcomed, she recalls that she was spoken to in such a nice way that all her worries simply vanished and all at once it seems she just knew she was going to be okay this time. She was expected, like 'good hosts' they were actually waiting for her, they told her *we have been waiting for you*, this was spoken in such a

warm and kind way that Christie ‘knew’ it was heartfelt. Christie realises that she is very much expected, they have planned for her and on this occasion her operation was going to go ahead. Yet her story points to more than this, it is not just that her operation was going to go ahead that has made her relax, it was that she was welcomed in such a way that all at once her fears about having surgery, her apprehensions about arriving have disappeared.

Her story suggests it was because of how she was spoken to, the tone of the voice of the person at reception was very *nice*, it showed genuineness to it and she could sense that, the staff really meant it, they were glad to receive her. This was perhaps unexpected, emphasised by the fact that Christie recalls three times in her story that they *were waiting for me!* Christie just can’t quite believe it, they really are expecting me, and this operation is going to happen for me today. She feels so welcomed when she arrives at reception that it begins to set the tone for her whole stay. She realises that she is not an inconvenience to anyone and that everyone is here for her to make her experience a good one. All at once her mood has altered and she is *happy*, in the midst of the moment she is *comfortable* and her anxiety dissipates.

This is perhaps all the more surprising as she then recalls that as this is a private hospital she needed to give the hospital a letter from her insurance company, as this was the guarantee of payment. However, for some reason she has yet to receive it, this could potentially have been a really big problem and created further stress for Christie because as she explains *it is the main thing!* Ensuring payment from patients in a private hospital is a necessity; the hospital could have adopted quite a different approach towards her at this stage and demanded an upfront payment before any treatment was given. However, the hospital was tactful and understanding in how they handled this potentially difficult situation. As Christie explains much to her relief and surprise, the hospital were very relaxed about it, they showed a great trust in her and just asked that she give them a

contact number. They *trusted me*, this must have been a massive relief to Christie that she was trusted in this way, it was great that the systems were in place to deal with this so that it did not further antagonise Christie, as it easily could have.

Christie has been welcomed, she is feeling comfortable and now she has been shown trust all these factors are giving her a very positive hospitality experience which are contributing to her going into surgery in a very relaxed way. Her story explains how this being made to feel comfortable continues when she leaves the reception area, the nurse is joking with her and she can tell she is speaking in this way to relax her. Christie's story appears to point towards the notion that she is so very surprised that she is being given so much attention because three times she recounts that *she was shocked* by the care she was given. She finds herself at the centre of attention, all the focus from the nurses is about her, can they take her bag and look after her shoes: nothing it seems is too much trouble for them. Christie is simply overwhelmed by this high level of interest in her and her situation, *they take care of even the simple thing*: she obviously did not anticipate the attention that would be shown with regards to the other aspects of her care. For example the taking care of her belongings, to ensure that she did not need to worry about them but could relax in the knowledge that they were being taken care of. It is perhaps these other things, the attention given to the smaller details of Christie's hospital stay that enabled her to feel so relaxed and comfortable about the more important event, that being her operation. Taking care of the detail, the little things led to Christie feeling comfortable in the hospital environment enabling her to be calm and relaxed as she awaited her surgery.

Christie's story highlights the impact of hospitality surrounding her patient experience, the sincere welcome and care that she received contributed to her feeling comfortable and relaxed in her surroundings. This story illustrates that Christie's lived experience of hospitality had a significant impact to her hospital stay; suggesting that when a hospital

understands the implications of the consumer experience it is able to deliver better care for the patient. As suggested by Hemmington (2007), the successful delivery of hospitality products is based upon a thorough understanding of the consumer experience. An approach which is not dominated by service delivery models and financial exchange, but one which recreates the 'essence' of earlier forms of hospitality (O'Gorman, 2008), to create memorable experiences for the guest.

## **Summary**

This chapter has retold the stories of participants in such a way as to uncover how hospitality existed for them during their hospital stay. It is not suggested that for each participant hospitality had the same meaning, indeed these stories have unveiled many different facets to the 'is-ness' of hospitality. Heidegger (1927/1962) describes three forms of being, 'that being', 'what being' and 'how being'. To clarify this further the 'that being' is referring to the existence of something, that hospitality is present as hinted at in these stories. The 'what being' is explaining what something is, the what hospitality is to these participants and the 'how being', describes the manner in which hospitality presents itself to each participant in their stories.

Thus hospitality from the hermeneutic perspective does not just present itself in experiences as one thing, but in the context of this study, it has a 'that-ness' a 'what-ness' and a 'how-ness' (Wright-St Clair, 2008), which varies due to the unique 'Dasein' of each participant. Which is why in this chapter the 'hospitality just is' has revealed itself 'as' generosity, as being entertained, as being listened to, as being made to feel safe and secure, as being welcomed, as receiving attention and as being made to feel comfortable. Each story has hinted at a different interpretation of the that, what and how of hospitality for each participant and the significant part it took in their hospital stay.

For these participants the very idea of hospitality and the way in which it may affect them during their hospital visit may not have actually entered their mindset before or even during their stay. It was perhaps something which only came to the fore as they retold their stories, these events just happened. Heidegger (1927/1962) believes that we encounter many things by simply taking them for granted. Is it taken for granted that hospitality does not at first seem to play a significant part in the surgical patient's stay in hospital? And for this reason it may be often overlooked by healthcare and hospital management. Yet these stories suggest that it is indeed quite significant in the memorable experiences of the patient.

## Chapter Five: Being at Ease

*“Upon the launch of a project in 2004 designed to enhance over 120 healthcare environment’s in the UK, HRH The Prince of Wales commented “It could not be easy to be healed in a soulless concrete box with characterless windows, inhospitable corridors and purely functional wards.” (Renzenbrink, 2011, p. 35)*

### Introduction

Hospitality encompasses more than a series of service transactions involving the delivery of food, beverage and accommodation; it also incorporates an element of entertainment and social interactions. When these are offered together in a harmonious way the guest feels at ease or ‘at home’ in their surroundings (Cassee & Reuland, 1983) or as Pizam (2007) suggests the ‘ity’, as in ‘hospital-ity’, factor is created, a philosophy of caring created in an environment with ‘the right feel’. A patient wants to feel comfortable and relaxed while in hospital and it is often the impact of the surrounding environment in which they find themselves, which has a significant impact on their emotional and physical state and their ‘being at ease’ (Bitner, 1992).

Traditionally, measuring the quality of the patient experience centred around the quality of technical care however, a recent report commissioned in Australia suggests that this is an outdated approach which understates the significance of other factors. It highlighted the dimension of interpersonal relationships and the impact of hospital amenities including the environment as being significant for the overall patient experience (Jenkins et al., 2011).

This chapter will not explore the significance of interpersonal relationships as this is discussed in chapter six, it will however uncover stories which speak about being in a space and how that may or may not create a ‘feeling of being at ease’ for the participant.

As suggested by Bitner (1992) the physical setting people find themselves in is able to impact behaviours and create images for customers and employees within a hospital setting.

It is the significance to the participant of the environment within which they find themselves which will be uncovered in the stories which have been selected for this chapter. I will explore through the retelling of the highly illustrative stories, what it is that leads a person to feel at ease (or not) in their surroundings. I will reveal through my understandings how 'being at ease' exists in different ways for each participant and what is the meaning and impact of this for them.

The first story by Susan speaks of when she arrives in the ward, having had her surgery; she finds that she does not feel at ease with her situation. She describes the action she took to ease this feeling which had the effect of leaving her with a new predicament.

*On the main ward I remember being pushed into position, I can't remember if there was someone there to meet me, but very soon a nurse would come in and introduce herself.... and that was nice! Well in the ward you are in the bed which is in a room with three other people, and you only have a curtain between you and the other people I suppose there are private rooms for people with infections, but this being a public hospital you just have to take what you get. One drawback for me was the fact that three other people in my ward were all men. I said to the nurse is there a ward that I could share with women as I would feel a bit more comfortable and she said "No, all the beds are full". So I had to stay in that ward and so I just pulled the curtains, I did feel a bit uncomfortable at first and then I just kept the*



*curtains pulled. But then if you keep the curtains pulled you are in a cell.*

*Towards the end of my stay I was shifted into a room with women and when I was in the women's ward, we had all our curtains open and you could see the windows and you felt a lot, just a lot better about where you were. Rather than being in a cell.*

*I was there for 10 days I escaped on the 11th day ha ha. (Susan)*

This story of arriving in the ward, suggests the nurse's way of coming to her to introduce herself suddenly disarms Susan's discomfort of having *no one there to meet her*. Susan suddenly knows who is going to be taking care of her and it creates a connection for her. Susan is quickly welcomed to the ward following her surgery; maybe she is expressing a feeling of relief, of comfort due to the simple act of the nurse introducing herself as this will be her space, her home for now.

Yet the story reveals how initial feelings of comfort and relief can so quickly give way to feeling ill at ease as Susan finds herself in a room with three men. All at once her mood changes and she finds herself feeling quite uneasy in this situation but she knows that she has no power to do anything about it, she is in a public hospital and that is just the way it is.

In Susan's asking to be moved she is revealing that she is now uncomfortable, perhaps a little anxious in her surroundings. She feels some discomfort at being with men only, within the confined space of the hospital room. Susan discloses how in pulling the curtains around her, she turns her *world into a cell*. Her cell closes her off from the outside; it holds her safe within it. Her words show how she wants to be private, to feel less vulnerable in this public space of being one woman amidst three men.

Susan's use of the term 'cell' has connotations of being in prison, not a place perhaps which is associated with being comfortable or creating a sense of ease. Research suggests that the design of the hospital environment has an impact upon treatment effectiveness, clinical outcomes and the overall experience for patients (Wu et al., 2013). How might Susan's closing her curtains impact her recovery, her healing? An indication as to just how much being on a mixed ward did affect her experience is given when she is finally moved. Susan expresses great pleasure when she is moved to the women's ward *we had all our curtains open and you could see the windows and you felt a lot better, just a lot better about where you were.*

The change in her attitude, her experiencing the comfort and emotional wellbeing is heard, she is at ease in her surrounds. The impact of being able to see out of the windows, open the curtains and interact with the women in the ward is recognised as improving the overall patient experience (Severt et al., 2008). As Susan tells, somewhat joyfully, of *escaping on the 11th day*, her using the term *escape* once again has undertones of being in a prison, of being released from involuntary containment. Her emphasis hints toward her experiencing her days in hospital as being longer than the ten calendar days they actually were.

The next story from Christie describes the effect that colour had upon her feeling at ease in the hospital environment, pointing to the notion that there are many factors which play a part in creating a space of ease for the patient.

*I was sitting on a couch in the reception with my husband we were just talking and I remember the colour was beige and it was making me feel calm. It was a kind of beige colour, to make me calm down and there were some plants in the lobby too. (Christie)*

Christie's short story reveals her uneasiness at waiting; of being in the hospital reception area, as she waits to be admitted. She speaks of how the colour made her *feel calm*. She makes the observation that the beige colour was perhaps deliberately chosen *to make me calm down!* Beige is a colour taken from nature's palate, historically from the Old French word 'bege', it is the natural colour of wool and cotton (Harper, 2014). This colour may have been deliberately chosen for this area, along with the plants to make this area feel natural and to create a feeling of calm. Research suggests that people respond positively to nature, to natural settings colours and textures rather than man-made ones (Youngson, 2012).

It is perhaps a little curious that Christie is so aware of her surroundings as she waits to be admitted. Her talk of being calmed hint at her feeling uneasy about what was to come. The fact that she remembers so clearly what colour the walls were and that there were plants around when she retells me her story suggests that this was a very significant moment for her in her hospital experience. The effect of the surrounding environment upon a patient's wellbeing is acknowledged, indeed a UK funded project called 'Enhancing the Healing Environment' was launched in 2004 and has led to 120 healthcare environments being redesigned to create spaces which now reduce the anxiety and enhance the wellbeing of both patients and staff (Ritzer, 2007). The significance of the reception area will often set the tone and contextual environment of the hospital. It will create an initial first impression for the care which will be provided to the patient during their stay and should not be underestimated (Patten, 1994). Within the hospitality industry, especially hotels, the lobby area is a focal point and regarded as crucial in terms of creating a welcoming feeling for the customer. Some private hospitals in America have been inspired by hotel design and have incorporated some of these design elements, like atriums with live trees in their reception areas (Wu et al., 2013). Christie remembers not only the colour of the walls but also that there were

plants, so this is congruent with the claim that the first impression created by the hospital does set the tone for a patient's stay. From feeling uneasy about being in the hospital, in her being calmed by the surrounds, Christie suggests she is already made to feel welcomed. Her words suggest she is reassured that such attentiveness to care will continue throughout her stay.

The feeling of being at ease exists in different ways within patients' experiences. The previous story talked about the impact of the surrounding environment which created an 'at ease' feeling for Christie and the following story also reinforces the importance of the context. However, this next story which was retold by Tina also draws attention to the idea that it is sometimes just 'the knowing' which made her feel at ease.

*I remember when I got there I remember thinking how organised it was, they took me to my room and told me to unpack and get myself comfortable. I remember thinking this was awesome, this is my actual room that I am going to be in after I have the baby, so I unpacked my stuff and yes, I won't have to move again. I remember exactly what it looked like (chuckle). I remember everything about it. It had a nice big bathroom, (chuckle) it was a nice cosy room with a nice big window, overlooking the city park area. Although it was a public hospital, I had been told I would have my own room. I remember being shocked about being in that room and I kept asking "is this my room?" It felt a bit like a hotel. I stayed in there for four nights and it never felt yucky! I was able to unpack and then I knew I was going back to that room, I knew where I was going. Because the worst thing is not knowing where you are going in hospital, where are they going to put me next what do I have to do next, I liked knowing that I was going back to that room.*

*If everyone had their own room I think hospital stays would be so much different, you know, people would have a much better experience! (Tina)*

Tina's recalling, *thinking this was awesome* at the welcome she receives, discloses her experience of being overwhelmingly at ease. Even as she retells this story many months after leaving the hospital she is able to describe 'her room' in detail. She says over and over *I remember everything about it*, exactly what it looked like. Her lived reality of being surprisingly at ease there lingers with her. Her delight in having not just her own room, but knowing that this is where she would go back to after having her surgery is apparent. As she unpacks and gets really settled she keeps talking about the importance of knowing and the not knowing, *the worst thing is not knowing where you are going in hospital*. Medical research suggests that one of the factors which leads to patient anxiety and feelings of vulnerability is the not knowing of what is happening (Sørli et al., 2006).

Tina's words suggest knowing of where she will spend her stay, where she will go back to after the birth, is comforting. The completeness of her ease and pleasure announce themselves as she keeps saying *Is this my room? It felt a bit like a hotel and it never felt yucky!* Knowing 'this room' is her place creates a homely space, a familiar space where she is feeling at ease. This knowing embodies a sense of Tina's at-homeness. Heidegger (1927/1962) describes the phenomenon of *canniness*, an embodied knowing which is experienced as comfortableness and belonging; of being-at-home.

This hospital event creates a special experience for Tina. It blends together physical comfort, security and psychological comfort which are identified as being some of the key factors that define hospitality (Hepple et al., 1990). Cassee and Reuland (1983) suggest that it is when the hospitality factors are combined together in a certain way that

an emotion is felt by the consumer which is of a huge consequence, as can be heard in Tina's story.

In expressing that she feels being in her room is like being in a *hotel* is interesting. The word 'hotel' carries the notion of being a guest, especially a paying guest, rather than a hospital patient. Yet Tina is in a public hospital and as such her expectations may have been less than if she were in a private hospital. Comparing her room to a hotel, reveals her comfortableness as being unexpected; as unforeseen. Her remark that it *never felt yucky* may refer back to her experience of a previous hospital stay, or simply her expectation of being in hospital as an uneasy place to be. Regardless, for Tina, having her own room and knowing that this is the room she will return to after her surgery played a significant part to her whole experience of being there. It made her feel at ease. This is summed up in her last remark when she suggests that if every patient had their own room, their hospital stay would be so different.

The next story was retold by Cody who describes how her feelings of being at ease were created in hospital in the way she was made to feel comfortable. However, she also reveals in telling her stories that there were occasions when health care professionals were not quite as comforting.

*It was a very old ward but it was clean and tidy, they don't have any doors now on the wards, they are all removed but that didn't particularly worry me because you had the curtains and they were all clean and tidy. Now I should mention the beds, the beds were amazingly comfortable; they said they were new beds in this ward and they were very comfortable. My bed went up at every angle, it was an electric bed and you could have your legs up or your head up or your arm up. It was so nice and what a huge, huge difference it made to me*

*because you didn't ache at all you could get really comfortable. Also, it took away that need for assistance because I could move it myself. I did ask to have extra pillows to support my arm and I got extra blankets but getting those wasn't an issue, that bed made a huge difference to me. But you know I did notice something the whole time I was there, they never actually made the beds. You know how they used to make the beds over you or straighten them; on none of the beds did they do that. (Cody)*

Cody talks about how well she is accommodated in the ward, despite the ward being old it is clean and tidy. This perhaps emphasises that many factors play a part in the impact of the physical environment, the old building didn't bother Cody, she was concerned far more that everything was clean and tidy. Her words convey relief, she might be concerned that following her surgery she will be exposed to infection and she feels comforted by the cleanliness of the ward. Careful planning of the hospital servicescape is important because it can affect the emotional and physiological state of patients and healthcare workers. A report by Jenkins et al. (2011) describes the servicescape as central to the patient experience and to patient safety.

Cody's feeling of being at ease encompasses more than the cleanliness of the ward as she speaks about her adjustable electric bed. She is able to move her body, unassisted into many positions; her delight is quite apparent *you didn't ache at all you could get really comfortable*. The added benefit of having this type of bed means she is not asking for assistance from staff to get comfortable. This bed makes a *huge difference* to Cody, she gains independence, she has control of her own wellbeing and she is at ease. Yet the feelings of comfort she is experiencing do not come solely from the electric bed, they are created by the independence she now has from others. By not having to constantly

ask staff for assistance each time she needs to move in her bed, she is now at ease; relaxed in the knowledge of not being seen, in her own mind at least, as a nuisance by others. It is good that this issue is alleviated from her and is not a worry to her. It appears that there has been some careful thought by hospital management to provide electric beds for surgical patients, in order that they are more comfortable and more in control of their own care.

Cody then speaks about the actions or perhaps it is better described as the inactions by health care workers. During her stay in hospital she makes an observation that nobody ever makes her bed, or indeed the beds of any other patients, *you know how they used to make the beds*. Cody is harking back to a previous experience in hospital when staff would always straighten and make the beds. Although she does not say it, she seems to be implying that this has great significance on her wellbeing. This is congruent with Heidegger's (1927/1962) philosophy which is to let something be seen as something, by not saying what Cody really means she is still revealing it. This may suggest that Cody associates the making of her bed as an act of caring from staff that makes her feel as though she is cared for and cared about. Maybe staff should understand that it is this small task of making Cody's bed which provides an opportunity to engage with her, to enquire after her and to show an interest in her, which has significance to the patient experience. It is the tucking her in and making her bed which makes her feel very comforted.

This next story is retold by Clare and is similar to those which have preceded it, as it reinforces the notion of context to the patient experience of being at ease. Yet this story speaks of something which is in the everyday of every patient's lived experience, it is quite surprising then of the impact that it has.



*One of the things I think is important is to be in a calm and good environment which is why I don't understand why they have chosen those curtains. The curtains are ugly! (chuckle) I think the curtains are terrible, especially when you come off general anaesthetic you feel really woozy and the curtains they have really make me feel quite nauseous. They are checked but they are very miss matched checks so it makes you think that they are actually moving (chuckle), and it makes me think why would anyone order curtains like that. So every time I see them it comes to a point when I start to hallucinate, as if they are moving, a very odd choice. I think you would choose something light and pretty, (laughs loudly).*

*The funny thing is that when I was waiting to go to theatre I lay in my bed in the waiting room and the corner I was put in was the kiddie corner. I was happy about that because it is so pretty, they have all these animals and colourful curtains which are pink and it just makes me feel happy. It definitely made me calmer, it made me giggle I always seem to get this corner as opposed to lying in a different place where it is just plain walls and ugly curtains. (Clare)*

In the retelling of this story Clare is describing the impact upon her wellbeing of the hospital curtains. It is quite curious that her story is not about a medical procedure or a communication with a health care worker which affects her being at ease; it is her curtains! It may seem quite extraordinary that the fabric of hospital curtains should evoke such a strong emotional outburst. Yet I can recall as Clare spoke to me about this, I could sense that she was almost reliving the emotion and physical impact that the curtains had upon her. The way in which she carefully described the curtains was quite

powerful and I could begin to envision just how the pattern made her *hallucinate* and feel *nauseous*.

This story reinforces those told by both Cody and Christie who talk about the impact of the environment upon their hospital experience. Some studies into the design of hospitals “have identified a positive relationship between the physical attractiveness of healthcare settings, patient satisfaction and perceived quality of care” (Jenkins et al., 2011, p. 29). This theory would appear to be fit with Clare’s story in the way that she describes the hospital setting she finds herself in and the way in which the design of the curtains, the strange fabric really affect her. It is especially congruent when she describes how she feels when she is moved to another space within the hospital, to wait for her surgery. *I was placed in the corner in the kiddie’s area*, this area is quite different, the curtains the walls are quite different, Clare speaks of an area which is colourful and pretty.

As Clare begins to describe the area she is now in I am able to detect an immediate change in her emotions. It is quite apparent the surrounding environment has a significant impact to her, as she describes that by being in this area she feels happier and calmer, just being there causes her to *giggle*. This story reveals as did Christie’s how important colour was in making a patient feel calm, when the colours and designs of the curtains are *ugly* the feeling of comfort and being at ease are absent.

This last story is retold by Susan and it points to another way in which the ward is able to create an environment with a more homely less sterile feeling.

*Oh another thing which they have which is lovely was around the walls of the ward they had artworks which people had donated to say thank you. So when I was doing my walk around I could look at these*

*lovely artworks. I thought when I get out I could donate a picture  
'cause there are lots of spare spaces. (Susan)*

Susan likes to walk around the ward, she seems to like to keep busy and perhaps to her surprise she notices something which is rather lovely. On the walls of the wards there are many pictures, these have the effect of transforming a rather barren and sterile environment to one which is rather more welcoming and hospitable. In contrast to the quote given at the start of this chapter by HRH The Prince of Wales, in which he describes the negative impact of being healed within “inhospitable corridors and purely functional walls” (Renzenbrink, 2011, p. 35), Susan describes walls which are full of *lovely artwork*.

Susan’s story indicates the gratitude of previous patients who have donated or painted artworks as a thank you for care they received when in the hospital. Susan is keen to donate a picture when she is well again because she is very happy with the care that she has received while in the hospital. It is nice that patients take the time to show their thanks and gratitude to their hosts, their carers. It is perhaps an indication that so much of what hospitals do is positive but it is the attention to the smaller details, the space which surrounds the patients for one thing which can have such a large effect upon the patient’s lived experience.

## **Summary**

Each story which has been retold in this chapter has discussed the notion of being at ease, in the context of a hospital environment. The stories have shown how for each individual the way in which the surrounding context with which they find themselves has either aided their being at ease feeling or left them ill at ease. Studies would confirm that a surrounding environment will elicit a particular emotional response from those who are within it, the situational factors which define the purpose for being in a

particular place will influence their mood (Bitner, 1992). In this study all the participants are having a planned elective surgical procedure; each individual will enter the hospital environment with their own particular mood. Some participants expressed feelings of anxiety in the retelling of their stories, whilst others who have had previous experiences of being in a hospital arrive with memories of that visit which affect their expectations. Each individual will respond to their surrounds differently, in other words the feeling of ease situations discussed in each story will not have the same impact for all patients, it will depend upon their 'Dasein'.

However, this chapter has revealed in the hospitality of *being at ease*, stories which may give comfort and at-homeness to many, and it has also revealed what factors and situations have made a patient feel ill at ease. These stories have described moments when patients have felt at ease which include being welcomed, being able to close one's curtains, being amongst other women, being surrounded by the right coloured walls, curtains and pictures, being in a comfortable bed, being independent and being able to leave!

There were other stories which revealed moments when patients felt ill at ease, being in a mixed ward, not having their bed made, being surrounded by ugly curtains and unattractive spaces. A previous study would support the belief that it is difficult for a patient to feel at ease while waiting in "shabby rooms with uncomfortable furniture and old magazines" (Renzenbrink, 2011, p. 29). This study also expressed the opinion that management are perhaps not taking the time to consider just how demoralizing this environment can be for a patient. It has been revealed that the physical setting of an organisation may influence the overall guest satisfaction of a particular service (Bitner, 1992). A hospital needs to focus on more than the technological aspects of medical care to incorporate good design and physical surroundings to reassure patients (Jenkins et al., 2011; Wu et al., 2013). It is these 'other' factors, which may seem unimportant to health

care professionals, which have shown themselves as being significant in their effect on the participants with whom I spoke to in this chapter.

## Chapter Six: Being healed

*“Healing means, first of all, the creation of an empty space where those who suffer can tell their story to someone who can listen with real attention. But listening is an art that must be developed not a technique that can be applied as a monkey-wrench to nuts and bolts. It needs the full and real presence of people to each other. It is indeed one of the highest forms of hospitality.”(Nouwen, 1976, pp. 88-89)*

### Introduction

Hospitality involves the relationship between a guest and a host (Lashley, 2000). The healthcare provider is paradoxically both the host and the guest in another person’s life, entering as a stranger who seeks to better understand the individual to aid their healing (Nouwen, 1976; Parse, 1992). Attending to the stranger and opening one’s mind to the other is to understand the lived experiences of the other and is described by Bunkers (2003) as acting with “a spirit of hospitality and attending to others in true presence” (p. 307).

The notion of presence emerged in the nursing literature in the 1960s, conceptualized as a philosophical model which was derived from the existentialism of Gabriel Marcel and Martin Heidegger (Stanley, 2002). Presence has been described as a ‘gift of self’ characterised in the one giving by availability and openness (Paterson & Zderad, 1976). There is a parallel with this ideology in healthcare and hospitality which is described by O’Gorman (2007a) as being offered as a ‘gift’ by a host to a guest, creating a genuine friendship which is shared between them for a limited time.

Stanley (2002) regards the paradigm of nursing presence as crucial in order to enhance patient lived experience; it is not a passive concept but one she describes as powerful, requiring strength, courage and doing. As expressed by Nouwen (1976), listening is

regarded as one of the highest forms of hospitality and he is in agreement with Stanley (2002) that it is not an easy skill to have. Furthermore he describes the experience of the stranger (patient) of finding themselves in a situation of pain and fear when in hospital. He suggests this situation may be altered when the carer (host), shows genuine compassion to listen, without judgment, to the stories of the patient. Nouwen (1976) explains that this act of reaching out and listening by the carer creates a free and friendly space where the patient becomes relaxed and confident to speak out and share their personal stories without fear, so that their new life (healing) may begin.

The stories in this chapter have been chosen because they illuminate the notion of presence of an emotional, socially connecting experience being created between carer and patient. These stories highlight the moments of human interaction when the participant as patient experiences a carer's presence.

Tina's story uncovers an occasion during her hospital lived experience when the action of a particular midwife created a 'wow' moment.

*There was one really amazing mid wife who bathed the baby. She rang Mum, she wanted Mum's phone number, she wanted to ring her, she wanted me to give her my phone so she could ring her, so that Mum could come in and help her bathe the baby. She said we will wait for you, so you can help with baby's first bath. At first Mum and I were taken aback; we thought it a bit weird. But she wanted Mum to be part of it, she had been counselling me a bit, she knew we had issues with the in-laws, that whole family thing, and Mum was feeling left out. The midwife had been listening to our conversations so she had got personally involved, I was shocked at that. I thought she was interfering at first but actually she was really, really nice; she was*

*going out of her way to get everyone involved, it was quite 'wow', that was amazing. She really went over and above what she had to do.*

*(Tina)*

As Tina talks about this moment as *amazing*, she conveys her astonishment at the midwife's attentiveness to the specialness of her baby's first bath. Through her actions, the midwife communicates to Tina that she is in tune with Tina's needs as a new mother as well as Tina's mother's feelings as a new grandmother. The midwife 'tells' Tina she holds dear what is 'best' for her. The active listening conveyed by the midwife of conversations between Tina and her Mum point towards an act of personal connection. Yet Tina's initial reaction to the midwife's attentiveness is one of concern, *as interfering*, perhaps Tina is disbelieving that anyone should display such an act of kindness it is just so unexpected. The midwife's insistence that she contact Tina's Mum: that they wait for her so that she can bond with the baby suggests that she is aware of some underlying issues which are affecting Tina. This connection, this intention to really listen; to have a better understanding of the stranger, in this case Tina as patient, fosters a quality of care and is open to be experienced by the receiver as an act of true presence (Bunkers, 2003; Gilje, 2004; Stanley, 2002).

It is interesting that Tina experiences the midwife as going *over and above* the technical duties she expected after her surgery to deliver baby. She adopts a more holistic approach and she establishes a relationship with Tina, by getting to know her, to be at one with her so that she can meet the 'whole' of her needs. The midwife appears to show a calling for her profession, she makes it clear that her actions are heartfelt; she wants what is best for Tina and her mum. When a carer demonstrates such a holistic approach to caring they see the whole person, their actions come from their heart and not their head - they are drawn to caring as a profession (Wright-St Clair, 2001). When



medical staff adopt this 'whole patient' approach patients feel more content with their treatment and more valued (Hepple et al., 1990).

Yet this midwife appears to recognise a benefit to Tina in meeting more than her immediate medical needs, that her needs are more than that, bigger than that. It is through a close personal connection and intimacy towards Tina and her mum that she provides a deeper level of healing. Tina is a little uncomfortable to realise that the midwife is listening to the conversation between her and her mum. She is taken aback when the midwife asks to phone her mum, this is a very courageous act by the midwife because she is stepping into Tina's personal and intimate space. This opening of an intimate space in which Tina has allowed the midwife to enter creates a very special kind of healing, described by Patten (1994) as therapeutic hospitality. Patten (1994) refers to this as the therapeutic use of self and is based upon Nouwen's (1976) paradox of hospitality which creates a friendly space where strangers and hosts can enter freely to share their own stories.

Perhaps the midwife's actions convey her naturalness towards healing, however the effect upon Tina is profound, these actions leave Tina taken aback, *it was quite wow*, providing her with a very memorable hospital experience. This action is received by Tina to be totally unexpected; she is shocked that a stranger, a person who has only just walked into her life should do so much for her. She finds it difficult to comprehend that anyone would give so much to her, so unconditionally. Yet the 'wow' moment which occurred in this instance brought Tina and her mum great comfort it brought closeness it brought healing to them both.

It is the actions of others which go beyond a prescribed service or technical procedure which create a hospitality memorable experience (Hemmington, 2007) and it is often

the interaction skills which staff display, rather than their technical skills that a guest remembers and leads to high patient satisfaction (Patten, 1994).

This next story continues with the theme of being healed and uncovers the notion of sharing some time; of giving a little of one's time to another. This story is retold by Susan.

*They were lovely, the nurses. Some were more rushed than others and more efficient than others but the Filipino nurses I have to say were fantastic! I commented by writing to one, that I thought he was really good. Most of the staff, yes their efficiency I thought that was very good. My ... I didn't tell them about the slack nurses up the top! But what really made a difference were the nurses that made a personal connection, "what are you reading? I have read that, what do you think of this?" Even those who were really, really busy if they give you a bit of time, that was very much appreciated, that they would share a bit of themselves. Sometimes I would be writing on my pad and they could see without asking, and they would take their time to read it and respond to a question. The ones that made me feel I was cared for were those people who gave you a bit more time and it is hard as they are so busy and they can't all do that. But some people just give that extra, even if it's just a smile and how are you today and hey you are looking better that sort of thing. (Susan)*

In the midst of recounting her story Susan talks a great deal about how lovely the nurses are on the ward, she observes that they are clearly busy, *rushing from one job to the next*, most displaying their efficiency as they hurry about their tasks. Susan understands that the nurses have many duties to perform and she is very accepting of that, she keeps

to herself her thoughts about the *slack nurses up the top!* And yet when one of the nurses makes some time to talk to her, to show a genuine interest in her; *what are you reading? I have read that, what do you think of it?* She feels really cared about. This small action, this inquiry about the book she was reading, created a brief momentary connection, an emotional shared experiential space between Susan and the nurse. This emotional hospitable act, can only occur when those involved ignore any rational judgements or preconceived ideas they may have about the other to create a moment of mutual wellbeing (Lugosi, 2008). Such a moment is described by Lugosi (2008) as a form of hospitality, called ‘meta hospitality’, when an emotional encounter is created by allowing an openness to be given towards the other. Each person is fully accepting of the other, for a brief and temporary moment, which is understood by both parties to be for a limited time.

Susan is quite transformed within herself, she is suddenly happier within herself, she recollects that it was those nurses who gave her some of their time, who got to know her a little that made a big difference to her patient lived experience, *what really made a difference were the nurses that made a personal connection*. When in hospital a patient may have too much time to just think and worry about their situation, perhaps experiencing alienation due to the strange environment they find themselves in. When a personal connection is made, it displays a unity of hospitality and true presence promoting a quality of care (Stanley, 2002). This connection may be demonstrated in a small gesture, the act of acknowledgement given to Susan from the nurse, *just a smile and how are you today*, made her feel valued, feel human and really cared about.

It is suggested that time spent in conversation with a patient is an act of caring which embodies the kindness of moral treatment which can play a significant part in the healing of a patient (Peloquin, 1994). The simple gestures which Susan describes were

performed not out of a sense of duty, but out of genuine kindness, despite staff being busy. The effect to Susan, of her perception of being cared about was overwhelming.

In reality ‘these acts of kindness’ took little extra time and were offered while the nurses were carrying out routine tasks. Why is it that for some staff, for example *the slack nurses up top*, this is not part of common good practice? This costs nothing and maybe a nurse will benefit by getting greater satisfaction in their job when a patient feels more cared about.

This next story speaks of being heard, of being listened to because actually enough bruises are enough! It has been retold by Beth.

*Ok, so I had bruises all up my arms, thankfully they had inflicted that upon me when I was asleep! I had bruises everywhere, and I had an IV over here which is only just functioning and then the blood taker comes to take more blood off me. I looked at my hands and I said to her “I have got no more veins, I have collapsing veins, so taking blood off me is a real problem.” I said to her can you use a paediatric needle and just go through this vein. And she listened to me, she did it and it worked! It was really good that the blood taker actually listened to me and didn’t ignore what I had to say as that would have stressed me out massively. She listened, thank goodness someone listened to what I said and it was a very good experience. (Beth)*

In the retelling of her story Beth appears to be joking about the fact that her body is full of bruises, *up my arms and collapsing veins*, yet as she continues with recounting her experience I can detect that her joking manner is perhaps covering an underlying distress. This begins to reveal itself as she begins to explain how worried she is about

having to give a blood sample. She describes the healthcare worker as *the blood taker*; this suggested to me that she is very worried at the consequences for her body of allowing anyone to take any more blood from her. That perhaps previous experiences had been difficult, that her concerns had not been respected. There is anguish in her voice as she retells me how she explains to the *blood taker* that, *taking blood off me is a real problem* she wonders if this person is going to listen to her and be respectful of her concerns. Beth is outgoing and appears not to be intimidated by the *blood taker* and proceeds to describe very precisely the best way to take blood from her which will not result in further bruising. This action from Beth is rather bold and is probably not a response that other patients who have less confidence than Beth would feel comfortable with. It is also an action that may have led to a certain amount of irritation from a professional health care worker, who perhaps does not like to be told how to do their job. And yet a rather interesting thing occurs, the blood taker listens, as Beth explains she *actually listened to me*. Why is Beth so surprised that she is listened to? Does she presume that as a patient she will not be considered in her treatment plan? A common complaint from patients in hospital is that their individuality is often ignored, leading to feelings of depersonalisation, the extent to which this exists will depend upon the attitude of each individual health care professional they are in contact with (Hepple et al., 1990).

Yet Beth is listened to, actually she is more than just listened to, the blood taker appears to Beth to show a genuine interest and duty of care towards her and inserts the needle in the way that she suggests. She demonstrates an empathy towards Beth, she demonstrates presence in her actions because empathy requires the blood taker to show a deep understanding of what is best for Beth, to have compassion and humility not arrogance (Stanley, 2002). She listened, she empathised. Beth is relieved, Beth is happy and Beth is being healed.

True presence may show itself in many ways, one such way is through intuition, the way in which a person shows an inner understanding of the needs of others. The next story is retold by Grace and highlights a moment in her stay when she is being healed through the presence of intuition.

*One night I couldn't go to sleep and I had plenty of drugs in me so I don't know why? But then one of the nurses said "Oh sometimes you know if we put an extra blanket over your feet and really tuck you in then you can fall asleep." And I thought, oh that's nice "Yes please". And it worked. Having the extra blanket over my feet must have just tipped the balance. (Grace)*

Grace's story hints of agitation at finding herself unable to sleep, she can't seem to comprehend her situation she has received all the drugs that she needs and yet she is lying wide awake. Grace does not ask for any assistance from medical staff, she is accepting that at this moment she is simply unable to sleep. She appears to resign herself to the fact that eventually she will simply fall asleep. Then something unexpected happens to Grace, a nurse comes to her, she observes that Grace is awake, perhaps she notices that Grace is restless - it is not clear. However, she recognises something in Grace's manner, she can tell that she is restless and keen to sleep, so she makes a suggestion of how she can help her, and she wraps her up in a blanket and tucks her in. She demonstrates a kind of intuitive knowing, she understands the needs of Grace, she demonstrates her experience and her willingness to care, she shows hospitableness and Grace falls asleep.

It is perhaps not the action of tucking Grace up in a blanket, which aided Grace in sleeping, but the action of someone showing real compassion and understanding of her situation. It is acknowledged by Stanley (2002) that presence requires intuition, it

cannot be learned but it may be acquired through the lived experience of the practitioner. It seems that Grace is recognised as an individual, as a person by this nurse, she goes beyond the delivery of purely technical duties to recognise that for Grace to be comfortable and to be healed she needs something else. Grace is connected with, Grace is comforted and Grace is being healed.

When patients are treated purely as an object of analysis in a uniform way as is the case in some hospitals because this is what is easiest for them, it can lead to feelings of devastating alienation (Renzenbrink, 2011). Such practice is unlikely to aid the healing process for patients.

Up to this point the stories in this chapter have revealed moments when the relationship between the guest and host has been a hospitable one. Where the host has welcomed the stranger, has listen to them, dispelled preconceived ideas, offered comfort, indeed where the other is attended to with true presence. This story which is retold by Clare uncovers occasions when this is absent.

*The nurses are the ones who look after you a lot more than anyone else in the hospital and their social skills are not always good they need some education about hospitality. Yes they are stressed, you have 20 patients to attend to but do all of them have a bad day? I mean maybe one has a bad day. I think it comes down sometimes to education and how things can be done a little bit differently, come across a little bit differently or said a little bit differently. I mean especially the nurses who come and jab the line in your hand, gosh, ha ha I am really hard to get a line in and I say "Oh no I don't want to do this." Some of the nurses they roll their eyes about it but then there are others who say it's ok, it will just be a small prick and it's*

*gone and I'll be done. That's so much better and you can feel the difference. (Clare)*

In the retelling of her story Clare talks about the lack of hospitality which is given to her by the nursing staff, she interprets hospitality as the way in which the nurses interact with her, their social skills. She is quick to empathise with the nurses in terms of their volume of work, that they are *stressed* and that they have many patients to care for. Yet she is unhappy with the way she is communicated with by so many, she asks *do all of them have a bad day?* It appears that the nurses are doing the jobs they need to do, they are taking care of Clare but the way in which they are completing their tasks are leaving Clare feeling depersonalised. She feels as though she is being ignored by the nurses, no one is interested in her as a human being, the illness inside the body is being treated but the person within it is being forgotten. Clare's lived experience, her history, who she is now and how the illness is affecting her life and her relationships with others is not considered to be of any consequence to those who are caring for her, she is alienated. It is only the symptoms of the illness which the nurses are addressing and not the person inside the body who has feelings, thoughts and emotions.

Within healthcare literature there is discussion around the depersonalization of patients who feel they are ignored as human beings, that healthcare workers are often silent, distant or disinterested (Hepple et al., 1990; Peloquin, 1993; Renzenbrink, 2011). It is suggested that healthcare practitioners should understand that they become significant others to the patient due to the special connection that illness brings (Peloquin, 1993). As discussed in previous stories in this chapter when a patient has a connection with medical staff they feel quite different within themselves, they feel important they feel more cared about.



For Clare this was not always the case, indeed her experiences with *the blood taker* were at times in complete contrast to that of Beth's. Clare makes a point of explaining to the nurses that she was uneasy with having her blood taken and told the nurses why and yet the action of some of them is *to roll her eyes*. Do they think Clare is making a fuss, being silly? No attempt is made to empathise with her, to consider Clare's previous experiences of giving blood and the effect it may have had on her. The nurses simply did what they had to do, misusing their power over Clare, showing no compassion, no care. Clare felt ignored. Peloquin (1993) suggests that the actions of staff who misuse their power ignoring the feelings of a patient, may discourage them at a time when what they really need is encouragement. A patient may begin to view a medical professional with fear because they exert power over them in various ways. They make decisions about them with no explanation, use terminology which they do not understand and perform procedures which cannot be questioned (Nouwen, 1976).

How does this impact Clare's healing? Clare suggests that staff need to be educated so that they understand the significance of their communication and interpersonal skills for a patient. Hospitality centres around the security, physical comfort and psychological comfort between the guest and the host (Burgess, 1982; Nailon, 1982), at times for Clare not all these were present. Clare experienced a disconnection. Clare was not being healed.

This last story is in contrast to the story which was retold by Clare, who described moments of her lived hospital experience when hospitality was absent, when at times the host was not especially caring in their attitude towards her. In this story from Susan she points to instances when health care professionals acted with a spirit of hospitality.

*I have never associated hospitality with hospitals however on reflection I think it makes a big difference and on the whole it was a*

*positive experience. You can train staff in how to behave with patients but you can't teach someone how to be warm, to have that ability and that willingness. To be able to make connections with people in a sincere way, not just "How are you darling?" but in a sincere way so that they look at you when you speak and you feel acknowledged. You can just tell can't you? And when a person makes a personal connection with you it is just lovely, you feel more yourself again and everyone likes to be acknowledged. (Susan)*

Something interesting occurs during the end of Susan retelling her stories of her inpatient hospital experiences, she seems to pause and her mind is thinking and then it's as if a light bulb sparks alight in her head. Hospitality, yes it has played a part in my stay, upon reflection she is saying *yes it made a big difference*. Yet what is it that Susan is hinting at? How is it that hospitality has made a difference to her? How has it shaped her experiences so that they are good in her eyes? Perhaps Susan is recognising acts of hospitableness in the way in which she is communicated with and is connecting these with notions of hospitality. Being hospitable, performing hospitable acts is closely associated to providing hospitality, Telfer (2000) suggests that truly hospitable behaviour is motivated by a genuine desire to please rather than to impress the guest. It is perhaps this behaviour which Susan is conscious of, that she is able to detect in the manner in which she is spoken to by various nurses. Telfer (2000) explains that hospitality presents itself with different motives, one of these she refers to as "good Samaritan hospitality" (p. 47), these are individuals who may be lonely or may need to feel valued as an individual, it is this group she explains are particularly well served by hospitality. This may relate to the way in which Susan is perceiving hospitality.

When Susan is recalling moments of her stay when she is spoken to in a sincere manner, she describes a sense of being connected with, and perhaps she is feeling suddenly important, human, acknowledged. It appears that when Susan is communicated with in a manner which is genuine, she feels respected; perhaps she is regaining a sense of dignity as a person. Stanley (2002) suggests that when a healthcare worker gives a patient attention, showing affirmation toward them and value in them it can help to restore a loss of self esteem which they may have and renew their self respect.

Yet Susan is quite astute in her observations of the health care professionals, and she is able to disclose when she is spoken to in a manner which is sincere or off hand. It is those who really look at her, really pay attention to her with whom she identifies with that make a real difference to her. Susan's story illustrates nursing presence as a mode of being, that is a presence which is immediately known by a stare, a tone of voice or a spoken word (Stanley, 2002). It was historically through the monasteries that hospitality was always generous and bestowed freely towards others. The roots of hospitality can be found in the care given to the sick by religious orders this was regarded as 'hospitality' (King, 1995). However meeting the physical needs of the guest counted for little if not carried out in a sincere manner (O'Gorman, 2006). True hospitality is more than providing a service or a product, it must also encompass a genuine act of kindness and care from the host to the guest. Thus at the centre of true hospitality is an emotional encounter, an openness towards the other which provides hospitableness in a shared experiential space (Lugosi, 2008). It is this emotional encounter that Susan experiences in the hospitableness and openness which is offered to her that leads her to talk about the significance of hospitality during her stay. The hospitality shown towards Susan leads her to being healed.

## Summary

The stories in this chapter have been retold to discover a deeper meaning of the hospitality of being healed for the lived experience of hospital patients. This chapter has explored the interpersonal relationships between the healthcare professional and the patient; it is these relationships which have a significant impact to the overall patient experience. It has been suggested that many patients will focus more on what was said to them and the way in which it was said rather than the technical skills of staff when rating a hospital stay in their overall patient satisfaction (Patten, 1994). It has been suggested by Nouwen (1976) that many patients may leave hospital healed of their illness but hurt in their feelings by the impersonal treatment which they have received. Clare describes in the retelling of her story that the staff really needed to demonstrate better social skills and indeed to listen to her. It is not uncommon for patients to describe their experiences with health care workers as uneasy which can leave them feeling alienated and dehumanised (Hepple et al., 1990; Peloquin, 1993). The illness experienced by a patient is often an event which is charged with emotion, a patient may be fearful and many health care professionals fail to acknowledge this in their treatment towards the patient. Staff distance themselves from the patient they remain silent and appear offhand when giving treatment and demonstrate a lack of empathy or interest in getting to know the patient (Peloquin, 1993). Some patients describe not feeling like a human because nobody shows any interest in them, of who they are, or who they may have been and how the illness is impacting relationships and life in general (Renzenbrink, 2011). The impact is that patients do not feel cared about and they are not being healed in a holistic way.

It is necessary to fully understand the lived experience of a patient through the notion of presence to offer healing. Presence is a subjective experience which takes many forms; presence is the intention to listen, to connect, a mode of being, to know, to empathise

and to value. It is suggested that presence is a powerful concept far from easy at times to employ which cannot be taught but may develop over time through life experience (Nouwen, 1976; Stanley, 2002).

For a person to get to know the other a friendly space must be opened, a space which is free from judgement, which is safe, which is open, it is then the patient feels comfortable enough to tell their stories to someone who will really listen (Nouwen, 1976). Presence involves an intention to listen to the other (Bunkers, 2003; Stanley, 2002). Listening with real attention is a skill described by Nouwen (1976) as one of the highest forms of hospitality. It is through the listening of the stories which are told, of being interested in the stories, that the host really gets to know and fully understand the guest, it is only then that healing will begin (Bunkers, 2003; Nouwen, 1976).

Some of the stories in this chapter have uncovered moments when healthcare workers have acted with true presence and demonstrated hospitality and this unity has evoked a quality of care where the patient has felt cared about which has assisted them in the being healed.

In the chapter which follows I will discuss my deeper understanding of hospitality within a hospital setting based upon these findings chapters.

## Chapter Seven: Discussion

*“Healthcare’s focus on physical disease and bio-medicine is unbalanced. We need to pay much more attention to emotional, psychological and spiritual wellbeing and the huge importance of healing relationships.”(Youngson, 2012, p. 13)*

### Introduction

This study asked the question ‘*What is the lived experience of hospitality for adults during a hospital stay?*’ I explored the topic using an interpretative phenomenological approach to gather stories of hospital patient experiences, more specifically of the moments when hospitality presented itself in the patients’ lived experience. I conducted interviews with seven participants all of whom had been admitted to an Auckland hospital for at least three days to have elective surgery. This chapter will discuss my deepened understanding of the meaning of the hospitality experience in relation to the healthcare environment based upon a synthesis of my findings as outlined in the last three chapters. Through this looking across my findings I will link the interpreted ideas and notions to the existing literature and identify similarities between hospitality and hospitals. It is through a link between my findings and the literature that I will make tentative claims and suggestions for changes to practices within hospitals. I will identify the strengths and limitations of this research as well as making recommendations for future research. It is beyond the scope of this research to make suggestions about the way in which medical care and treatment is given to patients and as stressed at the beginning of this thesis, it was not my intention to do so.

### Hermeneutic phenomenological methodology

Through adopting a Heideggerian interpretative approach for this study I have been able to explore and uncover more about the emotional transactional element of hospitality as

experienced by the participants during their hospital stay. It is from the participants' retelling of evocative stories about their 'lived experiences' that I was able to interpret the ways in which hospitality played a part in their stay. Hospitality is a subjective notion, as has been discussed throughout this thesis and it has shown itself within the findings in different ways to the participants. It was assumed that to gain greater insight into a phenomenon such as hospitality, to understand more deeply the situation of the lived hospital experience that, this could only be achieved through asking each participant open questions, inviting storied experiences in the form of an in-depth individual interview. It was from these stories that I began to immerse myself in the data and to select those stories which stood out as being the most significant to uncovering hospitality moments.

It is my personal history and my experiences, which Gadamer (1993) acknowledges as necessary for a hermeneutic study because they create a bond with my subject, and these were a starting point for my understanding. Similarly, my interpretations are grounded in my history, in my being and, as Heidegger (1927/1962) suggests, all interpretations are in the context of what I know; and it is my prejudices which have helped me to understand while always working to stay open to what might be. I am mindful that everyone interprets in their own way and I acknowledge that these findings are based on what I have uncovered through my interpretations of different situations.

I will now look across my findings, to consider the meanings that I have uncovered through my interpretations. What follows are the different notions of hospitality which began to present themselves to me as I read and re-read all of the participants' stories. It was during this process that I began to cluster stories together, and identify those stories which seemed to best uncover the meaning of hospitality in hospitals. One notion is neither more or less significant than another, they do not stand alone, indeed the notions

weave amongst themselves, they are at play, creating a richer and deeper understanding of what hospitality means to these participants through their experiences and words.

### **Hospitality ‘just is’**

Through this thesis journey I accepted that hospitality is not easily defined and may present itself in many ways, yet it exists; it ‘just is’; it is the ‘is-ness’ of hospitality that showed through in participants’ storied experiences. Such stories clustered together because they all spoke of significant and meaningful moments about ‘being’ and existing within a hospitality experience. Through interpreting these stories I began to understand more about the ‘that-ness’, ‘what-ness’ and ‘how-ness’ (Heidegger, 1927/1962) of hospitality and how it presented itself to each participant. The ‘that-ness’ of hospitality signifies that it exists and that it showed itself as mattering, that hospitality matters to the patients and that it is something they are attuned to. The ‘what-ness’ of hospitality is what it is, in the little moments when health care providers convey small acts of hospitality to the patient. The ‘how-ness’ of hospitality is the way in which hospitality contributes to the patients healing journey. I understand that the ‘just is’ of hospitality exists in the realm of participants’ unique human existence, or ‘Dasein’ (Heidegger, 1927/1962), and their always being-in-the-world in deeply contextual ways.

### **The ‘is-ness’ of hospitality**

The ‘is-ness’ of hospitality was revealed in a number of different ways including; being generous, being hospitable, being entertained, being made to feel safe and secure, being communicated with and being welcomed. It is perhaps interesting that much of the hospitality literature would support these notions in defining what hospitality incorporates.



An act of generosity is suggested as being central when providing hospitality to a guest (King, 1995; O'Gorman, 2007a), the notion of being entertained, feeling safe and secure and being welcomed are also well documented in the literature when attempting to define hospitality (Hepple et al., 1990; King, 1995; Severt et al., 2008). It is the manner in which hospitality is offered that creates a hospitable rather than a hostile environment (Hepple et al., 1990; O'Connor, 2005; O'Gorman, 2007a), and these stories have highlighted this 'is-ness' of hospitality, the occasions when hospitality or hostility was present.

### **Experiencing generosity**

Health practitioners' showing generosity was important to patients and presented itself in different ways, as was heard in Beth's story when she spoke of when she asked the staff if she could attend chapel, *I must say they were really, really good about arranging it*. Such findings suggest when health practitioners show attentiveness toward patients' needs and a willingness to give a little extra time to respond, that patients experience it as generosity. When experienced this way by patients, such moments may become what is remembered, the moments that become long lasting and special memories of the hospital stay, conveying ways in which patients felt valued and respected. Practitioners' generosity conveys being treated as a whole person with interests and with an identity not just as a patient with a health problem.

### **Being entertained**

When a patient is in hospital for several days they may express a desire for a diversion, for something to do to occupy them so that they are distracted. Several stories highlighted that there is a need to have some entertainment; recall Susan's story when she asked *what was available for me to do*, the initial response was that nobody really knew, she went on to discover that actually there were things for her to do including an exercycle, but this was in poor repair and she was unable to use it. This would suggest a

lack of knowledge and communication between staff of what is available, it also highlights that some of what is available is unable to be utilised because it is in poor repair. It maybe that what matters is just different, it may matter to a patient that they are kept busy and entertained, whereas what matters to health care workers is to get their 'job done'. Perhaps 'medical' staff do not see such things as important?

Beth's chapel story also spoke of the importance of being entertained, and for her, the whole experience of being taken to chapel was a great adventure. Clare's story also stressed that *there needs to be something to occupy people...a distracted mind.....you don't want to sit in bed and worry and be sad*. Offering hospitality has been historically linked with the provision of entertainment being offered by the host to the guest (King, 1995; Telfer, 2000) and entertainment should be regarded as significant within a hospitable transaction (Lugosi, 2008). These stories would appear to support the significance of being entertained in hospital, of the effect it has upon the overall embodied wellbeing of the patient. It is a key factor for healthcare professionals to understand, to recognise that patients are feeling emotional, they are vulnerable and are likely to dwell heavily upon their illness if not able to be distracted (Sørli et al., 2006).

So how might hospitals address the issue of providing entertainment for patients? There appears to be a lack of interest from some staff about this, perhaps because they are not able to understand the importance of being entertained for the care plan of patients.

Perhaps this seems quite a trivial matter, yet it is a way of filling in time in a meaningful way and of diverting a patient's attention away from thoughts of being in hospital. As Clare described *you don't want to sit in bed and worry and be sad*.

In addition there appears to be a lack of knowledge of what is available and time allocated for staff to explain this to patients. Perhaps a patient guide or handbook could be written of what was available and made accessible to staff and patients on each ward.

### **Being made to feel safe and secure**

Providing security to guests and their belongings has long been considered as central to the definition of hospitality dating back to when care was offered to the sick in religious times (King, 1995) and is a responsibility required from commercial hotels under the Innkeepers Act 1962. This study suggests it is no different in a hospital setting, yet for patients in hospital this study reveals that in terms of their belongings they did not feel they are necessarily safe.

Clare spoke of bringing in her laptop to keep her occupied *I thought I would take in a laptop* although she was advised against this due to security issues. Perhaps it is time to recognise the significance of the Internet to the lives of most people; that it is not unreasonable to expect that people want to access the outside world when in hospital. I am not suggesting that the Internet is made available to patients, the health provider has a budget which it must meet, but many patients may be willing to use their own Internet facilities but are fearful for the safety of their electronic device or interfering with medical equipment. For this reason perhaps hospital managers might consider a more effective way of managing the safety of personal belongings.

This could have far reaching effects because if a patient is able stay in contact with those outside the hospital, their family and friends they may feel less alienated and more human (Renzenbrink, 2011). It is the supportive dimensions to patient care that are recognised as aiding recovery and provide a sense of wellbeing (Jenkins et al., 2011). Perhaps it would be possible to offer some form of lockable safe or cabinet for patients secure their belongings, similar to that available in some hotel rooms?

### **Being welcomed**

It was decided that the participants selected for this study would be elective patients, who had been given a date for their surgery and as such would be expected by the

hospital. Much of the literature suggests that the patient arriving for surgery has a heightened anxiety because they have had time to worry about what will happen to them, feels vulnerable and is perhaps fearful of what is to come (Hepple et al., 1990; Severt et al., 2008; Sørli et al., 2006).

Christie's story uncovers how nervous and anxious she is about her upcoming stay in hospital, *I was very anxious as to what is going to happen....but they were waiting for me*. This story described what it means to be welcomed. When a patient receives a sincere welcome, when it is clear that they have been planned for and are expected it has a profound effect upon them. All at once the patient's heightened anxiety is replaced with feelings of reassurance and comfort, it is when a patient feels welcomed they become more at ease with themselves and in their surroundings (Gilje, 2004). An understanding of the overall consumer experience enables better care to be afforded to the patient. This approach is not dominated by impersonal, prescribed service delivery models but one that creates a memorable experience for the guest (Hemmington, 2007). Systems and procedures are important, and it is those that have led to the elective patient being expected. It is important to recognise that the welcome sets the scene for a patient's stay, it can either enable them to relax or to become stressed before anything has even happened.

I would suggest that training and educating is given to front line staff, to those staff who are the first person that a patient meets. This may be a nurse or an administrator who needs to understand the crucial role they perform in the patient experience in the same way a concierge does in a hotel.

### **Being communicated with**

It became apparent in this study that being communicated with sincerely and being given information from health care professionals is very important to patients. When a

health care worker distances themselves from a patient, or withholds information, a patient is often left feeling helpless and distanced (Peloquin, 1993). Cody's story spoke of asking to be allowed to leave hospital in order that she could attend the show 'Wicked' at the theatre. It is when a patient is spoken to about what is happening to them, when they are involved in conversations about them they feel as Cody explained *really respected*. When a patient is included in discussions about their care they are less likely to feel alienated and they are more at ease in the knowledge that they are informed about their care plan and their wellbeing. This individualised care, this humanistic approach creates a deep personal connection and can create a basis for healing (Patten, 1994).

### **Being made to feel comfortable**

Feelings of comfort were a recurring theme within the stories, and sometimes comfort came from a few spoken words of reassurance, Christie described *it wasn't an issue...she trusted me...she made me comfortable*. Sometimes it came from the tucking in of a blanket, and the attentive act of offering to tuck in the blanket gave the comfort rather than the warmth offered by the blanket. It demonstrated a caring act that somebody else was thinking about what another person may need. Other patients experienced comfort through interactions with others; Grace's story described elements of hospitality which brought her comfort and made her feel cared about. She described hospitality as *being all about the other stuff....of being nurtured....so you don't have dark thoughts you have happy thoughts* and she is perhaps describing the hospitable behaviour of those around her, as the actions of the staff appear to be motivated out of a genuine desire for the pleasure and welfare of the guest who is in need (Telfer, 2000). The 'is-ness' of hospitality presents itself in different ways to the patients. Often it is not considered until it has appeared, it is not observed until it is reflected upon but hospitality existed in these patient experiences. These stories describe moments of when

hospitals created what Pizam (2007) describes as the “ity” factor, a hospitableness which creates an atmosphere with the right feel for the guest. When hospitality was present, patients expressed various emotions including being overwhelmed, being shocked and the experience being unexpected. This study suggests that when hospitality is present it made a notable impact upon the embodied wellbeing of the patient who described feeling valued, respected and happy. This study has highlighted that when hospitality is absent patients became bored and expressed feelings of anxiety and being sad, so this may suggest that hospitality as Grace recalled as being *the other stuff* improves the overall wellbeing and way of thinking of the patient.

### **The surroundings**

The influence of the surrounding environment began to show itself within the findings as being a significant factor and an integral aspect of a patient’s stay in hospital. When participants found themselves in surroundings with which they were comfortable they displayed feelings of ‘being at ease’ whereas those who were unhappy in their environment expressed ‘being ill at ease’. These findings are consistent with the literature which suggest that the hospital environment can affect overall patient satisfaction (Jenkins et al., 2011), that surroundings can influence feelings of ‘at ease’ or ‘at homeness’ (Cassie & Reuland, 1983) and a physical setting can be intimidating and affect the nature of social interactions (Bitner, 1992). The surrounding environment and physical setting within a hospital may also be described as accommodation which is defined as one of the key functional aspects of hospitality (Brotherton, 1999; King, 1995). Different facets of the environment were uncovered in the stories, although some factors were mentioned perhaps only once whereas others were brought up on several occasions.

Being in a clean space was important. It was of less concern that a ward was old, as long as it was clean and tidy perhaps suggesting that having had surgery a patient is

anxious about contracting further infections and is reassured when the ward is clean. As this study specifically researched surgical patients it was interesting, but not surprising that the issue of electric beds was raised and Cody emphasised *the huge difference it made to her stay*. A surgical patient may be restricted in movement, unable to easily sit up or get out of bed unaided but when a patient is provided with an electric bed they regain their sense of independence and control of their situation because they are not reliant on others each time they want to move. Another patient talked about her room and the knowingness of having her own room, despite this being a public hospital, in which she could unpack and get settled before her surgery. The knowingness of where the patient would be staying, enabled her to settle in and led to feelings of comfort and of at 'homeness'. When a patient is at ease in their surrounds it can lead to feelings of 'at homeness' (Cassie & Reuland, 1983), when a patient is relaxed, calm and happy it aids their healing (Youngson, 2012).

The issue of curtains was raised on several occasions and in different contexts. Their physical appearance caused concern as Clare recalled *the curtains are ugly* which had the effect of making her feel quite sick and to *hallucinate*. In her case it was the design printed on the curtain which caused her such discomfort which is in contrast to the curtains which are in a children's corner of the waiting area which the same participant described as pretty and calming. This would support the literature which acknowledges that the physical surroundings impact behaviour and may create images for customers in hospitals (Bitner, 1992) and using hospitality inspired designs within hospitals can create a more attractive environment which is calming and reassuring for patients (Annunziato, 2000; Wu et al., 2013). Interestingly Christie recalled that the reception area had beige coloured walls and plants, this led to feelings of calmness in the naturalness of the surrounds. This was a private hospital which may suggest that a higher budget and expectation from customers resulted in more careful consideration in

the planning of this area. However, another participant in a public hospital, expressed her pleasure in discovering that the walls of the ward were covered in beautiful artworks, each donated by a patient to say thank you. Her mood was one of excitement and happiness. It clearly displayed the impact that an attractive space can have upon a patient. It is evident that creating a more attractive hospitable space which is welcoming aids the healing of patients as opposed to the negative impact of barren, poorly signposted, sterile and functional hospital areas (Renzenbrink, 2011).

Continuing the discussion around curtains, apart from contributing to the physical appearance, it became evident that they play a major role in the lives of most patients in public hospital. Curtains allow patients to have a little privacy, a small escape from those around them. By pulling them around their bed they can create a small space and they are able to hide from those outside. However, this can create what Susan described as *a cell* a feeling of being trapped. If this is the emotion that the patient has then one questions why they would not leave the curtains open? This is simply explained, it is because of the dilemmas of being in a ward with others with whom one is not feeling comfortable being around. On more than one occasion patients commented on the other patients who were on the same ward and how they impacted upon their stay. On one occasion a female patient was on a mixed ward with three men, so she felt ill at ease, perhaps vulnerable or scared, and the uncomfortableness of her situation leads her to her only solution, to shut the curtains. Her discomfort is evident because when she is eventually moved to a ward with women she describes a very different sensation *we had all our curtains open and you could see the windows and you felt a lot better.*

These findings would suggest that the surroundings in which a patient finds themselves is influential in affecting their way of being. It can make them feel content, happy, relaxed, independent, calm, in control and full of pleasure and 'at ease'. Conversely it can lead to feelings of nausea, anxiety, sadness, being trapped and of insecurity. It



seems logical that consideration should be given to planning hospital environments, to consider the patient as well as the functionality of the space. Within existing hospital spaces it may be that small changes can be made which would enhance the environment, for example the use of colour and images on walls, wards, waiting rooms and curtains. In order that surgical patients have priority for electric beds systems could be implemented to keep track of their movements so that they are brought back to surgical wards. The situation of having mixed wards of men and women was unsettling for some of the participants in this study, so is there a way in which wards can be organised differently perhaps by gender as opposed to by medical condition, to ease this situation?

### **Being present, a spirit of hospitality**

Hospitality and true presence are described as a unity (Bunkers, 2003) within the healthcare literature, this unity promotes a quality of care, creating a feeling within the patient of being cared about, of being healed. True presence is perhaps the highest form of hospitality (Nouwen, 1976), of the giving of oneself unconditionally to the other, to show real attention by creating a friendly space, where a patient is comfortable to talk and to be ‘really’ listened to (Bunkers, 2003; Nouwen, 1976; Parse, 1992). The findings within this study uncovered many occasions of health care providers taking the time to emotionally connect with patients, with a “spirit of hospitality and attending to the other with true presence”(Bunkers, 2003, p. 307). The effect of their actions upon the patients is consistent with the literature, the emotional, hospitable act which disregards any judgement of the other creates mutual wellbeing, described as pure hospitality (Lugosi, 2008; Patten, 1994).

Tina’s story described a midwife who *had got personally involved*, she had listened to conversations between Tina and her mum, through her attention, her acting with real presence the midwife had a fuller understanding of Tina’s situation. The midwife’s

action demonstrated a deeper level of care, going beyond technical duties to treat Tina as a ‘whole person’. Through taking a moment to understand more about Tina, of her history of who she is as a person the midwife recognised that Tina had underlying issues that needed to be treated. Through the midwife offering her full attention to Tina she demonstrated what Patten (1994) describes as therapeutic hospitality, her actions came from her heart creating a special kind of healing for Tina, which is evident in the way Tina says *it was quite wow!*

The findings suggested that it was sometimes just the smallest of actions, the briefest of personal connections from others which played the most significant part in the lived patient experience. This connection with nursing staff “facilitates care and a sense of wellbeing amongst patients” (Gilje, 2004, p. 37). It was often when a health care professional took a little time to show some interest in the lives of a patient that made the biggest difference to the participants that I interviewed. Susan described instances of when nurses took the time to connect with her, they would ask *what are you reading?* Or, *hey you are looking better today!* It was these actions that made her feel human, she felt valued and in her words *I felt cared about*. A patient wants to be treated as a person not an object of analysis (Renzenbrink, 2011), suggesting that it is being connected with that makes the difference to the overall wellbeing of the patient rather than just the medical care. It was acknowledged by the participants that the nurses were very busy and did not have time to sit and chat to them but whilst they performed some of the medical tasks that perhaps they could use that time to talk or listen to them. Youngson (2012) would agree that this is good practice, suggesting that by making the time to connect with a patient, by giving them some attention, the patient is more satisfied and less likely to keep ringing for assistance. He believes that “caring doesn’t take any time at all, it happens in a magical moment (p. 17).”

Yet patients often describe feeling vulnerable and detached within the hospital setting with which they find themselves (Severt et al., 2008) and it is the small attentive actions of others who offer presence which make the difference. The distancing of practitioners from patients, who show a lack of interest or attention can lead to patients feeling depersonalised and dehumanised (Hepple et al., 1990; Peloquin, 1993; Renzenbrink, 2011). This was illustrated in Clare's story when she spoke of the social skills of some of the nurses on her ward, she acknowledged that they were very busy but questioned *do all of them have a bad day?* It is sometimes the attitude of the staff, which patients become distressed about, when they are performing required medical tasks their body language is not particularly comforting and caring. The staff appear rushed and disinterested in the person who is beneath the patient, more concerned with getting a particular job done and moving onto their next task. This was highlighted again by Clare who like many patients is anxious about giving blood. Clare relayed her fears to the nurses, *Oh, I don't want to do this*, and the nurses' response was *to roll their eyes about*. This action from the nurses suggested a lack of care toward Clare and on this occasion the patient is not connected with, she does not feel healed.

However, to contrast this example Clare also spoke of the actions of a different nurse who took her blood, on this occasion the nurse put her at ease, she listened to her and she offered words of comfort. Clare described feeling relaxed and comforted *you can feel the difference*. The findings uncovered that it was often in 'the listening' by health care professionals to the stories which the patients spoke of that were valued most highly in their hospital lived experiences. To actively listen and to create an environment, or friendly space (Nouwen, 1976), in which the patient feels comfortable to open up and discuss their story is acknowledged as acting with true presence and a spirit of hospitality (Bunkers, 2003; Patten, 1994). Beth described the *blood taker* who took the time to hear her story, of her bruised arms as a result of her difficulty in giving

blood, she makes a suggestion to the blood taker to use a paediatric needle. She is listened to, the blood taker implements her suggestion and as a result Beth has a good experience. There are many stories in my findings when patients describe occasions in their stay when they are listened to by a stranger when they feel they have been heard, the effect is to give a memorable hospitality experience. The participants describe the effect this has upon them as leaving them feeling happy, feeling considered and feeling respected, they are cared for in a holistic way, the whole person is being healed not just the illness.

Nursing presence shows itself in other ways in my findings and is consistent with many of the assumptions made by Stanley (2002), who suggests that it is a concept which enhances the lives of patients. Presence occurs in the moment, it is a mode of being and is recognised at once by the tone of a person's voice, through a nod of the head, a look into the eyes or a comment (Stanley, 2002). My study indicated that the patient 'just knows' if the carer is genuine and if they are acting with presence as Susan explains *when they are sincere they look at you when you speak and you feel acknowledged*. Being hospitable and to demonstrate genuine acts of kindness is synonymous with hospitality, it is this emotional experience at the centre of the encounter which Lugosi (2008) describes as 'meta' hospitality. It is a temporary shared moment which acknowledges the other through a hospitable interaction (Lugosi, 2008) and it is this emotional, socially connecting form of hospitality which healthcare academics suggest forms the basis of healing and is most beneficial in healthcare (Bunkers, 2003; Gilje, 2004; Patten, 1994).

### **The meaning of hospitality for the hospital patient**

In this study, through the interpretation of the patients' stories, hospitality has presented itself in many forms although in not the same way for each participant. However, what has shown itself is that hospitality appears to have significance when it is present in the

lives of a hospital patient. When a patient experiences hospitality it leads to an overall feeling of being cared about, a notion which is supported by the literature (Bunkers, 2003; Gilje, 2004; Patten, 1994; Peloquin, 1993; Renzenbrink, 2011). Many such special moments of hospitality showing itself were uncovered in the stories and they evoked different emotions within the hearts of the participants for example; feeling respected, feeling listened to, feeling special, feeling noticed and feeling happy. This study suggests that the meaning of hospitality for the hospital patient is that it evokes feelings of being cared about, creating a greater feeling of being healed and wellbeing.

### **Strengths of this study**

A strength of this study was the methodology used. The interpretive phenomenological approach enables a deeper understanding of the participants' lived experiences.

Consistent with this methodology I interviewed seven participants conducting in depth interviews, most of which lasted over an hour. Participants were willing volunteers who were very open to sharing their experiences which resulted in a depth and richness to the stories which I gathered. The participants shared experiences from hospitals in the public and the private sector which enabled a deeper understanding of how similar or different an experience may be in two very different establishments, although this study did not set out to do a comparative study of public and private medical facilities.

Through the careful probing of questions using a Heideggerian approach I was able to uncover significant moments of participants' 'Dasein' (Heidegger, 1927/1962), the 'what is' and the 'being of' (Smythe et al., 2008) hospitality as a hospital patient. It is through interpreting the stories which were told by the participants that I was able to gain more understanding of this phenomenon (van Manen, 2001). The number of participants recruited were not predefined, rather when a sense of familiarity within the meanings of the text began to reveal itself I knew it was time to stop recruiting.

This style of research is not frequently used for the study of hospitality, although it is commonly used within healthcare research, as such it may be regarded as a strength to this research that a methodology has been chosen which is well recognised within this field. Another strength to this study is the gap in the research field of studies which investigate hospitality within healthcare. Existing studies have tended to use a quantitative and positivist approach, measuring patient satisfaction with the quality of care and treatment delivered (Sørli et al., 2006), rather than what it is to be human, to be cared about. This approach enables a better understanding of how a patient feels, of what a patient is thinking and an understanding of their anxieties surrounding their hospital stay. I have tried to illustrate this depth of feeling, through the inclusion of participants' descriptive stories in my findings, and it is hoped the reader is able to get a sense of 'how it was', perhaps to feel an empathy or an understanding for the patient when they read these texts. This is the real strength for this study, if I can engage the reader to feel as I did when I first heard the stories direct from the participants. The depth of understanding gained from this study about the significance of hospitality surrounding the patient's lived experience may be of value to healthcare professionals and management within hospitals.

### **Limitations to this study**

The limitations of this study are that all the participants were all adult women and those interviewed had all had elective surgery in Auckland hospitals. Despite attempts to recruit males I was unsuccessful in my recruitment but those women who did accept my invitation were willing volunteers. I am limited to only interpreting those conversations that were heard. The nature of 'what is hospitality', of what it means to individuals and to me as a researcher will be different because it is very subjective (O'Gorman, 2007a) and as such one must be tentative in generalisations, transferability and suggestions which are made in relations to this study. It is acknowledged that my interpretations of

the participants' stories are grounded in my 'fore-havings' (Heidegger, 1927/1962) which Gadamer (1993) describes as a 'fusion of horizons' that enable me to see far beyond that which is first appearing within the text to something far deeper. However, it is also recognised that my pre-understandings may limit the findings of this study. The findings are also limited in terms of what I did ask and what I did not, what was said and what was not. I was limited through the selection of stories which I chose to interpret from those which I left out. This was a considerable dilemma for me, and I spent many hours and many days reading and re-reading the stories, as I searched for the highly illustrative stories which would help me show my understanding of the question I was researching. As such my findings as presented are limited to the stories which were included, yet my interpretations were drawn from the whole of the research data.

### **Implications for the healthcare industry**

The findings within this study suggest that there may be some practical ways in which a hospital is able to improve the hospitality offered to patients. As discussed some consideration could be given to the planning of the surrounding environment, for example the decoration of walls and curtains. It would also be good to consider the importance of the supportive dimension and the role they play in patient care in terms of offering distractions and entertainment.

Within this study it became clear that 'knowingness' is important to patients, in terms of knowing where they will stay, knowing about what is happening to them, knowing who will take care of them and knowing that someone will listen to them. The implementation of procedures will assist with some of this for example patients like to 'be expected' and welcomed and this can occur through a system of appointments. However, it is understanding in a deeper sense the needs of a patient which needs to be better understood by management. This study supports the literature which suggests

that, to heal the whole person requires more than treating the illness but the body within. It requires a willingness of the other to get to know and understand the stranger so that they are able to care for them in true presence with a spirit of hospitality (Bunkers, 2003; Nouwen, 1976; Stanley, 2002; Youngson, 2012). I would suggest that this is a notion which needs to be better understood by all those who work within the healthcare sector, not just nurses. To offer hospitality is a quality and a skill which needs to be encouraged within a hospital setting and should form part of the teaching and learning of all staff, not just to nursing staff which was suggested by Bunkers (2003). I would suggest that it is just as important for support and clerical staff to understand the concept of hospitality in order that a more holistic form of care is offered to a patient. This study uncovered that it was the factors surrounding a patient's medical treatment 'the other stuff' which played an important role in their perceptions of how they were cared about. These other factors often led to an emotional and socially connecting hospitality experience it is this understanding of the 'other factors' which I suggest needs to form part of the training and education of health care workers.

### **Implications for future research**

There is a limited amount of research within healthcare on the subject of hospitality and the effect for a hospital patient globally let alone within New Zealand. This study was quite specific in the type of patient and experience it investigated; I would suggest there are far reaching possibilities for further research into hospitality in relation to healthcare. Some area for future research may be:

- Similar studies which explore how hospitality impacts the lives and experiences of other types of patients, for example a day-patient who attends a clinic or a patient admitted for acute care.
- Exploring the notion of hospitality for nursing staff and nursing management to better understand how they interpret it.



- Exploring the notion of whether hospitality leads to a faster recovery or earlier discharge for surgical patients.
- Do patients who receive hospitality become less demanding, in which case does this ease stress, pressure and burnout for health care professionals?
- Studies exploring ways in which hospitality can be effectively taught and understood by students and staff within healthcare, perhaps around creating a culture of hospitality within hospitals.
- There is an increasing interest in medical tourism where people are travelling to resort destinations for surgery, this arguably makes the hospitableness of the experience more important.

## **In conclusion**

The similarities of hospitality and hospitals are not found only within the functional and technical aspects of the work but in the emotional connection which may be displayed between the guest and the stranger. It is the occasions when a person, in this case a health practitioner, takes a moment of their time to show an interest in the life of the other, the patient in their lived experience, that is most remembered as meaningful.

There is no denying that the functional aspects are important, being administered with appropriate medical treatment or receiving a clean and well-presented room are essential requirements to the stranger in both healthcare and hospitality. My research did not explore experiences of medical treatment, nor did it aim to uncover patient complaints or concerns. Yet without a heartfelt (genuine) human connection by way of a smile, a look into the eyes of the other or a listening ear which demonstrates an interest in who the person is, the encounter is somewhat uneventful and empty. Without a genuine human connection a patient may be left feeling dehumanised and not cared about, and this was illustrated in Clare's story *the nurses are the ones who look after you a lot more than anyone else in the hospital and their social skills are not always*

*good they need some education about hospitality.... some of the nurses they roll their eyes about.*

This compares readily to a hospitality situation, for example when visiting a cafe the coffee or meal which we receive may be disappointing, yet we may return to that café because we enjoyed other aspects of the hospitality encounter for example the welcome, the atmosphere or the conversation from the service staff. Likewise the opposite may be true when the food we are given is excellent, yet the overall experience seems to lack something, perhaps we felt the service we received was impersonal, or that we were rushed. The memory is one that leaves us disappointed and we are unlikely to return.

In a healthcare setting, it is hoped that a patient will not have a need to return in the way in which a guest does to a hospitality business, the point here is that in treating a patient in a meaningful (holistic) way, one with a connection similar to that shown within hospitality businesses the patient feels more valued. This is important because when a patient feels they are cared about, rather than as an object for medical analysis, they will remember the encounter in a positive way which can aid their overall healing. As Youngson (2012) explains it is when the emotional and psychological aspects of the patient are treated alongside the medical aspects that a patients wellbeing and healing improves.

The way in which hospitality announced itself to the elective surgical patients within this study varied. Yet, this study has shown that when hospitality exists, when it ‘just is’, in the lived experience of a surgical patient it evokes a special moment which leads to feelings of great comfort and feelings of being truly cared about. It is through the offering of often small, yet heartfelt acts of hospitality, that health practitioners may evoke powerful lived experiences which benefit the patient. It is when hospitality is present that the person experiences being healed.

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# Appendices

## Appendix A: Ethics approval



AUTEC  
SECRETARIAT

854

9 August 2013

Erwin Losekoot  
Faculty of Culture and Society

Dear Erwin

**Ethics Application: 13/193 What is the lived experience of hospitality for adults during their hospital stay?**

Thank you for submitting your application for ethical review. I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 5 August 2013, subject to the following conditions:

- ✓ 1. Clarification as to whether the verbatim interviews or the worked stories are provided to participants for checking, and advice of this in the Information Sheet.
- ✓ 2. Reconsideration of the indicative interview questions; AUTEC was of the view that they might focus more explicitly on hospitality rather than hospital care and could be more explicit about cultural issues
- ✓ 3. Provision of a researcher safety protocol if interviews will be conducted in private homes.
4. Amendment of the Information Sheet as follows:
  - ✓ a. Clarification of what is meant by hospitality as a lay person would understand it
  - ✓ b. Review for overly persuasive language
  - ✓ c. Removal of the provision of counselling; The committee feels that the participants are very unlikely to become upset as a result of the research
  - ✓ d. Provision of information as to where the interviews will be held
  - ✓ e. Amendment of the contact details for the Executive Secretary to those given in the exemplar Information Sheet on the website.

Please provide me with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires copies of any altered documents, such as Information Sheets, surveys etc. Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz).

I look forward to hearing from you,

Yours sincerely

Kate O'Connor  
Executive Secretary  
Auckland University of Technology Ethics Committee

Cc: Rosalind Kelly [rosalindk@ais.ac.nz](mailto:rosalindk@ais.ac.nz)

Approved  
14 August 13

# **Participant Information Sheet**



**Date Information Sheet Produced:**

27<sup>th</sup> June 2013

**Project Title**

What is the lived experience of hospitality for adults during their hospital stay?

**An Invitation**

Hi, my name is Rosalind Kelly, I am studying a Masters in International Hospitality Management at AUT University. In order to complete this qualification I am undertaking a research project which explores the lived experience of hospitality for adults during a stay in hospital. Hospitality may be described as meeting all the needs of a guest, in a welcoming, safe and comfortable environment. I invite you to consider participating in this study.

**What is the purpose of this research?**

To understand what hospitality means for patients undergoing elective surgery as a hospital inpatient. I will complete a thesis which forms part of my Masters qualification.

**How was I identified and why am I being invited to participate in this research?**

You are receiving this following your response to the local newspaper advertisement asking for volunteers to participate in this research, You are eligible to participate in the study if you are an adult between the ages of 25-55, living in the Auckland region, who has been admitted to hospital for elective surgery in the past year and you stayed overnight in hospital for a minimum of three days, and are able to converse in English.

**What will happen in this research?**

You can reply to me indicating your willingness to participate. If I have not heard from you after two weeks I will contact you to see if you are interested. If you consent to participate, I will set up a time and place that suits you for an interview that will last between 60 to 90 minutes. The interview may be conducted at your own home or in a designated office at AUT. The interview will be conversational in nature, and I will ask you questions about your non-medical or surgical experiences of being cared for when staying in hospital. You only need to discuss what you are comfortable with. With your agreement, the interview will be audio recorded. Afterwards I will send you a copy of the stories which are drawn from the transcripts to confirm they are accurate and to verify that you are comfortable having them included in the study. If you require a copy of the verbatim transcripts this can be provided upon request.

**What are the discomforts and risks?**

The risk to you in participating is minimal, although you may become emotional when recounting your experiences depending upon their nature. You are welcome to bring a support person with you to the interview if that would make you feel more relaxed and comfortable.

## **How will these discomforts and risks be alleviated?**

You should first be aware that you may become emotional or upset when discussing your experiences, however, you should feel comfortable in the knowledge that the interview can be stopped at any time and that you should only discuss what you are comfortable with.

## **What are the benefits?**

The benefits for you of your participation may be limited, although you may feel that by telling your stories it is in some way helpful. The researcher will gain insight into the personal experiences of patients in relation to the hospitality lived experience. The findings of this research may be presented to healthcare workers and managers in the future and may be of benefit to them providing services to future patients.

## **How will my privacy be protected?**

Your privacy will be respected and the information that you provide during the interview will be confidential and only accessible to me and my supervisors. Reference to you in the study results will be made by using a pseudonym.

## **What are the costs of participating in this research?**

The cost to you in participating in this research is approximately 2 hours of your time when being interviewed and checking your stories.

## **What opportunity do I have to consider this invitation?**

You have up to four weeks to indicate your interest in participating.

## **How do I agree to participate in this research?**

If you wish to participate, please respond to me by phone, email or text message. You will need to complete the enclosed consent form and either post it to me in the envelope provided, or hand it over to me before your interview begins.

## **Will I receive feedback on the results of this research?**

If you would like to receive feedback on the results these will be published in my thesis and I would be happy to send you a summary of my findings upon completion of my thesis.

## **What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Erwin Losekoot, [erwin.losekoot@aut.ac.nz](mailto:erwin.losekoot@aut.ac.nz) 921 9999 ext 6347.

Concerns regarding the conduct of the research should be notified to Executive Secretary of AUTEK, Kate O'Connor, [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz), 921 9999 ext 6038.

## **Whom do I contact for further information about this research?**

### ***Researcher Contact Details:***

Rosalind Kelly, [rosalindk@ais.ac.nz](mailto:rosalindk@ais.ac.nz) 021 035 8497. WK 845 5606 ext 222

### ***Project Supervisor Contact Details:***

Erwin Losekoot, [erwin.losekoot@aut.ac.nz](mailto:erwin.losekoot@aut.ac.nz), 921 9999 ext 6347.

Approved by the Auckland University of Technology Ethics Committee on 14<sup>th</sup> August 2013, AUTEK Reference number 13/193.

## Appendix C: Consent form

# Consent Form

For participant interviews



*Project title:*                      *What is the lived experience of hospitality for adults during their hospital stay?*

*Project Supervisor:*   *Erwin Losekoot*

*Researcher:*                      *Rosalind Kelly*

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 27th June 2013.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....  
.....  
.....  
.....

Date:

***Approved by the Auckland University of Technology Ethics Committee on 14<sup>th</sup> August 2013, AUTEK Reference number 13/193.***

*Note: The Participant should retain a copy of this form.*

## Appendix D: Researcher safety protocol

# Researcher Safety Protocol



*Project title:*                      *What is the lived experience of hospitality for adults during their hospital stay*

*Project Supervisor:*   *Erwin Losekoot*

*Researcher:*                      *Rosalind Kelly*

Researcher safety protocol for interviewing participants in their own homes:

- The interviewer will advise the principal investigator in writing in advance of the dates, times and addresses of each interview, motor vehicle being used & registration.
- The interviewer will phone or send a text message to the principal investigator prior to the commencement of each interview indicating expected time of completion.
- As soon as is practicable after the interview I will phone the principal investigator to advise the interview is successfully completed.
- Each interview will last up to 1.5 hours. If the principal investigator does not receive a call from the interviewer after 2.5 hours he will firstly call the interviewer's mobile. If no response, he will phone the interviewer's nominated contact who is authorised to phone the police to report the concern.
- Should the interviewer feel any concerns about safety at any stage during any interview, she will terminate the interview, leave the dwelling and phone the principal investigator.

***Approved by the Auckland University of Technology Ethics Committee on 14<sup>th</sup> August 2013, AUTEK Reference number 13/193***



## Appendix E: Advertisement for participants

**Have you recently had surgery and been  
admitted to hospital ?**

**If yes then PLEASE read on**

**Volunteers are needed to help with a research project.**

**If you:**

✓ Are between the ages 25-55.  
✓ Have been admitted to an Auckland  
hospital for elective surgery in the past  
year.

✓ Stayed in hospital for a minimum of 3  
days.  
✓ Have good conversational English.  
✓ Live in Auckland region.

I am interested in finding out about the hospitality you experienced while staying in hospital  
and I would love to hear from you.

For more information please contact:

Rosalind Kelly

Email: [rosalindk@ais.ac.nz](mailto:rosalindk@ais.ac.nz)

## **Appendix F: Indicative interview questions**

1. Tell me about being a patient in hospital?
  - a. Prompt questions: Tell me about what happened when you first arrived etc
2. Tell me about the things that happened that in any way made you feel welcome?
  - a. When you arrived
  - b. During your stay,
  - c. By any staff including attendants.
3. What happened to make you in any way feel comfortable and relaxed during your stay?
  - a. Tell me about how your surrounding environment-ward made you feel.
  - b. Prompt questions : temperature, lighting, noise, bed/chair
  - c. Other patients /their visitors/your visitors
4. What about things that made you feel unwelcome or uncomfortable?
  - a. Prompt questions: Say more about ....
5. Tell me about things that happened that influenced your personal sense of being attended to.
  - a. Did staff connect with you you...emotionally....more than just on a technical medical way.
6. Can you recall a moment when you felt you were being cared for?
  - a. Did it seem it was out of a sense of duty... or were you cared about
  - b. Prompt... can you say more about it.
7. What about a moment when you felt this was not the case?
8. Were there any occasions that made you feel upset during your stay? Say more about that.
  - a. Do you think this could have been avoided?
9. Do you think you were given enough information about your surgery/hospital stay?
  - a. Before you arrived.... Can you tell me about that
  - b. While you were in hospital..... Can you tell me about that.
10. Because of your culture were you treated differently to other patients?
  - a. Tell me about that moment.
11. Hospitality is often talked about in relation to customer service for restaurants or hotels. What does the term hospitality mean to you in relation to a stay in hospital?
12. Hospitality may be described as interactive between host and guest (staff and patient), creating a hospitable or hostile environment.
  - a. How did it feel to you? ..can you tell me why you felt that
  - b. Did it feel interactive ... that you had some control/power in decisions made about you? Can you say more about that..
13. How much do you think hospitality made a difference, positively or negatively, to your hospital stay?
14. Is there anything that hospitals could do to improve your hospital experience (in relation to hospitality).