

**Patients' lived experience of  
encounters with hospital staff that  
made a difference**

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A thesis submitted to Auckland University of Technology  
in partial fulfilment of the requirements for the degree of  
Master of Health Science

**2014**

Faculty of Health and Environmental Sciences

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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

A handwritten signature in cursive script, appearing to read "M. Keegan".

Date

31 July 2014

## ACKNOWLEDGMENTS

Firstly I wish to thank the seven participants for allowing me into their homes and sharing their stories, without which there would be no study.

I acknowledge the combined wisdom of my supervisors, Annette Dickinson and Shelaine Zambas and thank them for keeping my feet on the ground and pointing the way, reminding me that others have survived the journey.

I wish to acknowledge Brian Broom for a moment of insight that began this journey into moments that matter, who can say so little and change so much. Also, Liz Smythe whose wisdom offered the opportunity to find the fit for research that I resonated with and appreciated the poet within.

Hidden from view I thank my husband Gerard for his unfailing support, lending an ear when needed and being my partner in life, and my daughters Danielle and Alex for their belief that I could do this never wavering.

Finally I acknowledge the financial support, by way of a grant, from the Southern Cross Hospital Education Fund which eased the way and gave me time to study.

## **ABSTRACT**

The nature of patient encounters in hospital accounts for hospital as an un homelike space which contributes to how encounters with staff are structured, and moments of care arise. In exploring the meaning of patients' 'momentary encounters' with staff in hospital I seek to uncover what made a difference to their lived experience, to deepen our understanding of what constitutes making a difference.

The interpretive phenomenology underpinning this study is guided by Heidegger's notion of being in the world together and thrownness, which reflects how we are as human beings in the world. Adding to this is Levinas's notion of encountering others face to face and being called to respond to ease suffering as key to patient encounters in hospital. Analysis of text was guided by van Manen's existential dimensions of lived body, time, space, relationship and actional aspects in relation to pathic practices in health care.

Seven European New Zealanders, aged 20 – 82 from a semi rural population who had a variety of experiences associated with hospital care were interviewed. Their stories were gathered through in-depth, personal conversations using open ended questions. These were taped and later transcribed by the researcher to enable engaging with the data more deeply to collect anecdotes which formed the study data.

Moments of care were revealed through two main themes, Relating-to and Attending-to. Each theme consisted of a number of dimensions that occurred singularly or multiply in the moments that made a difference.

In delivering care to patients we enter a space of joined-ness that is human in nature, recognising the qualities in each other that connect us in-the-moment. It appears that the heart of what matters to patients remains the relationship and simple, small actions of comfort care as foundations that appear to gain significance beyond their seeming simplicity for patients when performed in hospital. The findings offer a challenge to balance the technicality of the hospital space with the human needs of patients and their families.

## CHAPTER ONE: INTRODUCTION

*In order to see the world and grasp it we must break from our familiar acceptance of it.*

(Merleau-Ponty 2002, p. 240)

This interpretive phenomenological study will explore the meaning of patients' 'momentary encounters' with staff to uncover what made a difference to their lived experience of hospital. It seems important to note that encounters between staff and patients can occur in 'the moment' in a way that can seem instantly transforming through a touch, a moment of eye contact, and our voice. By paying attention to, and reflecting on, how patients express their experience through anecdotes, it is hoped to deepen understanding of what constitutes a moment of difference.

### **Definitions of words and phrases used**

In this study the term *momentary* is defined as:

A brief indefinite interval of present time which is of importance, influence, or significance. A brief period of time that is characterized by a quality such as; excellence, value, importance or distinction. ("Moment," 2009)

The term *encounter* is defined as:

To encounter a new situation or come upon face-to-face, especially an unexpected or brief meeting. ("Encounter," 2009)

*Intersubjective* is used in this study to represent a shared experience of the world that arises between the self and other, through connection or engagement in the moment. It is defined as:

Involving or occurring between separate conscious minds, *intersubjective* communication. Accessible to or capable of being established for two or more subjects: *intersubjective* reality of the physical world. ("Intersubjective," 2014)

*Pathic*, a term used by van Manen (1999), describes a pathic dimension of practice, which is seen as relational, situational, corporeal, temporal, and actional. Buytendijk (as cited in van Manen, 2007) related "the pathic experience to the mood of the lived

body” (p. 21); while Heidegger (as cited in van Manen, 2007) used the term *Befindlichkeit* to describe this felt sense or “the way one finds oneself” (p. 21). This includes an implicit felt understanding of ourselves in situations even when we cannot always put this into words.

*Empathic*, as described by Rosan, (2012), correlates with van Manen’s notion of pathic practices that are based on a sensed understanding of the other as if they were self. It is described as a way of being with another person that focuses on a receptive way of being in the world. One’s responses are called forth by the expression of feeling from the other person that lead to the feeling that one shares an understanding of another person’s experiences and emotions.

### **What drew me to this research and why does it matter?**

Patients are whole persons who come with life connections that affect how they are in hospital and how they respond to staff. Moreover, how patients cope and see the future is often influenced by the health care professionals (HCPs) they encounter and the moments they share together. I believe that moments that we share are powerful and meaningful aspects of care that bear exploring further, shaping health professionals’ awareness of the ‘actions’ that matter to patients. This type of encounter is not so unusual in health care; and yet how we learn to understand them is reliant upon who we are as a person and the skills we have attained in life, rather than addressed in healthcare discourse.

Momentary encounters are under reported in professional discussions, presenting a gap in the knowledge associated with patient care, that is worthy of exploring. Practice is more than skills and empirical knowledge (Tanner, Benner, Chesla & Gordon 1993), it is about the ‘knowing’ that comes from existing as a human being in-the-world. This is an ontological question about how we find ourselves with others and how we are connected by just being in-the-world-together. This notion is especially interesting and important to me as a HCP to better understand the patient encounter in hospital and the possibilities this offers for future ways of conceiving of health care. The nature of this inquiry suggests that interpretive phenomenology is suitable for uncovering the meaning hidden within patient encounters.

## ***The why***

I was led to this study by my curiosity around comments received from patients and friends alike stating; *something you said/did* changed things. The impact of these moments appears as a felt instant, that something has happened here, suggesting that these shared moments of connection may change lived existence in some way for both patient and HCP.

As a nurse working within a pre-operative area I often had encounters which showed the richness of our shared existence but also made me curious in regard to what was happening. For example:

A woman came to the day stay unit for a minor procedure under local anaesthetic. She appeared well informed on admission and stated that she really wanted the operation. Yet, in pre op, she couldn't cope, displaying anxious and fearful behaviour and saying, *I know this is something minor, it's so silly that I feel like this*. Taking time for a brief conversation revealed that her life had been full of stress, other family members had become sick and dependant; additionally a close friend had been diagnosed with cancer, all of which occurred in the weeks prior to her admission. Once these issues had been acknowledged and time taken (5 minutes) to allow for reflection and insight into how she found herself in that moment, she was able to acknowledge the burden she felt. She stated that she felt she could cope better and went on to have the procedure with no further issues arising.

In order to find out about what is happening within these momentary encounters it is important to collect different views from patients until the picture is built, uncovering the heart or essence of this phenomenon.

## **Aim**

The aim of this interpretive phenomenological study is to explore the meaning of patients' momentary encounters with staff in hospital; to uncover what made the difference.

## **My understandings**

Being aware of my own position and how this may affect the outcomes of research, I acknowledge my nursing background. I am a practicing clinical nurse with experiences

across surgical, intensive care, education and primary health environments spanning over 20 years. Alongside of this professional development, is a 25 year journey discovering natural healing methodologies that include the use of Homeopathy, Massage, Visualisation, Acupuncture, Reiki techniques and esoteric teachings of other cultures, with a focus on story as a narrative for healing. My world view also includes the notions of alternative cultural beliefs informing health care practices such as Durie's (1998) Te Whare Tapa Wha and Traditional Chinese Medicine. I have a strong interest in philosophy and am a sometime poet. All of these things have shaped how I view well-being and illness, and how I find myself in the world as a person.

My MindBody (MB) orientation is based on my pre-understandings; they are an extension and development of my worldview, and fit the shape of my practice. MB study was a way of validating and languaging my practice that is a showing of the interconnectedness of existence for me. MB ideas about personhood are woven throughout my understandings, which refer to human beings as unitary, non-divisible, integrated, multi dimensional whole persons. Such a view of person places importance on the interconnectedness of people in the world and is reflected in the writing of many authors across medicine, nursing, philosophy, psychology and linguistic dimensions (Broom, 2001; Cassell, 2010; Egnew, 2005; Rogers, 1970). MB explicates the connectedness of practice for me that, combines underpinning philosophy with practical application in a way that resonates with phenomenology. Such pre-understandings arose prior to starting this study

### **My experience of the phenomenon**

I have been in hospital on a number of occasions and recall moments that I felt made a difference to me. They centred around feeling involved in my own care, being treated as a fellow human being and the unasked for kindness that staff will sometimes show just when you need it – with a word of encouragement or hope. I remember my last hospital stay with a dislocated collarbone after trail riding, being covered in petrol and mud soaked gear that was going to be hard to get off. The ward nurse's first response when I was admitted was: *I bet you would love a shower; can I help you with that?* This simple care was what I wanted most after hours sitting in the gear, and I was relieved that it was going to happen easily and quickly making me feel considered, cared for and hopeful of getting comfortable at last.

As a HCP I have experienced ‘moments’ with patients when their suffering appears to change by just being there as a whole person, sometimes able to ‘do’ things that help and other times not appearing to change much. Yet I have heard patients say those moments were significant and meaningful, making all the difference. Even though they seemed insignificant to me, it made the difference for the patient. For example:

I was asked to visit a patient in the ward with uncontrollable pain to administer Reiki to aid relieving his distress. When I arrived we had a five minute conversation on what was happening for him, and talked about ways he could help himself. I described what Reiki therapy was and how it might help. Before I did anything a nurse arrived with strong medication that was administered, and was quickly effective, so I left the patient beginning to relax thinking I had not done much. He was able to go home later that day and sent a message up to me to thank me stating that I had really helped him, I was surprised as I had done little except be there.

In seeking to deepen my understanding of the nature of such encounters I will need to account for hospital as a space that affects patients and language as the way in which human beings communicate thoughts, feelings and insights.

## **Background**

### ***Hospital as context ~Technical spaces***

This study is situated in hospital as a place where patients encounter HCPs. The hospital space is experienced by most people in some shape or form at some time in their life as patients, family or staff. Hospital is not commonly perceived as a place where people feel comfortable or at home; it is often seen as a strange and stressful environment to negotiate. Technicality forms a large component of hospital care, especially in places such as Intensive Care Units (ICU), Emergency Departments (ED), Operating Theatres and diagnostic imaging suites where life may be in the balance. It is well known that technology can be helpful and contribute to care, especially when critically ill, terminally ill or in need of expert care for loved ones. But when ordinary human beings come face to face with technology it can be an intimidating scary encounter, one in which the HCP becomes the person between the patient and the technology. Therefore, technology becomes a major factor contributing to how encounters are structured and moments arise for patients in hospital. Adding to this is

the notion that the public expect competent staff who know what they are doing along with waiting and uncertainty linked to the technicality of the hospital (Davis, 2005; Elmqvist, Fridlund, & Ekebergh 2012; Lasitier, 2013; Wassenaar, Schouten, & Schoonhoven 2014).

Florence Nightingale understood the importance of “place (site location and building design) and the need to be integrated with elements of people (spirituality) and processes (care delivery) to create an optimal healing environment” while delivering health ‘care’ (Zborowsky, 2009, p. 186). Rollins (2004) analysis of health design showed a direct link between patient health, quality of care and the way a hospital is designed, stating that “the healthcare environment where care is actually provided and received has substantial effects on patient” (p. 338).

In describing how hospitals have been seen in the literature Puchalski and McSkimmings (2006) stated that hospitals are “efficient, impersonal, scientific, sterile environments that foster a sense of dislocation and alienation from the hospital organisation when they need human care and interaction the most” (p. 30). Such tensions between the science and care delivered in hospital is described in Cowling’s, (2000) article on the unitary conceptualisation of healing as the “clinicalization” of the human experience by the health care disciplines; cited as being “instrumental in denying important facets of human life and not fully accounting for the essence and wholeness of experience or the unity, and uniqueness of human existence” (p. 16). The tensions in the literature are captured by Heidegger (1966) with his concern about how technological progress “increased the distance between hand and world” (cited in Galvin & Tordes , 2013, p. 24), suggesting that we face an increasing lack of intimacy between our human experience and the world around us; this will be further explored in chapter two.

### ***Relationality of care***

It is not uncommon to hear patients, family or staff describe HCPs using the phrases: “*I’ll never forget him/her ... They made all the difference*”. It is this idea that is the focus of patients’ momentary encounters that appear to matter in the current study. When things that make the difference are felt and remembered, it shows the significance they have to patients. There is a tension where patients appear to expect clinical competency but seem to have less expectation of simple care or connection in hospital. HCPs, nurses in particular, are practice oriented occupations with a focus on

connection with people. It is the patient who we connect to with our hands, hearts, mind and spirit when we engage in care practices. In seeking to uncover what makes a difference to patients in momentary encounters, I seek that which is hidden within these moments; that which is taken for granted. In this light, interpretive phenomenology will aid uncovering the essence or heart of what matters when simple or small actions of care might gain significance beyond their seeming simplicity for patients.

### ***Temporality***

Time as lived, is evident when people disclose their hospital experiences. Time is an important dimension of hospital where patients commonly identify 'waiting' and perceive staff as always 'busy', which influences their own perceptions of the care they receive and the time that things take in hospital. Time in hospital stands in contrast to normal time for patients and affects how they find themselves and the mood in the moment.

There appears a paradox in hospital with the possible necessity and benefit of surgical intervention in the best dualistic, biomedical traditions versus the healthcare environment that is peopled by many different care givers from cleaners and administration staff to HCPs. This raises questions concerning the nature of the lived experiences of patients and their encounters with hospital staff. Interpretive phenomenology points to what is hidden within moments of care between the tension of technicality versus the person in the hospital world.

### **The role of language in understanding**

We are born into a world where language surrounds us from birth, shaping our world and our awareness of it. Holtgraves and Kashima (2008) stated that language is "a tool for constructing and exchanging meaning...in social interactions" (p. 73), it is through language that we access and share experiences, although not always from the same perspective. Hermeneutics is grounded in the scholarly interpretation of text, with the notion of deciphering the words to form an understanding and interpretation of linguistic and non-linguistic expressions. This represents how we make meaning from the signs and symbols of written or spoken language (communication).

Adding to this, Broom (2001) stated “attention to a patient’s verbal language reveals a rich fund of information with regard to the wider and deeper meaning of illness” (p. 17). Following on from this, Mehl-Madrona (2005) suggested that as health professionals, we may have to approach what is presented to us by the patient from more than our own viewpoint to truly find the significance of their experience. If we acknowledge these views it seems plausible to suggest that people seek to find metaphors for illness that make sense and are meaningful to them; informing us of how they relate to their own experience of such encounters.

The methodology best suited to guide my thinking and aid understanding comes from the interpretive phenomenological paradigm that seeks the essence of what it is to encounter staff in moments that make a difference to patients in hospital.

Consequently, data for this study was formed from first hand narrative in the form of participants’ story or anecdote as a valuable source of every day encounters with staff that made a difference, gathering participants’ stories as a showing of the different ways in which the phenomenon was experienced. Analysis was guided by van Manen (1990), pointing to themes of importance that might reveal the nature of being in the moment with staff. Interpretation will occur through circling with the data, identifying the parts to show the whole until the essence of these experiences can be uncovered.

### **Is this important?**

Why such a study would be important rests on the notion that nursing is a practical occupation that deals with people. How we *do* what we do in practice is often based on a momentary encounter with an ‘other’; when we are called to respond as human beings and HCP. Speaking to the notion of connecting in some instant felt way, that may not even have language, and being changed by that connection, brings about a conversation regarding what practices are best encouraged in the practice and education of health care workers. The patient, as the recipient of care, is a voice that should be heard and allowed to shape the experience of care giving in hospitals.

## **Guiding influences**

Guiding influences for interpretation came from the writings of Heidegger and his concepts of being in the world with other and thrownness; and Levinas' notion of being called by others through face to face encounters to act in ways that respond to how patients are in the moment. Analysis is guided by van Manen (1989, 1990, 1997, 2002, 2006) using the existential dimensions of reality that include lived space, time, body and relationship, adding the felt or sensed pathic dimension of practice. I am further guided in my thinking and interpretation by the poet/philosophers who have been quoted and woven throughout this work.

## **Reflection**

This chapter formed a beginning, introducing my pre-understanding and showing the fit between my assumptions and the choice of methodology guiding this study. It introduced the importance of how we gather and write using descriptive text as a way of pointing to the phenomenon of patients' momentary encounters with staff. It placed the first step on the path that will be followed throughout this study describing the process of research and showing the wisdom and truth of the participants' experiences to aid deepening our understanding about the phenomenon of interest.

*The gate lies opened  
the path before me reaching into the distance  
the first step is made  
along the way other paths join mine  
walking together for a while  
I cannot see what is over the hill  
I am drawn on by the mystery  
the promise of discovery*

## **The map of the parts that form the whole**

Each chapter begins with a quote that points the way and ends with a reflective poem, crafted by myself, to capture the essence of the chapter as I experienced it. Chapter one has revealed the focus of this study, the question and the background informing my position as researcher, and pointed to why I chose this topic. Chapter two forms the literature review and explores the tensions and the literature, predominantly nursing based, around how relationships are built between staff and patients, caring relationships, intersubjective connection and theories that inform practice. Literature is presented on hospital as the context of encounters, time as lived in hospital and the notion of suffering encountered by patients in hospital are also discussed. Chapter three outlines the methodology underpinning this study. Primarily Heideggerian interpretive phenomenology guided by Heidegger's notion of being in the world in relationship, thrownness and being not-at-home; and Levinas' face to face encounters with other as the heart of human experience providing the call to action. Hermeneutics is guided by van Manen and seeks to discover what is hidden within the text using a reflective stance, to stay circling with the data and writing until meaning emerges deepening my understanding of the phenomenon. This chapter further outlines ethical considerations, how I went about this study and the steps taken to recruit, interview and collect participants' story. Chapter 4 is the first of two findings chapter focusing on 'relating-to' as the main theme. Chapter 5 forms the second findings chapter focusing on 'attending-to' as the main theme. In Chapter 6, the findings in relation to the question posed and my interpretations of findings for practice are discussed. Conclusions about the significance of this study in relation to education and ongoing research are drawn.

## CHAPTER TWO: LITERATURE REVIEW

*Weaving is full of symbolism and hidden meanings that embody spiritual values and beliefs.*

(Puketapu-Hetet, 1989, p. 24)

The presentation of the views that follow are like the strands of harekeke (flax leaves) that when woven together contain the meanings and the current knowing that hold this study within. It is a process of looking to the present by searching the past to find others' views. In reviewing the literature, my aim is to find works that seem to communicate something about how patients find themselves in hospital. I seek to listen for metaphors that relate to firsthand experience of talking to patients about their hospital encounters, creating windows through which I could glimpse what made the difference. This literature review forms a broad collection of scholarly publications from HCPs, reflecting the knowing of other researchers and my interpretation of what they wrote; there could be other interpretations. Understanding is always incomplete and always unfolding.

### **The chapter**

Within this chapter the collection of views offers snap shots revealing patient encounters across a range of writing that forms what is currently known in the literature. Included are relevant theories, in the literature, describing a unitary view as an emergent paradigm of health care that could change how patients find staff in hospital, creating opportunities for moments that make a difference for patients. The views presented are shaped around how we form relationships and connections associated with persons and practices in healthcare, and how patients perceive such care. The affects of hospital systems as the place where patients experience momentary encounters is explored, pointing towards the notions of suffering and time in hospital, shaping the mood of experiences as lived.

## **The search**

Surveying what is out there, the quest for others' thoughts and words was led by key terms that moved and changed to uncover the different views. These were carried forward into this study contributing to meaning that sometimes supported participants' voices and at other times stood in contrast.

Searches were made using the Auckland University of Technology (AUT) library and electronic databases. Search engines: EBSCO, Ovid, Scopus, Psyc INFO, and Pro Quest were accessed in order to find the most relevant, recent data from a health care perspective.

The initial search looked at patients' lived experiences in hospital but was found to be too broad and included much literature that had a pathophysiological focus in relation to how disease was experienced, rather than encounters with staff in the hospital itself.

Further terms searched for meaning included:

Hospital encounters, patients' lived experiences of hospital care, connection in nursing/hospital, relationships in care, moments in healthcare, momentary encounters, patients' perceptions of care in hospital, being in hospital as a patient, suffering (in hospital) time and night time.

In the literature it is nursing that speaks most often, and I have an easy understanding of this. However, Eco (as cited in Hale, 2011) stated that: "everything is a potential clue or sign .... humans' communicate with language but also with everything else we do" (p. 257), and so what is said by one may have meaning for others.

## **Understandings within moments of care**

Practices of care giving in nursing are underpinned by theory. In this section, some of the theories in the literature that seem to talk to the notion of momentary encounters that make a difference are presented.

Nursing theorists Tanner et al. (1993), in their study exploring how nurses know patients in the context of clinical care, stated that knowing patterns of response and responding as a person are the central themes to making clinical judgements. This 'knowing' is in the form of a personal, subjective knowing of the person rather than

the objective in depth knowing of how the person presents to the world. It allows for nurses to particularise care that patients attribute to feeling cared for and making a difference.

Hawley's (2011) theoretical article on 'the nursing moment' stated that such moments include knowing on the spot, in the moment, what to do or how to act, that this is often intuitive, and without conscious reasoning, described as 'pathic practice'. Benner and Tanner (as cited in Hawley 2011) and van Manen (1999) have suggested that having a feeling of connectedness enhances nurses' ability to recognise clues that facilitate the intuitive experience. Hawley posited that nursing is a 'being' rather than a doing practice; being present with patients in the moment creating possibility for making a difference.

Adding further, van Manen's (1999) article on phenomenology of practice coins the phrase 'pathic knowing' which centres on the person himself or herself. "A pathic relation is always specific and unique. Even a relatively brief encounter between a patient and a health care provider can have this personal quality ... there is something deeply personal or intersubjective to the pathic relation" (van Manen, p. 15). This relationship forms a significant contribution to how patient encounters are made and the methodology of this study which is developed further in the next chapter.

Nursing theorist, Jean Watson (1997, 2007, 2008) developed the Caring Theory/Caring Science framework as an integrative model of care that could form a foundation for nursing as a profession. Watson stated that caring moments that arise between a nurse and a patient are influenced by the nurse's world view. She argued for the development of nursing practices that incorporate healing modalities and arts that form a "caring ethic of an integral worldview" as foundational to nursing. (Watson, 2008, p. 57).

Tordes, Galvin and Dahlberg's (2007) theoretical Lifeworld-led healthcare framework claimed "its core value as a humanising force that moderates technological progress" (p. 53). The authors argue that technology distances us from people, creating instrumental environments that focus on efficiency rather than a humanitarian view where the individual patient is central. They further state the benefits of such care focuses on the qualities of the person to form a "holistic context for understanding quality of life" (p. 59). In a similar way but pointing to the notion of connection embedded in caring practices, as aligned to a humanitarian

world view, Berglund, Westin, Svanstrom and Sundler (2012) posited that increasing knowledge about existential dimensions of illness and healthcare experiences may be needed in order to improve care. Moreover, Jackson's (2010) article, on her theory of Loving Care, stated that loving relationships are formed when nurses tune in and connect with patients through their daily practices of care as: "intricate webs [that] provide safety and sustenance for all who enter healing environments" (p. 185).

Galvin (2010) theoretical/philosophical article on caring science as a way of developing knowledge stated that caring science can be considered grounded in the discipline of nursing, but it is informed by related fields (e.g., philosophy, ethics, theology, education and studies on health and healing, to name a few). Putting forward a 'caring' phenomenon, that argues for an openhearted capacity rather than biomedical science as an appropriate response to the call of the human heart. The key point being evidence requires judgement, and caring judgement includes evidence but is larger than evidence based care. Caring judgements come from an "embodied relational understanding that can draw on all the technical, personal and evidence resources available" (p. 173) and requires an integrative approach that addresses the whole of one's lifeworld.

The ethical foundations for caring practices are discussed in Cameron's (2014) article. She argued that the challenge for practice is to "recognise and respond to the call of individuals in need" (p. 53), responding to such vulnerability forming an ethical moment in practice. She posited that seemingly small questions such as 'how are you?' become ethical moments that open possibility for attunement that "turn us back to who we are as health professionals" (p. 53). Such questions hold the possibility for connection between HCPs and patients enabling caring actions to occur.

Much of this theory has shaped nursing practice and education in the recent past. These theories show awareness and movement towards more patient centred humanistic care practices that account for patients as participators/collaborators in their own care. This further points to a return to more fundamental values related to the hands/heart or healing aspects of care as opposed to the technology of care. Some of these articles speak to how practical knowledge is developed and include notions of subjective, intuitive ways of connecting that are not accounted for in biomedical models of healthcare, but are an increasing voice in nursing research. It seems likely that patients'

experience of momentary encounters with staff relates to how HCPs are in the moment, the underpinnings of their clinical practice and the circumstances of the encounter. How HCPs build connections with patients is described in the literature that follows.

### **How care relationships are built between patients and staff**

Much is written about how relationships are built in a hospital context. Articles often included words such as communication, presence, empathy, connection, caring, affective listening, and authenticity as descriptors of the qualities or characteristics that point to encounters that transform the moment.

Inui (as cited in Egnew, 2005) stated that healing occurs in context of “real persons in connection with other real persons” (p. 257). This suggests that we can transcend personal suffering and reinstate a sense of personhood through building relationship and continuity with one another. Tanner et al. (1993) article suggested that relationship is built through a shared connection with patients as human beings. Halldorsdottir and Hamrin’s (1997) study on caring connections highlight the importance of the perception of mutual caring and trust being present in relationships that increase well-being, healing or empowerment in palliative care. Furthermore, Fox and Chesla’s (2008) study, on relationships between nurse practitioners and women with chronic illness, suggested that “relationships with HCPs that are connected, and characterized by partnership, and personableness resulted in the women feeling better across many dimensions” (p. 109). Moreover, Mok and Chiu’s (2004) study stated that holistic care that builds trust and partnership are “important elements of nurse–patient relationships” (p. 475) in a Chinese nursing context of palliative care.

In Davis’ (2005) study of patient expectations of nursing care, ‘good’ nursing is described as relationships that aided finding meaning in encounters or “existential spiritual care” (p. 133). This was identified as occurring within a holistic framework based on being open and available through ‘being with’ patients, taking time to care and being technically competent even when time is constrained. Further confirming other studies state that such relationship builds trust and allows for more encompassing

dimensions of care to be considered (Berg & Danielson, 2007; Gustafsson & Gustafsson, 2013; Mok & Chiu, 2004; Williams & Irurita, 2004).

In discussing the meaning of a caring relationship in daily nursing practice, Berg, Skott and Danielson (2006) “gave an understanding of the phenomenon through the illumination of the patient’s and the nurse’s thoughts, feelings and actions ... that led to a more profound knowledge about how they together create an encounter through their unique competence” (p. 42). They posit that such care is participatory and relational where staff are present and take time, despite time constraints, thereby proving their trustworthiness as a foundation for nursing encounters. Adding to this, Berg and Danielson (2007) identified dignity, self competence and being cared for as important to patients in hospital; which in turn led to building trust and caring, through brief encounters with nurses and other healthcare staff “who took their time, despite strained work situation” as making a difference (p. 501).

Changing the focus of care from biomedical or nursing centred to patient centred care as a way of relating in hospital is richly represented in the literature. Tordes et al. (2007) developed a philosophy for Lifeworld Led Care that seeks to provide more person-centred trends humanising healthcare. This notion relates to a study by Jeffs et al. (2014) addressing a strategy for patient centred care in Canada that initiated bed side handovers by the nurses. Patients’ described this experience as keeping them informed, involved and engaged in their own care. Furthermore Marshall, Kitson and Zeitz (2012) presented a patient view of patient centred care in the Australian context, stating patients want connected, involved, attentive care from nurses.

Additionally the article by Brill and Kashurba (2001) promoted the expression of a caring attitude as being with patients through simple compassionate touch, via Reiki Therapy, that comforts and build rapport. Such moments of touch can change a hospital from a cold, clinical institution to a warm light healing centre “through reconnecting care providers with their patients on humanitarian level” (p. 8).

Alternatively, Ludvigsen’s (2009) study on patient life in hospital identified the importance of relationship, not with staff, but between patients who share the experience of waiting in hospitals together. This study found that the building of

relationships in the present moment with other patients was a mutually shared experience that led to patients' increased sense of well-being.

This literature points to the importance of relationship as a pivotal component of care that creates meaning for patients in encounters with staff. The notion of being present as an authentic person who is open to working in partnership with patients for their care appears to build trust, rapport and helps to make moments of care memorable for patients in hospital, making a difference.

### **Intersubjective connections**

The notion of intersubjective connection is relational, it speaks to the idea that when we are in the world we are in relationship with the places and the people that affect our mood or how we feel in the moment. The notion of intersubjective connection is shown to be important when considering relationships. This notion acknowledges that we connect on a level beyond physical and appears to speak to how we find each other in the moment. Fredriksson's (1999) research synthesis developed a model that accounted for modes of relating in caring conversation, identifying that nurses caring conversations occur in two main ways; by either connection with high intersubjectivity or 'being with', where the patient and nurse are present to each other as persons. Another mode of communication was task oriented contact conversations that formed 'being there' for patients in a more limited way.

Rosan's (2012) article on empathic presence defined intersubjectivity as:

Being open to a variety of ways of knowing the other that entwine perception, memory, image, affect and bodily enactments. Further describing this as an empathetic presence "given in the form of joining or being with the other" that is marked by a "dramatic and poignant quality". (p. 119)

Rosan (2012) suggested that the 'other' actively participates in forming relationship that shapes and engages both participants in novel and unexpected ways. Building on the notion of empathic processes, Dowling's (2008) study explored the meaning of nurse/patient intimacy in an oncology setting. The article revealed themes associated with developing and experiencing the outcome of intimacy between the nurse and patient as an empathetic process that was reciprocal and involved self disclosure for

close relationship as central to caring in oncology nursing, with the role of the nurse seen as central.

Such articles highlight the notion of being present which Doona, Haggerty, and Chase (as cited in Godkin, 2001) defined presence as an:

intersubjective encounter between a nurse and a patient in which the nurse encounters the patient as a unique human being in a unique situation and chooses to spend her/himself on the patient's behalf. ...as a consequence of nursing presence, both the nurse and the patient are both changed and affirmed as unique human beings. (p. 6)

In the literature, being present, connected, and interpersonal, all appear to describe building relationship where two persons join in such a way that potentially affect each other through some unseen shared dimension of the world or the intersubjective dimension. Such a notion points clearly to the ways in which staff are 'with' patients, forming relationships that are reciprocal and unique. Such connections influence how patients perceive HCPs and the encounter which is developed in the next section.

### **Caring relationships and patient perceptions**

Interpretive phenomenological studies appear to be a growing presence in the literature describing relationships in healthcare. In the literature on patients' perception of care, many authors pointed to the quality of interactions staff had with patients as meaningful in reducing feelings of anxiety, suffering and vulnerability when in hospital.

These views related to the importance of explaining and providing information identified across many studies (Ballard, as cited Wassenaar et al., 2014; Elmqvist et.al., 2012; Hofhuis et al., 2008; Larsson, Sahlsten, Segesten & Plos, 2011; McKinley, Nagy, Stein-Parbury, Bramwell & Hudson 2002; Williams & Irurita, 2004). In a study on the older patient acute care setting, Lasiter and Duffy, (2013) termed the phrase 'oversight' for informing patients of what was happening. In a similar way, Samuelson's (2011) study reported that ICU patients wanted to know what was happening in their care and Elmqvist et al. (2012) identified the importance of knowing expectations associated with encounters for first time patients in the ED. Moreover, Andersson, Burmen and Skar's (2011) study on elder patients in a medical

ward found they had a desire to participate in their own care and form relationship. The participants stated that obtaining information from staff lessened anxiety and built trust leading to heightened feelings of security.

Samuelson's (2011) study on pleasant and unpleasant memories in ICU patients identified five types of distress linked to physical, emotional, perceptual, environmental, and stress inducing care that created unpleasant memories. Inversely reducing such stressors for patients, in this context, is attributed to building relationship with staff that created pleasant memories implying the importance of relationships from both perspectives, identifying encounters that made a difference to patients.

Furthermore, receiving personalised care was often mentioned in the literature, from a patient's perspective, as making the difference. McKinley et al. (2002) identified personalised care as a theme of their study that linked to feeling comforted and valued in a similar way to that of Marshall et al.'s study (2012). Adding to this, Lasiter and Duffy (2013) suggested that personalised care lead to older patients feeling safe; while other studies found personal care was linked to the personality or attitude of nurse (Samuelson, 2011; Wassenaar, et al., 2014). Such personalisation of care appeared to be associated with patients feeling less stress and increasing comfort and security, especially in an ICU context. In addition, personalised attitude was linked to encouraging patients' sense of joy, will to live, motivation and feelings of being valued (Wahlin, Ek, & Idvall 2006), and feeling understood and having possibility for hope (Ballard, as cited Wassenaar et al., 2014). Building on these findings, Marshall et al. (2012) identified the use of humour, being treated with respect and contributing to their own care as important for patients to feel valued, secure and informed. William and Irurita's (2004) study on therapeutic and non-therapeutic interrelationships found that personal control was central to emotional comfort and enhancing recovery. This was described by participants as: feeling secure when staff became personally involved, frequent contact, quick response. Furthermore, engaging in conversation and attending to little things by all hospital staff, friends and family or other patients, led to feeling valued.

Moreover, family and staff support was mentioned in several studies as making a difference to patients' perspective of their care (Gustafsson & Gustafsson, 2013; Hupcey, 2000; McKinley et al., 2002; Samuelson, 2011; Wassenaar et al., 2014). Hupcey (2000) added being known to staff adds to patients' perception of security. Other qualities patients identified as making a difference included: staff advocacy for patients (Elmqvist et al., 2012; Lasiter & Duffy, 2013), compassion and interest in the patient as a person (Andersson & Lingren 2013; Jeffs et al., 2014; Marshall et al., 2012), and having common connection (Gustafssen & Gustafsson, 2013; McKinlay et al., 2002; Williams & Irurita, 2004). Stewart's (1995) review of communication and outcomes between physician and patient stated that the patient-provider relationship can either foster or hinder a patient's recovery and overall well-being. This was supported by Marshall et al. (2012) who stated that patients saw staff who provide care as "synonymous with their experiences of that care" (p. 2670).

From a psychiatric view point the hospital environment is perceived somewhat differently, and Stenhouse's (2013) narrative study identified patients' perceptions of feeling unsafe physically and psychologically in hospital environments. Adding to this, Larue et al.'s (2013) mixed method study highlighted patients' feelings of loss of control and abandonment when seclusion and restraint were applied, pointing to alternative ways to look at control issues in hospital environments. It must be noted that a certain amount of lack of safety is due to the nature of the illness and the fact that other patients are equally unwell at times, making this a more challenging environment to inhabit for patients. Consequently Borge and Fagermoen's (2008) study relating to psychiatric in-patients' experiences of time and space were found to be related to a sense of wholeness which included wanting a combination of professionalism, kind hearts, and aesthetic qualities of the place. Altogether this contributed to the patients' experience of self-worth and equality. Carlsson, Dahlberg, Ekebergh, and Dahlberg's (2006) mental health studies stated that showing human concern can transform behaviours in violent situations, pointing to the importance of personal authenticity as a key element in these encounters.

In a new and slightly different way from other studies, Gustafsson and Gustafsson's (2013) narrative study on the experience of meaningful encounters between staff, patients and next of kin described such encounters as complex phenomenon associated

with a surface plot of nourishing fellowship via mutual responsibility, sharing and life changing moments. Further containing hidden or deep plots that were identified as metaphors for connection and healing. Such moments were described as: trustworthy and safety (a rock); safe, warm and secure (maternal, warm wave and becoming as one); close fellowship (altruistic love) and (healing hands) forming a metaphor for the felt actions rather than dialogue of care, and (defrosting) as metaphor for realising patients by opening up possibility noting that insights from such meaningful encounters originate in the patients not HCP.

It would appear from the literature that many common themes exist within encounters that make a difference for patients in hospital. The literature suggests that what patients perceive as being meaningful and making a difference in hospital links to being treated as a person, providing relief from stress and suffering that provides hope for future possibilities. Being informed, from interested staff who appear to value patients as a person, and provide positive attitudes within the patient encounter, are perceived as trustworthy, all of which point to making a difference in patients perception of encounters with staff.

### **Hospital places - Technical spaces**

Having dealt with how relationships form within in a hospital context, I will turn to the hospital as the space in which these encounters or connection occur. Hospitals as an environment structures how services are delivered that influence how patients encounter staff. Hospitals are acknowledged in chapter one and the literature as places where tensions exist between the science and caring that patients experience as a lived reality. Norlyk, Martinsen and Dahlberg's (2013) meta analysis described hospital as a world of its own with its own modality of spatial meaning that patients cannot influence, which is described as "a complex intimidating web of power" (p. 5) containing its own rules, language and culture/behaviours. The authors go on to state that such services are structured and designed for interaction of HCPs, not patients, putting pressure on patients with implicit expectations about how to be a patient, filled with meaning and significance for their well-being.

Marshall et al.'s (2012) patient centred care study identified the care experienced as twofold: "something done by the staff (collective 'they') to the patient, and the system

in which they operate in” (p. 2666), acknowledging that hospital experiences have a culture of disempowerment and lack familiarity for patients increasing vulnerability and stress when they encounter hospital environments. Furthermore, barriers to patient care were linked to organisational structures around planning and implementing nursing care that were nursing centred (Larsson, et al., 2011).

This is illustrated by Olausson , Lindahl and Ekebergh’s (2013) study on ICU rooms as a space for patients’ care experience. These authors stated that this setting was a “complex multidimensional phenomena” ( p. 234) made up of patients, staff and equipment, and often associated with struggling to survive. They propose that design of these rooms is as important as the tone and touch of the care received in them in influencing mood or lived experience. In this study the rooms were described as places patients felt alone and abandoned or safe and hopeful depending on their encounters.

In contrast to these views, Wassenaar et al. (2014) noted the patients’ perception of technology and staff competence or knowledge of the technicality of care created a sense of safety for patients. Similarly participants in Lasiter and Duffy’s (2013) study of older populations in an acute care setting perceived safety as linked to predictable, competent, skilled response from nurses. Moreover, Thyssen and Beck’s (2014) study of inpatients indicated that the hospital “surroundings are essential for the patients with respect to their ability to participate in their own care and treatment” (p. 585). In this study patients were responsible for participating in self care activities such as, tea making, simple laundry and recording fluid balance, which created a greater sense of normalcy for them while in hospital.

Such studies describe the multidimensional aspects of hospital that have to be negotiated by patients and their families, which include system requirements (paperwork, protocols and processes), time (waiting), perceptions of powerlessness in relation to time, actions, progress and information, vulnerability and fear as common experience for patients in hospitals. Literature shows diverse perspectives associated with the need for technical competency in staff and care which speaks to the humanity of patients experiences within such settings. It would seem unsurprising to suggest that patients’ perceptions of care are linked to the places and practices of the organisations or systems that deliver them, enhancing the need to investigate further patients’

experience of moments that make a difference to better understanding and inform how services are delivered to patients.

### **Time as lived**

One of the barriers to patient encounters with staff is linked to the nature and structure of hospitals as an organisation, as previously mentioned. The focus of this study is shaped by temporality in relation to the notion that things can change in a moment, making a difference. Care time encounters were described in several studies in relation to clock time and body time. Clock time is described as linear, controlled time, outside the person related to the organisation and structure of the hospitals; that Oflaz and Vural's (2010) study implied was hidden within perceptions of staff being task oriented in cares. Body time is described as internal time connected to the rhythms of the person and living in the world (Lovgren, Hamberg & Tishelman, 2010; Zhou, 2010). Researchers highlighted the conflict between the two affecting how patients encounter staff and the mood of such encounters.

Furthermore, time is identified as a critical factor affecting patient encounters in relation to response time from staff, shaping the mood of the encounter (Berg et al., 2006; Berg & Danielson, 2007; Davis, 2005). Elmqvist et al.'s (2012) research on patients' perspective related to first encounter with emergency care, described waiting as "a timeless encounter" (p. 2613). Several authors noted that many hospital encounters related to waiting resulted in patients failing to ask for help due to perceptions of time pressure and feeling that staff did not have enough time to care, inform or respond to them, fostering a sense of uncertainty (Andersson et al., 2011; Berg et al., 2006; Elmqvist et al., 2012; Williams & Irurita, 2004). In contrast, as noted earlier, the inverse is also true. Patients describe staff who respond with information about expectations and structure of care, being associated with feeling valued, competent and secure (Williams & Irurita, 2004).

In the literature, patient experience of time in hospital was altered most in situations associated with critical care, severe illness, non-treatable disease and end of life encounters in hospital. Ellingsen et al. (2013) studied the embodied experience of time with incurable disease as altering perceptions in relationship to perceiving no future. They affirmed the importance of moments of time as: time taken, unasked for, and

received, as making a difference; while also acknowledging the social and economic value of time as a factor in hospital organisation, suggesting time is value laden in hospital. Studies in similar contexts noted that uncertainty and awareness of death changed how people found themselves and the way in which they perceived time in the moment. Such circumstances render construction of time explicit, creating agency to reinterpret future possibilities and maintaining hope as a way to manage such situations. In most cases, momentary encounters with present, compassionate staff compensated for the time pressures felt by patients making the difference (Brown & de Graaf, 2013; Lovgren et al., 2010).

Time in hospital is often researched in relation to instrumental values of organisation and efficiency, management of patient flow, nursing organisation and response time. Studies on patients' lived perceptions of temporal aspects of hospital seem less visible. Holloway, Smith and Warren's (1998) seminal article, on patient experience of time in hospital, stated that patients' normal way of being is disrupted by hospitalisation that patients perceive as lost time and "life goes on without them" (p. 461). The authors further suggested that patients found hospital time 'slow' and described this as associated with feelings of loneliness, boredom and depression. A finding similar to studies by Andersson et al. (2011) and Lovgren et al. (2010) who found that patients commonly perceived themselves as having too much time and staff, especially nurses, as having too little time for encounters with patients; thus encounters with others are seen as important in making the difference in hospital..

While temporality is woven throughout our existence the powerlessness and uncertainty of hospitals brings the dimension of 'time' from the background to become a focus. Patients will articulate overtly that this has an impact on their experience, not only of the hospital but the opportunity for, and mood of, encounters with staff as well. Showing again how the hospital environment and staff as people are important at shaping possible momentary encounters with patients that make a difference in hospital settings.

## **Suffering**

Patients encounter hospital via the notion of suffering in the context of their medical condition and the organisational delivery of care, as described in the sections above.

Arman and Rhensfeldt's (2003) article defined suffering as hidden within experiences of pain and anxiety that challenges us to find the meaning in our experiences and encounters. They define suffering as a subjective, lived, embodied experience unique to each person, associated with loss and disintegration of how they perceive the self; citing numerous sources to support their ideas (Casell, 1992; Kahn & Steeves, 1986; Lindholm & Eriksson, 1993; Morse, Bottorff & Hutchinson 1994; Rogers & Cowle, 1997).

Berglund et al.'s (2012) study of suffering, caused by care for patients with ongoing health issues in a Swedish hospital context, stated that patients' embodied experience of suffering was related to four concepts: mistreatment, struggle for autonomy, feeling powerless and feeling objectified. Suffering was found to arise due to healthcare actions that neglected a holistic and patient centred approach to care. The authors suggested a need to increase knowledge about the existential dimensions of illness and healthcare experiences in order to decrease patient suffering and improve care. Thus encounters that address patients suffering in the moment will be seen as significant by patients.

Latterly, Johnston's (2013) theoretical article on praxis and suffering stated that "suffering involves the loss of acceptable meaning and nourishing connection" (p. 230), self conflict and crisis when that which we take for granted is questioned. Such encounters change how we find ourselves in the world/hospital suggesting that how HCPs are present to those who suffer makes a difference. Morse et al. (1994; Morse, 2000; Morse & Proctor, 1998), identified themes related to different experiences of 'body' in illness, finding that the notion of helping patients achieve comfort is still a key goal in nursing, which is underpinned by the notion of relieving suffering. Literature clearly points to moments when staff relieves patients' suffering as making a difference.

### **Why are so few studies conducted from a patient's view?**

Issues that relate to hospitals as a lifeworld are more challenging to approach due to the multidimensional interconnected layers needed to run such places, which include administration systems, bio medical specialties, technologies, regulating bodies and

standards for safe delivery of care, the lists goes on. It shows the complexity of the nature of hospital environments suggesting that patients' perceptions, while central, fade somewhat into the background; it seems taken for granted that HCPs are patient centred and striving to account for the patients as the reason for care in hospital.

In order to understand the implications for movements that call for the humanisation of healthcare practices, it will be essential to conduct more descriptive studies that explore how patients perceive the structure and delivery of care, which may create tensions between the organisation and dominant forces that currently shape health care.

## **Conclusion**

Overall the literature reviewed contains a mix of theory and practice perspectives. Being holistic, patient centred and bringing humanity forward as a component of practice is clearly proposed as a balance to the stressful nature of healthcare environments. Relationship and connection remain a priority in forming meaningful encounters with patients that are personalised and contribute to patients feeling secure, valued as person and confident within the hospital setting. Encounters that promote engagement with patients as unique persons, in ways that empower self-care that is collaborative helps to normalise the hospital environment leading to increased confidence and independence as a different way of being a patient.

## **Reflection**

What is currently known about how patients experience encounters in hospital is described in this chapter that, together with the current study, illuminates how patients encounter hospital. The insights point to the need for developing a curiosity and interest in taking a new position when we encounter others, to hear and see new possibilities for practice that enhance connecting and being in moments with patients as human beings. Technology and time have long cast a shadow over the landscape of hospital, when we cast our gaze beyond we might see a new landscape, one where the heart and care of the human experience returns to guide and shape practice as a way forward into a future health care system that considers what patients want as a core component and focus for the organisation of care. The power of metaphor for making

meaning within encounters in hospital is acknowledged as a growing edge of understanding, a way in which we can explore how care is perceived and add to the existing body of knowledge through descriptive texts.

*The stories are told*

*The fire burns low*

*We sleep to dream*

*In dreaming*

*We see a new landscape*

*The way forward appears*

*Lit from within*

*I am accompanied on this journey by the wisdom of others*

*It is their story that shows the way*

*Moving forward with them*

*Into the future together*

*Opening pathways from mind to hand*

Health care is a practice based occupation with people and things of the world in relationship. The most appropriate methodology for this study is identified as Heideggerian interpretive phenomenology, with hermeneutics informed by van Manen and underpinned by a MindBody perspective, which will be disclosed in the next chapter.

### **CHAPTER 3: METHODOLOGY AND METHOD**

*Writing is thinking. To write well is to think clearly. That's why it's so hard.*

*(McCullough as cited Cole, 2002, p. 53)*

The study design is the gathering and organising of things to discover meaning within moments that mattered to patients in hospital. It shows how the underpinning philosophy pointed, or gave direction, to the actions taken. The nature of this inquiry explored how participants' lived experience of being in hospital, with staff, was a reflective process – with the research question as a focus for thinking.

Interpretive phenomenological inquiry seeks to make visible the essence of moments that made a difference for patients and this was the core of the current research. The literature reviewed appears to rest largely on relational elements of care and formation of connections within a hospital setting, but lacks clear understanding of how patients' lived or felt experience is built.

The aim of this interpretive phenomenological study is to explore the meaning of patients' momentary encounters with staff in hospital; to uncover what made the difference to their experience of hospital. Uncovering the findings was revealed through the use of anecdotes as a “methodological device in human science to make comprehensible some notion that easily eludes us” (van Manen, 1990, p. 116).

Many authors describe phenomenological text as a poetic form of language or art that goes beyond the words and technicality of language into the realm of semiotics and symbolism. A collection of the parts that make the whole which cannot be divided or reduced down to single words because together they create something that is not the sum total but has a felt sensed meaning and that is directly correlated to phenomenology (Askay, 2011; Boedeker, 2005; Buytenjik (as cited in van Manen, 2007); Heidegger (as cited in Abram, 1997); Lafont, 2005; Standing, 2009; van Manen, 1999, 2002, 2007). I found resonance with this perspective and so my research is linked to the rich evocative nature of such writing as an expression of the human experience of living. Charalambous (2010) added that “hermeneutics is recognised as a philosophy that supports an approach to health research which focuses on meaning and understanding in context” (p. 1285). Such a statement points to interpretive phenomenology, and hermeneutics informed by van Manen (1990, 2002), as suitable guides for this study. Using van Manen's writing the process of being in a hermeneutic

circle involved reflection on the text as oral/ heard, written and read. Descriptive anecdotes were used as a way of discovering the lived or felt meaning of things that are hidden from sight and contained within what is said. The descriptive nature of the text in this study brought forth participants' experience on many levels of existence. Reflecting on the existential qualities of the lived body, lived space, lived time and lived relation to other, as aspects of the lifeworld, pointed to disclosure of the phenomenon of interest. The anecdotes invited engagement pointing the way to new understanding. Furthermore, a non-cognitive, as well as a cognitive method, is needed in order to address lived experiences; incorporating the notion of non linguistic, sensed or felt experiences, that has been described as an intersubjective dimension of reality between self and other that shapes our knowing and understanding of the world.

### **Core Notions of Importance**

Heidegger's concept of *dasein* ~ *there being* is the notion of openness or being in the here and now; attending to what is happening, noticing or being called by the experience to respond as being-in-the-world. This is a lived experience "in the moment", and includes the notion of being-in-relationship as fundamental to human existence. For Heidegger, the origin of meaning and our understanding of the world comes from the things we use and the practices of living in which we engage. These notions make the world collectively structured for the familiar practical everyday things. Further to this, Standing (2009) stated that "the central concept of 'being-in-the-world' indicates an inseparable connection between mind and body, lived experience, and historical or social context" (p. 20).

Heidegger (as cited in Lafont, 2005) stated "to be human is not primarily to be a rational animal but first and foremost to be a self interpreting animal" (p. 265). The notion of interpreting meaningful text offers a model for understanding the human experience. Human beings interpret via private perceptions and experiences of isolated subjects in relation to the-world-they-live-in or lifeworld. As such, human beings have the freedom to choose to act by projecting into the future things that might or might not happen. Such ideas suggest that human beings move forward through seeking the known and familiar as ways of finding themselves at-home and making sense of the world. This notion is important in this study because the nature of the hospital experience, for patients, is one of being thrown into possibility. Wheeler (2013) added that the notion of *dasein* is present as a dynamic interplay with the world that balances

being thrown into situations as not-at-home, with possibilities in the future. How patients find themselves in hospital forms the important links to moments that matter with staff.

Levinas (as cited in Peperzak, 1993) posited that being face to face in service of other is the heart of what it is to be human. This notion centres on the idea that when we see others, we see ourselves – they are ‘like me’. Levinas stated that when you are seen by an other you discover yourself as different ... “unable to escape from being regarded, touched, and disposed of by your encounters” (p. 29). This notion of being ‘regarded’ relates to how we are ‘seen’ in the moment and ‘calls’ to the other to respond. Such calls trigger going into dialogue, connecting using language or touch, to encounter each other with the potential for dialogue creating understanding or meaning.

Moreover, Levinas (as cited Peperzak, 1993) suggested that by being in relationship, interconnected on a level beyond verbal, contains the possibility to respond in a caring or ethical way to such calls from the other. He sees the world as socially constructed and face to face encounters relate to collectively structured intersubjective relationships with other. He recognised the goodness in being human and the desire to be happy and have fulfilling relationships that increase a sense of meaning, belonging and relationship to the world we live in our life world. Behaving ethically is part of being human. For example, if I am walking along the park and I see a distressed child I would not walk past thinking that is the parents’ responsibility, I would be drawn to give comfort and aide even if it meant not finishing my walk; the child would call me to act in a caring way.

The notion of caring is built on by van Manen (1999) through the notion of a pathic dimension to practice, which speaks to the shared connectedness of all that exists in the world as a whole, and is particularly relevant when applied to health care. The “pathic dimensions of practice resonate in the body, in relation to others and in the context of being- in-the-world, they are a ‘felt experiences’” (van Manen, 1999, p. 22). As such pathic knowing includes an implicit felt understanding of ourselves in situations even when we cannot always put this into words, and our actions as practitioners are sensitive to this knowledge. How we *do* what we do in practice is often based on a momentary encounter with the other we are called to respond to – as one human being to another.

van Manen (2007), in his article phenomenology of practice, stated that a language is needed to express our understandings, one that is oriented to the “lived sensibility of the lifeworld” or story (p. 20). It is this notion that guides the design of the current study into patients’ lived experiences with staff in hospital. van Manen suggested the possibility for “creating formative relations between being and acting, between, who we are and how we act, between thoughtfulness and tact” (2007, p. 13). While reflexive practices allow theory to arise out of practice; thinking, writing and talking about what we do aids finding understanding and meaning in these practices that ultimately affect that same practice. Such a view illuminates the importance of patient anecdotes as a way of knowing about and informing health care practice.

Whereas theory “thinks” the world, practice “grasps” the world — it grasps the world pathically ... Perhaps a phenomenological text is ultimately successful only to the extent that we, its readers, feel addressed by it – in the totality or unity of our being. The text must reverberate with our ordinary experience of life as well as with our sense of life's meaning. (van Manen, 2007, pp. 20 & 26)

van Manen’s (2007) notion of a phenomenology of practice is based on ‘pathic knowing’ which leads to practical action in encounters with others; “not unlike the poet, the phenomenologist directs the gaze towards where meaning originates, wells up ... then permeates us, infuses us, infects and touches or stirs us exercising a formative affect” (p. 12). Moreover he stated that if we are to be “sensitive to the pathic nature of [practice then] we need to pursue forms of research that uses pathic language” (van Manen, 1999, p.16). Thus poetry is present in this study as a creative mode of engagement with the text, a way to show my understanding by attempting to go beyond words to the experience the text had on my felt understanding of the findings.

Anecdotes used in this study are a ‘special kind of descriptive story’, defined as a short narrative form of personal/private experience or life story that is often a fragment of biography regarding a meaningful moment. This form of insider information shows the essence or view from the inside which allows the researcher to make distinctions about the phenomena. They compel reflection by involving us personally in interpreting our own responses to deepen our ability to make sense of things of the world. Anecdotes may disclose an incident of significance as an exemplar for acting on.

## **The thing**

Based on Heidegger's understanding of existence as located in the everyday ordinariness and familiarity of life, described as being 'at-home' in the world, the assumption was that the phenomenon of making a difference (the thing) would be hidden in the everyday taken for granted. This research explored the meaning of momentary encounters that made a difference through focusing on the everyday language participants used to describe encounters with staff as a way of uncovering the phenomenon.

Heidegger stated that human beings primarily interpret nature in terms of entities (things); it is how we understand being. But often entities show themselves in terms of semblance. He suggested that we live in a world of semblance and the challenge is to find the true essence that is hidden within what we perceive as 'the thing', to let it show itself as it is, as experienced (as cited in Brandom, 2005).

Phenomena show themselves through their appearance, and such appearance can also take the form of mere semblance or deception. A semblance seems to be something that it is not; for example, a person can pretend to be happy by smiling and laughing when they may not feel happy, suggesting the existence of something which is not really there. In studying moments of connection we seek to see that which is hidden, not the mere appearance of it, but the essence of the encounter itself, that points to how human beings connect in the moment. In seeking, we may uncover moments that are not really moments of connection but a semblance. For example, a patient may experience staff inquiry as appearing to be interested in having a moment of real connection, but if this is just a form of routine robotic speech from staff who fail to actively connect with the patient in any real way, then this is a semblance of connection in the moment. Things in this study may be semblances.

## **Ethics**

### ***Consent***

I provided full disclosure regarding this study to participants, through an information sheet (see Appendix A) regarding the background and aims of the study, and outlined that all participation would be strictly voluntary. Before commencing the scheduled interview, I provided a discussion time to allow participants to clarify or ask questions regarding the study and interview before signing the consent form (Appendix B).

Signed consent forms were stored in the primary supervisor's office. Confidentiality of personal data was maintained with source material and working documents secured in a locked cupboard, on a password protected external hard drive.

To minimise personal risk during interviews, I stayed in public areas of people's homes, kept dress, body language and interactions respectful and neutral, and maintained appropriate social distance determined by the participant as a comfortable conversation space. I observed participant's levels of response to the interview process, recognising effects of discussion on participants, through non verbal cues, facial expression, tone and body language, allowing time for expression of story but offering withdrawal if distress occurred. An exit strategy involving a support person was formulated (Interview Protocol Appendix C, Safety Protocol Appendix D).

Ethics approval for the study was granted by Auckland University of Technology Ethics Committee (AUTEK) on June 23, 2013 (Appendix E).

### **Recruitment**

The recruitment process flowed easily with participants coming from the community I lived in, who were interested in my study, and from nursing students and their families in the region who were known from sports and social networks. Four participants volunteered from within known social networks of myself and my 18 year old daughter. Three participants were referred from within my local community by others who were aware of this study including the local practice nurse and neighbours. The first seven people who came forward formed the participants of this study, no people were turned away. It was decided, in keeping with phenomenological research, that depth of data did not require large numbers and as the seven participants represented diverse perspectives this would form adequate depth of data. If more data was needed we could return to the community and recruit further by asking if people were interested in being part of this study.

In total there were seven participants in the study; comprising 3 males and 4 females. Their ages ranged from 20–82 years. It was necessary that participants had been in hospital long enough to have a momentary encounter, thus 24 hours was set as the minimum time frame. Their hospital experiences ranged from first time acute admission, minor over night surgery, traumatic acute admission and included participants who had multiple admissions over many years. Three participants had

experienced life threatening admissions that were rich with story. One participant was an experienced health care professional and one participant was a student. All participants were of New Zealand European descent, living and working in a semi-rural area of New Zealand.

### ***Exclusions***

Children were excluded due to the nature of the particular vulnerability of children and possible difficulty verbalising experiences in relation to recalling events such as hospitalisation. Also those who have difficulty expressing themselves in English were excluded due to the limited ability to employ translation services.

Additionally, participants who are well known to, or had been nursed by, myself were excluded from this study due to possible perceived power imbalance in the relationship and the possible issues this creates around how freely the participants would structure their responses, versus saying what they think I want to avoid distress or embarrassment of criticising myself or my profession.

### **Conversations**

Phenomenology deals with a mode of language that reflects thinking on things. For this study I used first hand anecdotes about everyday interactions as the foundation for inquiry. Guided by van Manen's (2002) understanding that experiences are linked to everyday expressions that are hidden in language, I sought to gather, from participants, everyday accounts of moments that made a difference by way of conversational individual interviews. Data was gathered through face to face interviews with initial conversations that lasted from 30–55 minutes, with follow up conversation if needed to clarify or add to the story. Two follow up conversations occurred, once where I returned to the participant for further clarification that lasted 20 minutes. The second follow up occurred when the participant rang me the day after the interview and asked to add more data she felt was important and had not included in the interview, this occurred over the phone and lasted approx 20 minutes. Both follow up conversations were taped with participants' permission and added to their original transcript.

Interviews occurred at locations chosen by participants where they were comfortable; usually their home, so they felt safe. As a visitor I was mindful of the privilege of

entering their space. To reduce discomfort participants did not need to answer any question that they found embarrassing and were able to terminate the interview at any time. I was further cognisant of my participants' rights to privacy by avoiding the use of any data that could identify them. Even though most participants were happy to be known by their first names, to protect confidentiality, I assigned each participant another name.

Questions used open ended format to allow for a broad range of responses. Such questions included:

Tell me about someone (staff) who made a difference to you when you were in hospital?

Tell me about a moment that made a difference to you in hospital?

What was it like for you to be in hospital?

Tell me your story of being in hospital?

Such questions were also used to encourage further disclosure such as, 'what was that like' or 'tell me more about that'. Participants' own descriptive words, such as, 'you said it was like ... tell me more about that', was a technique also used. Conversation was an evolving dialogue, each one different and unique, never the same. The challenge was to stay open and find ways to show curiosity and interest that opened memories. This reflected a persistent anxiety related to how I could ask without guiding participant responses.

Conversation was captured using a digital tape recorder. Recordings were then transcribed verbatim, by myself, as another way to be with the data, to hear the dialogue differently and be with the words. A reflective diary was kept to record my experiences of the interview including first impressions about the context of the participant's world. This formed a record of insights and experiences from the interview itself, as a source of data, analysis, ongoing thinking and development of ideas.

Caelli (2001) stated that "transcripts had to be reduced to narratives that focus on the central matter of the interviews" (p. 279) creating a coherent story using participants words. Narrative was derived from transcripts after removing the interviewer's voice (questions), obvious repetitions and data that was deemed irrelevant to the focus for this study. Bits of transcript were combined when told in a fragmentary way to aid

logical flow, with one participant, this formed a collection of anecdotal stories over many years. This was then returned to participants for confirmation to validate that there was a 'rightness' and truthfulness in relation to their experience. All of the participants accepted the returned stories as accurate and no changes were required. It is this data which formed the anecdotes and moments of this study. The participants' stories were returned to them at the end of the study as a form of personal biography.

Re-listening to interview recordings as I typed and transcribed the interviews helped bring my prejudices to the fore. My supervisors were the gatekeepers for wandering off with my own assumptions, or making assumptions too quickly, bringing me back to stay with the data and look more deeply.

### **My understandings**

Prior to engaging in this research my supervisor conducted a conversation regarding my understandings; a self interview that was an experience of what was to come and how it might feel for my participants. I found difficulty in being faced with remembering and thinking that got in the way of simply responding. My practice and background in health and education became a screen I had to step around to find experience; to engage with a memory of who made a difference when I was a patient in hospital. My remembering spoke to being treated like a person and having real kindness shown to me.

My pre understandings have shaped who I am and impact on this study as hidden behind my eyes, ears and thinking. Those pre understandings are mostly related to a long, rich history in health care and Complementary Alternative Medicines (CAM) therapies. I acknowledge my own strongly humanistic perspective that culminated in a MindBody orientation to my practice which are outlined in chapter one.

### **Tensions within**

Tension in research is revealed by Levinas (as cited in Peperzak, 1993) who stated that "language originates in the self, the 'saying' precedes and never coincides with 'the said'" (p. 30). This statement suggests that we experience things before we language them. Adding that language cannot express the totality of the whole experience of a person, rather it can only capture what they might identify with, or are triggered to remember so it is always a retelling of the experience which is altered from the living of it. Furthermore, Polkinghorn (2007) and van Manen (1990), raised concerns about

writing which places people at a distance and in danger of forgetting context and intellectualising the experience through the pursuit of academic writing.

There is a tension in qualitative research that Jones (2001) identified as the interpretive lens of the researcher's own experiences shaping how or what he or she chooses to note as a researcher. d'Entremont, Smythe, and McAra-Couper (2013) stated that "the concept of the hermeneutical circle highlights the fact that many different understandings and interpretations are possible" (p. 304). The challenge was being clear on whose story/view was being represented, with the ever present potential for misinterpretation due to my pre understanding. The process of maintaining this clarity was most often guided by my supervisors challenging and checking my presumptions and insights from the data, and the process of staying with the data until it 'talked' to me with a voice of its own showing itself when the time was right. Being mindful of what I chose to include with the help of supervision allowed participants' words to be illuminated and expanded my understanding until I could uncover their experience and understandings within this study. This led to participants as co-creators of this study.

Tension was always possible between my pre understandings or world view and that of my supervisors. Their impact on the shape and outcomes of the study was also related to the nature of our distance relationship via skypeing, e-mails and missed moments. This was managed by continuing conversations and talking at other times, when the need arose, to aid building understanding of each other as persons. To be removed geographically from my supervisors proved to be an uncomfortable process at times and beneficial at others. It was managed as a process that was evolving requiring active communication as an important quality.

### **Data Analysis and Interpretation**

Analysis was written to expose the life world of the participants and bring into language their experience, aiding the discovery of essential meanings, themes and relationships that emerged from within the narratives.

Words are symbolic, but through the process of analysis I will attempt to show readers my understanding of the meaning my participants' stories created in me after dwelling with their words. According to Lafont (2005), the things in the world are already there for me to discover and I can only describe my encounters with them suggesting that

humans interpret via private perception in relation to the-world-they-live-in. Taylor (2005) stated that according to Heidegger's view, language is not instrumental:

but constituted by or arising out of human life experience. This new view requires a reflexive language to react to and enable us to grasp something as it is, sensitive to and inclusive of human feelings, activities and relations that give form to creative expression. (p. 437)

Anecdotes, as text, form another conversation which I returned to often to seek deeper understanding and clarity regarding what was said, and not said. Phrases beginning with; *the most important thing, I remember, I'll never forget* became a focus, pointing to meaningful or significant moments for study. Finding similarities across participants' anecdotes built interpretation and themes; grouping anecdotes together to show moments from different aspects building being in the moment. Some anecdotes described one dimension while others were richly descriptive showing multiple dimensions of reality as lived by being in the moment with others. I was always striving to stay with the participants' words through the constant circle of reading, writing and thinking around the everyday taken for granted things in their lifeworld. Refining as I went, interpretation developed becoming a greater whole. Moving between parts and whole, a greater conversation emerged, coming to understand unexpected moments of connection with staff emerged as a presence that I could write to.

Moments of insight formed when the data began to talk to me and drive the process, bringing to light how unexpected moments of connection might be in hospitals. 'Aha' moments occurred, going beyond the text to 'seeing' associated with a deep and clear knowing that this is how it is, revealing different layers of meaning. New perspectives continued to emerge, suggesting themselves as the text became more familiar, as what was not fell away, leaving what 'is'. Meaning was explicated and thinking led to writing and rewriting to show my understanding, uncovering it for view.

Insight came through engagement over time, flowing more freely as data was gathered, and deepening with respect to that which stayed present throughout. Becoming was renamed after questioning if it was a semblance, looking at what was taken for granted? For example, the theme Relating-to was disclosed as being there, being with through coming back, being known or familiar, interested and through the use of humour or distractions.

Uncovering what made the difference was the unexpectedness of connection with staff. I discovered that interpretive phenomenology is not just a way of doing research but a way of being-in research; of going back to go forward and evolving understanding that is not static but a dynamic lived relation with the work of understanding. van Manen (1989) stated that “writing constantly seeks to make external what is somehow internal” (p. 29), and the struggle was with expressing my knowing and understanding of what mattered to patients.

Interpretations are disclosed in the findings chapter as the understandings that I reached forming a joining of worlds; the participants’ and mine. Although the understanding becomes mine, there were times of struggling with the data asking what is trying to show itself? There were times of undoing and rearranging to move my thinking forward; taking detours only to return to the question to refocus. Guided by intuitive moments where the knowing illuminated the next cycle of thinking and writing, moving forward in the hermeneutic circle. Continually attending to what I was contributing and what the text was trying to show as a constant way of being with the data and writing leading to understanding as a circular movement between the researcher and text. Engaging in regular supervision and keeping notes on thinking aided staying focused on the task of participants’ subjective experiences of moments that mattered.

### **Trustworthiness**

What then is good research? The notion of goodness points to trustworthiness, sound practices and worthiness. Additionally, robustness is found in being auditable through clear writing that others could follow and replicate, meeting academic standards and adding something of value to the knowledge base in a way that is useful to others. A tension exists in phenomenological research due to the large number of theoretical and methodological positions making one single structure for evaluation unlikely according to de Witt and Ploeg (as cited in Pereira, 2012).

Much literature is written about what constitutes ‘good’ qualitative interpretive research, especially in nursing. Sandelowski (2000) stated that contextual relevance of data or finding a fit with the audience is important. I am guided by this notion of fitness also espoused by Giddings and Grant (2009), Standing (2009), Tracy (2010), (2011) and Koch (1999). Fitness relates to congruence that is established when there is a ‘fit’ between methodology, method and meaning, when the analysis and findings

illuminate the data, and other readers such as staff and patients could recognise or resonate with what is said as a truth that is trustworthy pointing to research as credible. Fit is also a representation of an academic contribution that is 'good', robust, credible and adds to the body of knowledge.

The researcher position in interpretive phenomenology is an influence that needs to be clearly identified as an element of the research (Ballinger, 2004; Giddings & Grant, 2009; Koch 1999, 2006; Pereira, 2012). Explicated in chapter one and early in chapter three of this study my pre understanding shows my particular perspective of the world underpinning and influencing interpretations and choices I might make, they are unique to me and may differ from others. Tension was centred on not thinking like a nurse or philosopher and this was aided by a MindBody view which was sympathetic to story/metaphor as a way of understanding meaning, easing this tension, along with regular supervision.

Reflexivity promotes rigor (Giddings & Grant 2009; Giorgi, 1997; Jootun, McGhee & Marland 2009). Jootun et al. (2009) posited that self awareness and observation through the research process aids maintaining an awareness of how my pre understanding influenced my choice of data and interpretation. This was achieved through the experience of phenomenological interview prior to commencing this study, the use of a reflexive diary of my thinking and experiences throughout interviews, analysis and interpretation which was further aided by regular supervision and peer review in the form of presentations that allowed me to reveal my understanding to professional audiences.

A MindBody research day led to questions about underlying assumptions of philosophy. The day provided confirmation that 'moments' existed for others and were worthy of study, that created resonance with some of the audience and phenomenological nods were visible. van Manen (1990) refers to the "phenomenological nod as a way of demonstrating that good phenomenological description is something that we can nod to, recognising it as an experience that we had or could have had" (p. 27).

At an AUT Faculty of Nursing Practice presentation I was encouraged and supported by the presence of the phenomenological nod, the acceptance of the findings as appropriate generating discussion on how the findings supported a return to foundations of care as relevant and important for patients in hospital.

Reflexivity is also visible via participant engagement in checking their personal stories for accuracy and trueness making them co creators of this study.

Questions about whether this is a true reflection of the phenomena that explored the question at the core of this research is found in relation to revealing a single underlying reality, that was explored from different aspects that pointed to the core finding(thesis) of this study. It appears that the findings of this study can be seen to support the current literature adding to the relevant body of knowledge and showing congruence (Giddings & Grant, 2009).

### ***Congruence***

Congruence is seen as a fit between methodology, method and meaning. This is visible through generating meaningful results grounded in the participants' experience. 'Readability' (Pereira, 2012), suggests finding a fit with the reader that resonates and evokes a sense of truth or knowing regarding patients experience in hospital, describing patients experience of moments with staff that mattered as a recognisable phenomenon. Finding a fit speaks to reliability, transferability, validity and congruence. It is suggested that this study achieved what it set out to do through the presence of the 'Phenomenological Nod' showing recognition of rightness or congruence in this research. This was seen at both presentations of this study pointing to a description of the phenomenon that capture its essence and is recognised as relevant.

The findings show my knowing is not the only possible knowing but the sense of understanding I have arrived at to date on this journey. There appears to be relevance to the real world where the findings support practice and practical environments within health care.

### **Reflection**

This chapter made visible my study design and how philosophy underpinned the doing of this research. It shows the thinking that informed my research journey, describing how participants were recruited and how interpretation was guided. The trustworthiness most evidence by congruence between philosophy and method guiding interpretation, thinking and writing that formed a hermeneutic circle is also presented.

Insight arrived intuitively when time was right related to the depth of understanding and being in the research.

This moment of insight formed the beginning of thinking not a definitive statement about moments that matter to patients in hospital. Interpretation revealed an overarching theme of unexpected moments of connection with staff that made things in hospital bearable and the nature of this unexpected connection was woven throughout each sub theme, Relating-to and Attending-to which will be described in the following two findings chapters.

*Invitations accepted*

*Conversations flowed*

*Thoughts and writing emerged*

*Often moving*

*Rearranging*

*Meaning is found within*

*What is becomes apparent by looking sideways*

*glancing backwards*

*seeing in glimpses*

*Emerging from the depths of dialogue to show itself*

*A circular dance*

*A chance to see*

*Behind the costume to the truth within*

## CHAPTER 4: RELATING-TO

*It is necessary to dig deeper, down to the very meaning.*

(Levinas, 1989, p. 1)

In this chapter I begin to explore the quality of unexpected connection in relation-to momentary encounters that make a difference. 'Relating-to' formed one of two themes that emerged. It describes the way we are with each other as human beings and how that makes a difference.

The philosophical underpinnings for this study are drawn from Heidegger's notion of 'Relating-to' that suggests we cannot separate our existence from the living of it, with others, in the world (as cited Parsons, 2010). Moreover, Levinas (as cited in Peperzak, 1993) described moments of connection between staff and patients as being reciprocal in nature; "when you are seen by an other ... you are unable to escape from being regarded, touched, disposed of by your encounters" (p. 29). These ideas suggest that it is not the length of time, but the nature of the connection that appears to make a difference in Relating-to patients in hospital.

In this study, 'Relating-to' represents the patients' relationship to the things of the world in which they exist; the people (staff, patients) and how they make meaning from these relationships in specific moments in the hospital setting. 'Relating-to' showed itself in the following ways: 'being there' is being with and being known. Being there can be revealed through an unspoken gesture, touch or a look that speaks to the other as a person. Being there is also explaining or getting information in a way that reassured.

'Relating-to' was further revealed as 'being known', through recognising a familiar face that changed the experience instantly. As such 'being known' reveals the temporal nature of 'Relating-to' in the present and future, through reconnection when staff came back, showing an interest and making life more bearable for patients in hospital. Moreover, 'Relating-to' was disclosed in the data as 'distraction' through the use of humour and ordinary conversation or chatter that appeared to make the difference.

## Being there

‘Relating-to’ is shown through the dimension of being there; revealing the nature and essence of what it is to be human. It also represents relating to temporally; that is, pointing to the idea that a felt moment in time can be discovered by connecting the past with the present and future.

‘Relating-to’ through being there is reassuring to patients in hospital. Em, who had day surgery to stabilise her knee, had never had an overnight stay in hospital before. She had to travel to a main centre with her mother to have surgery. They found themselves in a strange hospital where they knew no one. When Em awoke in the post anaesthetic care unit (PACU) she described:

*freaking out and the nurse sat there with me for a while and I went back to sleep ... I don't know she was just there. I just had someone with me it made you feel a bit better... You feel kind of safe in that you know they are going to look after you. You feel quite vulnerable but if you know the nurses are around that helps and you feel a lot more comfortable.*

Em’s description showed how her behaviour ‘called’ the nurse to action and allowed for a connection in that moment. The nurse was ‘just there’ for her, showing that moments of unexpected connection can happen when staff respond to patients’ needs. Em used the first person suggesting a personal felt connection as making a difference to her. The use of the word ‘You’ instead of ‘I’ in this anecdote suggests a more general or global statement that might be the same for anybody as human beings. There is also a sense of things being more bearable if they are shared by another human being – you are not alone. Em’s ability to go back to sleep while the nurse is there, suggests a felt sense of safety or trust that someone was there for her, watching over her, providing a sense of caring, comfort or compassion that made a difference.

Em’s description of *freaking out* upon waking in PACU, suggests a sense of dislocation or disconnection as a result of emerging from unconsciousness in a different place and not knowing what has happened. This sense of vulnerability may be associated with the unfamiliarity and strangeness of the location (PACU), the uncertainty or sense of being not-at-home for Em. The nurse eased the uncertainty of the moment by simply being there. There is a suggestion that connection to patients, when they feel vulnerable, may make the moment more bearable.

Deb, a woman admitted as a patient in a private hospital, was undergoing major abdominal surgery that required a four or five day stay in hospital. This admission followed a year of uncertainty and worry, and Deb described her relief and hopefulness at finally getting appropriate treatment. The only thing which concerned Deb was the fact that she suffered bad responses to anaesthetic. Deb revealed an unexpected moment of connection when she awoke in PACU and saw that the anaesthetist was there. She stated;

*the fact that he was there when I woke up... he was just there. I just felt amazing I've never felt like that in my life. I just remember saying wow, and he said, 'that's what we are here for...' I felt fantastic as if nothing had happened.*

The language Deb used described the positive nature of her experience; that Deb was the focus of the doctor's care appears affirmed by his response, suggesting he was there for her. This reinforces the notion that moments that make a difference happen when staff are *there* for patients. The temporal aspect of this moment is revealed through the doctor being there at the beginning of the operation and again when she awoke, providing Deb with the perception of continuity in relation to felt time. It is almost as if these two moments had little time between them, like the gap between one breath to another. The doctor was a link for her from the past to the present moments. When Deb did not feel the dislocation of general anaesthetic or suffer the bad side effects, as she had in the past, her fears were not realised; and this made a difference to her experience in this moment.

The emotive language *wow* described the unexpectedness of this moment for Deb, further influencing the way she related-to the world at this moment. Deb's experience of this anaesthetic and surgery contained a sense of joy and relief that was powerfully reinforced via her lived body and temporally via mood. It made a difference both in the present moment and in her experience of that remembered from the past.

The notion of relating-to through empathy, forms part of pathic practices that can be seen to influence patients' perception of staff and consequently how they feel in the moment. This is revealed when Deb talks about one particular nurse in her interview:

*the way she dealt with me and her empathy was phenomenal, she built up a rapport... wasn't over the top but she didn't just do her job she just took it one step further... I recall her really well, I often think about her, she stuck in my*

*mind, she was just a very genuine person... I felt cared for, probably almost special.*

Being related-to by this one particular nurse is a demonstration of being there and developing relationship as a genuine person. How Deb was attended to by this nurse suggests these encounters were experienced positively, as shown through their memorable nature visible in Deb's comments; *I recall her really well, she stuck in my mind.* Deb's description of the nature of this relationship suggests that the way in which this nurse related-to Deb was beyond what was expected. This nurse related-to Deb in a way that made a difference.

Dan, an educator who is normally fit and well, visited the ED with acute abdominal pain prior to being admitted. This was his first hospital experience and he described encountering a familiar nurse on arriving at hospital;

*she just came and got me instantly, I felt she was amazing. For the next I don't know couple of hours I had her undivided attention... I'd go 'Ah' everything will be ok; something was happening straight away I know I'm going to be alright ... because I didn't know what to expect.*

Dan expressed the felt quality of this moment with this nurse who appeared to give him her undivided attention as; *wonderful, instantly, undivided, amazing, immediately.* Such words suggest significant moments associated with this nurse and how she related-to Dan, which in turn affected his perception of the care he received.

The temporal nature of being there, when the nurse responded to Dan's distress straight away, is described as instant. According to van Manen (1999) time is a subjective dimension of existence and the hospital environment changes our perspective of lived time through its foreign or alien nature. This is especially so when there is uncertainty or pain in an unfamiliar setting like a hospital waiting room, identified as "isolated in a timeless encounter" (Elmqvist et al., 2012, p. 2613). It appears to be common sense to suggest that how staff present themselves to patients makes a difference in hospitals.

‘Relating-to’ through being there, linking past and present, is vividly recounted by Don after his heart attack. Don described an encounter with his doctor which suggested that:

*I had been dead but now I was alive again, and on the mend again. That gave me reassurances.*

This reveals the fundamental nature of connecting past to present; by being alive in it, suggesting that moments of unexpected connection relate to simply existing in the world and surviving as a person. Forming a sense of conscious connection with the self as existing becomes visible when one survives a near death experience. The awareness that you existed in the past, and continue to exist in the present provides hope for the future.

A final aspect of being there was revealed through the notion of staff attitude. Peg a woman with a complex surgical history who has been in ICU many times described her nurse’s attitude as important:

*his attitude that we will beat this [and] not always what he said but the how he said them ... his positivity.*

The perceived attitude of staff appears to have contributed to moments that make a difference. This notion of attitude visibly shapes how we relate to each other in moments of connection. Personalised attitude from staff was linked to encouraging patients’ sense of joy, will to live, feelings of being valued (Wahlin, Ek & Idvall, 2006). It follows that momentary encounters relate to a lived relationality affecting mood, and making a difference to patients in hospital.

The importance of relating-to, through being there, is revealed when patients are vulnerable. Further, linking the present with the past or future possibilities makes a difference to patients who report feeling valued, safe or hopeful when staff are interested and genuinely there for them.

## **Explaining**

Relating-to was further revealed through explaining to patients. Participants described explaining in relation to times of uncertainty, acute admissions, first time in hospital and in relation to lived body experiences following a surgical procedure or special care

unit admissions. Explanations provided information to aid understanding, suggesting it may assist reconnecting patients with their own body which participants described as both reassuring and sometimes life affirming moments.

Dan revealed the use of ordinary language and openness of explaining, in a slightly different, yet related fashion as follows;

*He (doctor) even said at the end, with a smile, 'I don't know, we don't know what it is'. He (doctor) even commented on the small nana surgeon (house surgeon) that was on the first night and said something from his report like, 'that's really good that he noticed that, and that and that'. So that you know just makes me feel even better. I felt that they (doctors) would always turn and speak to me in normal language, so I always understood what was going on.*

As Dan had never been to hospital before, and there was no actual diagnosis for his acute pain, it might be expected that he would have some uncertainty. However, the quality of moments when staff explained things to him revealed that was not the case. When his doctor admitted not knowing what caused his pain and openly commented on the content of his notes in relation to his care, this appeared inclusive of Dan as a participant and showed respect for him as a person. Such an example suggests that informal explaining using everyday language can aid understanding and connecting to staff. It makes a difference.

'Relating-to' as explaining is revealed as reassuring when Em described;

*the surgeon came and saw me and explained what had happened and what he had found, because we weren't sure about what was happening that was reassuring ... because the doctor explained it to me and I kind of forgot everything.*

In this anecdote Em described her uncertainty, suggesting the importance of having an understanding connected to her lived body which included knowing the outcome of her surgery and the future. It appears that explaining is reassuring when it comes from the surgeon who was 'there' performing the surgery. However, medical information is unfamiliar to most patients and may be lost in the moment, as Em described. Forgetting could be associated with the unfamiliar medical language used as opposed to the everyday, ordinary language described earlier. Additionally forgetting can also be associated with, being given information when still under the influence of

anaesthetic drugs, pain relief medication or experiencing pain changing how much information we are able to remember and reinforcing the importance of being told things more than once.

In a similar way, Shaun described a moment of explaining;

*the doctors coming and talking to me telling me what they had done, telling me how it went ...knowing that was reassuring. They told me how not to break what they had just fixed.*

In this anecdote Shaun described his understanding of the nature of his treatment as being reassuring. Explanation appeared to give Shaun information about how to protect himself and avoid further injury, which he had found unpleasant and painful. Explaining how to care for himself after hospital, through the provision of accurate and useful information for the future, links to the notion that self care is personal, supporting a sense of autonomy as a person and making a difference.

Medical interventions can change how we see ourselves and lead to uncertainty. Relating-to, by explaining in ways that the patient understands, can negate some of the uncertainty, provide reassurance and link patients' to reconnecting with their lived body. Em and Shaun described having their surgeon explain what had happened in theatre, and how to prevent problems in the future as *reassuring*.

In a slightly different way, Deb described explaining as feedback that made a difference;

*Being reassured that I was doing really well, probably reinforcing, cause you know you always wonder if you are normal or not and so nursing staff saying you're doing really well whether it was true or not, you know just positive feedback.*

Deb described positive feedback in a similar way to Shaun and Em's description of explaining, as reassuring and comforting. Deb's description of staff feedback was meaningful because it allowed her to put her recovery in context. Feedback is temporal and it explains progress, locating patients in the moment while connecting them with possible recovery time frames, making things bearable. Furthermore, feedback appears to suggest that Deb was noticed or 'seen' by staff and affirmed as a person which made a difference to her.

These anecdotes show that when staff are ‘there’ as a person, it can provide a sense of continuity across time and relationship for patients in hospital, making things seem more bearable. These anecdotes also suggest that it makes a difference when staff respond to being called-to patients when they are *vulnerable* treat patients as genuine persons and link past, present and future. Explaining in ordinary language may be reassuring when patients are uncertain. In addition, unexpected moments of connection were also associated with patients experiencing changed mood as *feeling better*, *feeling safe*, and *feeling like nothing had happened*. Such moments are memorable to the patients who experienced them because they have a felt relationship to the staff in that moment of care that makes a difference to them.

### **Distraction**

While I have previously revealed ‘Relating-to’ through being there as a person, it was further disclosed through the notion of distraction, providing a moment of respite from discomfort, pain or uncertainty. Distraction, as described by the participants, was linked to the use of everyday chatter and humour that drew the patients gaze from the current situation which allowed for a moment of relating to staff as human beings rather than health professionals. It provided an opportunity to attend to something other than the impending procedures, processes or pain.

For Deb, a moment that made a difference was revealed while she was being transported to theatre and she became involved in the idle *chitter chatter* of *everyday conversation* with staff. Deb described;

*being wheeled to theatre and having a person at the top and bottom of my bed, just normal everyday conversation going on, nothing about focusing on the event that is imminent, it was just focusing on such and such has done this, or we are going to do this, or what’s happening down your way today, so it was just idle chitter chatter which invites, whether it was conscious or not it was, just involves you.*

In this anecdote Deb is being taken to theatre for surgery, suggesting a journey, a time of uncertainty which is fast approaching, containing a sense of the unknown. Deb suggested that this encounter helped her to avoid thinking about the end of the journey. Chitter chatter with the staff allowed her to distance herself from the feeling that theatre was looming, even as she was physically drawing closer. As with relating-to

through being there to explain, unexpected moments of connection can occur when there is uncertainty for the immediate future and, at such times, normal conversation appears to make a difference. Contrasting this view others may have found such idle chatter excluding if it did not involve connecting to them as a person, suggesting less connection to the staff, which in turn may have appeared to diminish the import of the moment for the patient.

Additionally, the multidimensional aspect of relating-to is described by Deb as being accompanied by staff, suggesting a shared journey, physically linked together by the bed and linked as human beings by the idle *chatter* distracting her; ultimately linking them all as people. Deb is at home with the everyday nature of the conversation and finds it familiar. Deb's involvement in such conversations allowed her to transcend herself and experience other, representing the social or communal nature of existence. In being there and 'Relating-to' patients in hospital, as a person in an everyday way, there is an openness that acknowledges our shared existence in the world, demonstrating the social nature of Dasein as being-with-others. Such behaviour by staff seems to suggest to patients that they are available and willing to connect through relating-to them as a person in-the-moment which has the potential to make a difference. Covington (2005) stated that such connecting provides a context for mutual human-human connection that gives meaning to relationship. It appears that moments of distraction, when staff involve patients in ordinary everyday conversation, may make things bearable for a moment.

The use of humour also came through in the data as another dimension of 'Relating-to' that made things more bearable through distraction. Shaun described a moment when humour distracted him from a painful procedure and connected him to a young doctor, who made mistakes and was therefore human like him. This moment occurred in a busy, noisy ED where Shaun was quite unwell and undergoing multiple assessments with increasing pain. He remembers:

*one doctor that was trying to put a needle in my hand missed a few times, he was the only guy I remember from there, just messing up those three times to be honest. We had a laugh about it; he was making me laugh and cringe at the same time.*

Humour could be seen as a way of 'Relating-to' or connecting with 'others' where there is suffering, vulnerability or uncertainty. This encounter reveals humour being used to mediate the uncertainty and discomfort of the moment. The laugh in this

anecdote has many possible interpretations. There is a suggestion that Shaun chose to have *a laugh* instead of cry because it was physically uncomfortable, showing how we are socially constrained by other, and the public nature of the ED department, in this case the laugh hides real distress, and uncertainty about how many more tries might be made. Alternatively, the use of the word *we* could represent the shared aspect of the moment and the possibility that humour made it less uncomfortable for them both, to cover embarrassment and discomfort on different levels. It suggests that ‘Relating-to’ through humour is a way of easing discomfort physically and emotionally and possibly making the moment more bearable.

Shaun could even have shared a sense of the doctor’s humanity; the doctor missed a few times, making him more like an ordinary normal guy. This suggests unexpected moments that matter to patients’ in hospital may happen when staff *mess up*, and they are seen to be more human or like their patients. We all make mistakes, we are human. It seems to make a difference when patients perceive staff as like them. This anecdote also raises the issue of how long a strategy like this can be used before the doctor would get someone more skilled to do the job. How many tries is enough before the patient’s suffering becomes the driver when staff fail to get it right, how do we make such a call?

Dan described a moment of humour when the doctor suggested he might benefit from a prostate exam;

*so when the big surgeon guy (consultant) came down he said, ‘have you had that done?’ And I said, ‘no I haven’t, but my wife has told me that I really should’ and he said, ‘do you think maybe we could do it now just to make sure’, and he said, ‘your wife will be so happy with me’.*

The humour Dan described is associated with a test which Dan imagines will be uncomfortable but his wife feels he should have. When the doctor replies that it will make his wife happy, it shows a relating-to Dan on the same level, sharing a felt moment when discussing men’s health and wives in general. It suggests a shared experience of being husbands in this moment and that made a difference to Dan.

Peg, described humour in her relating to one particular ICU nurse:

*And I've been in every ward of the hospital except the children's wards. And [this nurse] said, 'you're gonna love the children's ward chook, There is all those toys to play with. You'll have a ball up there chook'.*

This nurse is seen as someone who jollies her along by having *a laugh* with her, lightening her mood. When such laughter is shared it is an uplifting and uniting connection that is associated with joy and celebration, that Peg had survived and that she is progressing. It brings the hope that she would recover and leave the unit; all of which is held within this moment, suggesting that unexpected moments of humour are uplifting and may make things more bearable in hospital.

The final description of humour occurred when Deb described a moment that was heard rather than a personal relating-to. For Deb, this moment was reflected through the felt mood in the hospital;

*the other thing was the laughter, the nurse's laughter; it's the thing that was really cool, just to hear that there was a good environment.*

In this anecdote it is the sound of the laughter which contributed to the mood in the moment and made a difference. In contrast to this particular participant's experience, it is also possible that the inverse is true for some patients trying to rest, sleep or who are critically ill or in need of the staff's attention. As such, noisy staff may seem as disrupting rest rather than promoting it creating a different mood for such patients.

It shows that relating is not limited to verbal encounters but can occur through non-verbal gestures, a look, a sound or a sensation that add to the mood of the moment. This notion relates to van Manen's (2007) pathic dimension of care that contains the felt dimensions experienced beyond conscious verbal relating.

Being-there is also associated with the idea of comfort as a feeling of being at-home with the relationship or the environment that implies feeling cared for in a more personal way. Being able to laugh is positive and uplifting, it changes the mood of the moment. These examples show 'Relating-to' through distraction as a way of connecting and reducing discomfort. Moments which make a difference are shown as those which make things bearable and provide hope through the familiarity of shared humanity.

## **Being known**

The notion of relating-to is also associated with familiarity. It is revealed through the data in two ways, firstly, as recognition of ‘a familiar face’ that changes the experience where being known occurs in a different context from normal. Secondly, being known is revealed through staff coming back, reconnecting with patients and becoming a familiar person. This suggests moments of being related-to by staff can be repeated to build experience over time. Such personalisation of care appears to be associated with patients feeling less stress and increasing comfort and security (McKinley et al., 2002; Samuelson, 2011; Wassenaar et al., 2014). It speaks to Levinas’ notion of being face to face with other, being called by, and responding to other as the heart of the human experience (as cited in Clifton-Soderstrom, 2003). Finding out we are known, through being recognised, is to discover we are not alone and this makes a difference.

This anecdote from Dan about his first admission reveals the dimension of being known through recognising a familiar face in the ED when he arrived;

*It made a big difference because, we saw the nurse and we know her... something was happening immediately.*

Dan described arriving in ED and unexpectedly seeing a familiar face that changed how he felt in that moment. The effect of introducing something familiar in an unfamiliar environment, suggests a point of reference to something known, a connection to his ordinary world. This unexpected moment of recognition was associated with reassurance and hope. Dan described this as an immediate sense that he would be okay. Not having to wait in pain, and the possibility that his suffering might be relieved, is all held within this moment of recognition. The two moments overlap, the moment he saw the nurse as someone he knew and the moment when she came and got him straight away. Dan felt confidence and trust from being known by a member of the staff which was confirmed when the nurse saw Dan’s distress and responded to him, showing that unexpected moments of connection can appear to happen in an instant.

Dot also experiences relating-to through familiarity but in a different way to that of Dan. For Dot, a health care professional of many years experience across many fields of practice, with numerous familial and social connections both within and outside the hospital environment, the possibility of seeing a familiar face when she is a patient in hospital is high. Recognising and being recognised by staff, when a patient in hospital,

holds a sense of *home coming* for Dot. It is a place where she has existing relationships and a long standing sense of familiarity with the staff and the environment, where she feels at home, which appears to suggest that being known not only makes a difference but is comforting and adds to a sense of security (Hupcey, 2000).

While being known or recognised as a familiar face revealed a moment which made a difference for some participants, many participants also described the importance of the familiarity developed by staff coming back, as making a difference. Williams and Irurita (2004) stated that “frequent contact (popping in) and responding quickly” (p. 812) led to patients feeling secure. This dimension of ‘Relating-to’ through being known suggests coming back and reconnecting with patients, sometimes over time, allows for familiarity and developing relationships to emerge which become memorable to patients making a difference.

Being known contributes to the felt quality of the relationship. Peg described how the relationship which had developed with one particular nurse over the time she was in ICU built a familiarity which enabled mutual disclosure;

*He was just so good and rattling on about his own kids and his wife, because his wife had had a couple of health issues.*

Peg’s knowing personal details of this nurse’s life shows their relationship as one which involves familiarity and interpersonal relating-to each other as people. Being known is revealed through conversation about their families, which is ordinary and everyday suggesting a knowing of each other that made a difference.

In this anecdote Dan described being known through staff coming back;

*I had a an older nurse, she was really cool she wasn’t a grumpy person at all she was really friendly... then she went off shift and when she came back on, she came round and said hello to everyone and she was back and how were they and how had their night been and all this sort of stuff. I remember her because she did that, that really stands out, it was as if she hadn’t been away because she would come back and she might say, ‘so how’s the pain on that side today’, even though you’ve only had this food, how’s that been, she was just sort of catching up which is like a couple of friends meeting over a cup of coffee and having a yak, I thought that was really cool.*

This anecdote illustrates how greetings offer moments for reconnection with patients. The nurse’s behaviour links becoming known and ‘Relating-to’ patients as a person

through showing an interest. She became familiar to Dan over time, suggesting that he felt more at home (friendly) with this nurse. This nurse's inquiry reflects a genuine interest in relating to Dan in the present regarding his lived experience of hospital. Temporality is revealed in the use of the word 'today' suggesting it is in-the-moment but also related to the past yesterday and future tomorrows when she may be there again. This relationships suggests a continuity over time which developed through coming back, creating a feeling of being more at-home or ordinary when Dan related-to this nurse. Such experiences are constitutive for patients; reconnecting through coming back offers possibility for multiple moments of 'Relating-to' that build relationship over time, making a difference to patients.

'Relating-to' through being there and being known is further described as memorable when Peg recalled her last time in the ICU and described a particular nurse; *the one guy in ICU I don't think I will ever forget. And he'd come in and stand at the door and go well, well, well, how's it going today?* There were many moments when *he'd come in* and be there, as a person on multiple occasions over time. Peg reveals the significance of the relationship they shared through its memorability, showing how we can be touched by others when they are there for us. Memory is associated with the temporal and relational dimensions of existence, suggesting that past experience influences our actions or feelings in the present, through being in the moment together. How Peg felt about her moments of care from this one particular nurse is reflected in the mood or feeling of her anecdote. Peg's recollections show that when staff relate-to patients by being there for them in a genuine way, the memories of this stay alive to influence patients long after the encounter has ended. As Hawley (2013) stated "real nursing is a matter of moments of genuine encounters" (A further moment, para. 1).

Peg's anecdote illustrates 'Relating-to' through a more spatial dimension shown when this nurse arrived and announced his presence. Standing at the door seems like normal, ordinary behaviour anyone would do before entering someone else's space, which allows for an invitation. This behaviour suggests an honouring of Peg as a person rather than a dependant patient; he acknowledges the room as 'her space'. Peg described reconnecting with this nurse through his inquiry. The temporal nature of coming back is revealed in the word *today* locating Pat in the present, showing the nurse's inquiry was related to this moment in time, but acknowledging that it came from Peg's many past experiences and their shared yesterday, linking past and present.

This behaviour seems to suggest respecting patients' space when reconnecting makes a difference.

As someone who had a long relationship, Peg recalled this particular nurse's connections to her with affection; his presence was a comfort to Peg and recalled in many of the other moments she described during the interview.

*They'd be wanting to do something to me, give me an injection or turn me over or something and he was always there and he was always strong and he was pumping the Morphine pump and saying, 'come on you can have some more of this stuff'.*

Peg's description indicates that it was not only his physical presence and strength in attending to cares, but also his emotional or mental strength as a support for Peg. van Manen (1999) stated "I trust this hand then it has the power to reunite me pathically with my body, it reminds me that I am one with my body, and thus makes it possible for me to heal, to strengthen, to become whole" (p. 15). When staff are strong for patients, coming back and being there makes a difference; things become bearable.

In this last anecdote Deb described a further dimension of relating-to through being known when she is able to share some 'time out' with her nurse at night:

*just catching upon the events of the weekend ... girlie chitter chatter*

Suggesting a relating to this nurse through normal everyday conversation about their ordinary lifeworlds. The conversation is not the distraction described earlier, but a relating to this nurse as a person. Deb's language informs us that this is a nurse to whom she had a relationship with on a more personal level and felt close to, *like friends*. There appears to be a familiarity within this relationship, a reconnecting in the form of catching up which suggests being known. In this anecdote the time out to reconnect made a difference through bringing the ordinary to the fore, and is described in the next chapter.

It appears that being known is closely linked to building relationships with staff over time; suggesting that such relationships make a difference by being more familiar and bringing a sense of being at-home into the hospital environment. They reveal a difference being made when staff show an interest in relating together as genuine

people becoming connected to each other's lives in ways that seem to have meaning as human beings.

In conclusion, relating-to appears as those unexpected momentary connections that occur through 'being there', to relieve moments of uncertainty or fear of the unknown in relation to the hospital environment. 'Relating-to' is also 'being known' which is shown as recognising staff as a familiar face and through coming back over time, thus building relationships. Finally, 'Relating-to' appears as 'distractions' showing relating-to through the use of humour and ordinary conversation in moments of uncertainty. All of these expressions of relating-to staff in hospital suggest that such connections increased patients' feeling of security and comfort or at home-ness in the unfamiliarity of the hospital, affirming them as persons in ways that made a difference to their lived experience in the moment.

## **Reflections**

In conclusion Abram's (1997) captures the essence of 'Relating-to' with his statement, "I am subject to moods – entwined in my world in a reciprocal way. I cannot extract myself from this world while I exist in it" (p. 4). Being is about the nature and essence of our existence as human beings and is relational, including notions of being-there, with-other as a person in-the-world. 'Relating-to' shows itself through the temporal and spatial dimensions of reality that points to the idea of a felt space in felt time, potentially able to be discovered by being in it together which connects the past, present and future in relation to momentary encounters in hospital. This encourages a certain attentive awareness to the details of our everyday lives that makes us thoughtfully aware of the significance of the taken-for-granted which become hidden from our view. The temporal dimension of existence becomes altered in hospital, unfamiliar, loaded with uncertainty, the giving of information and making careful explanations is important to how patients' experience time in hospital. Wheeler (2013) stated that "it is the awareness of temporality which establishes that the relationship that human beings have with the world is through concern" (section 2.2.7). In this chapter I have attempted to uncover the nature of such moments of connection revealing different dimensions of 'Relating-to' that appear to make a difference to patients in the hospital world.

*When I am vulnerable*

*I will call to you*

*When you are just there*

*I feel your presence*

*When you relate to me as a person*

*I remember you*

*When you show a genuine interest*

*You form links*

*When you are strong*

*I feel cared for*

*When there is uncertainty*

*Distract me with everyday conversation*

*Let's have a laugh*

*When I am in pain*

*Give me undivided attention*

*Come back*

*Be a familiar face*

*It makes it all bearable*

*I have hope*

## CHAPTER 5: ATTENDING-TO

*Since you cannot do good to all, you are to pay special attention to those who, by the accidents of time, place or circumstances, are brought into closer connection with you.*

(Saint Augustine, p. 39)

The previous chapter showed unexpected connection by relating-to patients' vulnerability through being there with them in ways that made things more bearable. This chapter brings together anecdotes that show the different dimensions of 'Attending-to' patients, through unasked for things or actions that bring a sense of the ordinary or being more at-home into hospital.

The underlying philosophy that guided my thinking about 'Attending-to' through unexpected moments of connection is linked to Heidegger's (as cited Fox, 1996) notion that places we find ourselves not-at-home have the potential to throw us into possibility for our future on a bodily, affective and rational level. It appears that hospitals are associated with an unfamiliar strangeness which can lead to feelings of vulnerability. Such moments can be associated with feeling uncertain regarding the unknown possibilities, things that might or might not happen, suggesting that patients are thrown into possibility when they enter hospital.

Furthermore, Levinas (as cited in Bergo, 2013), sees moments of connection as linked to the intersubjective space that exists when two beings come face to face and share a moment together, a lived instant which transcends self for other where I see him/her as like me, and am called by other to respond to his/her need. This suggests the possibility of attending to moments of care through being in service of other as revealed in memorable moments when patients felt put first. Adding to this, van Manen (1999) identified a pathic dimension linking our existence as human beings with our practices as health care professionals who 'Attend-to' patients. This pathic dimension reveals the possibility of connecting in an unspoken way that includes notions such as intention, intuition and instinct, which can be exhibited by a look, a touch, and the unspoken gestures that show the essence of where the patient or the staff is in that moment. 'Attending-to' how we find our patients through moments of connection reveals discovering their need.

Attending to the language that shaped participants' descriptions of moments that made a difference uncovered words like simple and basic. Everyday words were visibly

present alluding to meaning and guiding interpretation. Connected together they formed descriptions of moments that suggested a showing of existence in parts, where unexpectedness emerged to link with everyday things, ordinary things, in an unfamiliar landscape. Taking time with the *little things* kept appearing in conversation, small and seemingly insignificant, hidden by their everydayness to become visible, as unexpectedly important. The ordinariness of things contained a sense of being more at-home. Drawing our gaze to the little things came to the fore to reveal something about moments of connection where being unasked for emerged as a further aspect of making a difference. Being in hospital somehow overshadowed being someone, suggesting that the quality and nature of how we find self becomes changed. Time passed in different ways brought forward as taken, made, spent and given, flowing through anecdotes describing ways of experiencing being in the moment and alluding to future possibilities.

‘Attended-to’ forms the second theme, where unexpectedness is revealed as unasked for; and appears when health care professionals act in ways that put the patient first by:

- Just knowing what is needed
- The little things
- Ordinariness
- Temporality as life affirming

Participants spoke about little things, often in relation to changes in mood, showing how they mattered to them. The unasked for nature of such actions by staff spoke to a different way of knowing, through a more connected pathic dimension to our practices as care givers which is woven throughout this chapter.

### **Just knowing**

Attending-to appeared as something which seemed like staff had a ‘knowing of what was needed’. This form of knowing is linked to what van Manen (1999) described as pathic practices in health care. Attending-to is associated with the unspoken or intuited moments of care described by Dot as; *she just knew my care and did it*, and Deb suggested; *it’s almost like she read my mind*,. Being attended-to in this way was often described by participants as *going above and beyond or one step further* than expected, and appears throughout this chapter as making a difference.

Marshall et al. (2012) stated that “patients’ see staff who provide care as synonymous with their experiences of that care” (p. 2670), implying that ‘Attending-to’ is revealed as making a difference when associated with moments of care that are memorable. This can be seen in Peg’s description: *I’ll never forget him*, she then goes on to describe another nurse as: *making sure that I had everything that I needed*. Peg’s experience is similar to Dot’s recollection of staff who; *recognised the needs and met them*. The phrase, *took care of everything*, was used often throughout participants’ interviews and contains a sense of wholeness that describes the unitary nature of such cares when staff just seemed to know what was needed. Such descriptions suggest that just knowing is a showing of the pathic dimension of practice experienced within attending-to patients ‘needs’.

A moment of ‘Attending-to’ occurred after Deb’s major abdominal surgery when the ward nurse noticed Deb *crossing her ankles*. Deb describes this nurse’s care as:

*she seemed to know exactly how I was feeling ... [it was] like she read my mind.*

Deb described this apparent *knowing* by her nurse as beyond expectation;

*She (the nurse) just went that step further, crossing ankles was the first one, cause I remember thinking at the time oh I’ll be fine, but it’s almost like she read my mind, then she said look, this is what is happening, and this can happen and you are low risk, however.*

These comments point to a pathic dimension of the nurse’s practice, disclosed through Deb’s comment about thinking she was fine and did not see the point of worrying about crossed ankles. At which point, the nurse seems to intuit Deb’s non verbal body language, facial expression or attitude, appearing to Deb as if she read her mind. The nurse then goes that step further, taking the time to explain the significance of crossed ankles, appearing to accurately perceive Deb in this moment. It appears that pathic awareness was associated with the attending-to nature of this explaining that is slightly different to relating-to, as described in the previous chapter.

In another example Deb described the moment when she was taken outside at night by this same nurse as: *above and beyond the call*, going one step further than expected when Deb suggested it would be: *cool to go outside*, and described the difference it made as: *feeling almost special*. As such, unexpected attending-to appears linked to feeling valued and considered as a unique person, making a difference.

Furthermore, Attending-to patients through a sense of knowing, discloses an awareness of how patients find themselves temporally when in hospital. It could be suggested that how Peg found herself at home in the world had undergone a significant shift in relation to place after spending many weeks in a highly technical ICU filled with machines, monitors and daily routines that were far from her normal rural existence. In this momentary encounter Peg reveals how her nurse ‘just seemed to know’:

*He (nurse) seemed to have a really good idea of how he would feel if he had been there that long ... the nurse down in ICU would turn the bed around a different way ... so I could see the mountain. “I don’t know why you’re lying here with your back to the mountain, look at it, it’s nice outside you’ll be there soon”.*

This encounter discloses the empathic dimension of this nurse’s practice, his connection to Peg was beyond what is seen, heard and felt; an intuitive knowing of how another person might feel if they were in the same situation that appeared to guide his care. Peg made the suggestion that this nurse attended-to her in a different way from other staff by appearing to reconnect her to her own world, affirming her as a person in the present and with a future that existed beyond ICU, making a difference to her.

Moreover, Peg noted that the actions of this nurse brought about the possibility for a change to Peg’s mood associated with her view of the world – figuratively and literally. When he turned her bed around so she could see outside to the mountain, it changed how she felt in that moment. Attending-to changing the physical environment by turning Peg’s bed around becomes a metaphor for turning her around to see things from a different perspective, thereby encouraging Peg to look beyond the present moment to the future. Such a change gives her hope and suggests possibilities for a future when she will return home.

In the next anecdote, Dot experienced an overnight stay in the hospital where she used to work after sustaining a compound fracture to her little finger. Dot described her care from the hospital care assistant (HCA) as:

*She just naturally knew my care and addressed it before I even had to ask, recognised my needs and meet them... without me even having to ask.*

Dot recollected being attended-to through staff just knowing what was needed as unasked for, suggesting that when we engage in pathic practices it may seem like they happen in unspoken ways. Such practices are described by Dot as *natural*, revealing the fundamental nature of such practices, linking attending-to care through engaging in pathic practices to the notion of being aware and sensitive to how we are in the world as human beings. In that moment, the unasked for nature of such actions made a difference to Dot.

In this section, attending-to, is uncovered as a knowing of care that occurs in an unasked for way. This appears to suggest that patients perceive intuitive, pathic practices by staff as making a difference – seemingly beyond expectation. The temporal aspect of attending-to encounters is shown as memorable and associated with hope for the future, as visibly woven through many of the anecdotes. Furthermore attending-to is associated with patients’ descriptions of feeling understood and special as a person; showing how such pathic practices makes things more bearable. Consequently moments which made a difference were revealed in situations where the health professional seemed to just know what was needed and acted in unspoken ways, making a difference.

### **The little things**

‘Attending-to’ has been revealed, thus far, as making a difference through staff who just seemed to know what was needed, described by participants as beyond expectation. This section reveals attending-to *the little things* associated with seemingly simple, small things or actions that participants described as making a difference through feeling comforted, protected and nurtured. Heidegger (cited in Parsons, 2010), posited that existence is an embodied state for human beings and moments of connection are often disclosed through engagement with the practical things that make up our world, *the little things*. The notion of *the little things* suggests they are simple, normal everyday things or actions that, according to our everyday use places them in the background as taken for granted. It is not until this is altered in some way that they become visible and draw our attention. Being in hospital where things are not ordinary links to Heidegger’s notion of being not-at-home and consequently the little things, through their familiarity and everyday nature, become a way of being more at-home in hospital (Boedeker, 2005).

Almost universally, all participants in this study identified moments associated with staff who attended-to the little things as having significance. This was described by Deb in relation to, *normal stuff like you know puffing up the pillows, that sort of thing*; while both Don and Dot mentioned staff *getting pillows right*; and Peg described staff coming back with more *warm blankets*. Additionally, Dot described having her *food prepared* as another example of simple little actions that made a difference in hospital. Attending-to the nature of seemingly small encounters with staff emerged visibly, flowing through the anecdotes as unexpected or unasked for moments that made a difference.

The first anecdote concerned Dot's overnight visit to the public hospital with a compound finger fracture. She stated:

*One of the most, simplest kindest things was the recent one two weeks ago when the Hospital Certified Aide (HCA) who bought my tray to me actually took the time to prepare my food and butter my toast and open everything up. That is the most, simplest thing but that was the most basic care that I needed attending to at the time and it was taken care of without me even having to ask. She just took care of everything and she fluffed my pillows got them right, got me an extra one you know and she was good, you know just all these little things.*

Within this encounter the word *simplest* is often repeated; associated with words like *kindest* and *basic* pointing to the fundamental everyday nature of these actions. To butter toast, fluff pillows, prepare food are things we all do every day in a taken for granted way in our ordinary lifeworld. The fluffing of pillows that Dot describes links to similar moments for Deb who described puffing pillows as a *normal stuff*, and Don having the nurse organise his pillows and propping him up as caring. All of these moments of connection are associated with simple comfort cares that appear basic and everyday; yet link to moments of significance which made a difference for patients. It appears that taking time to perform such basic care carries meaning for patients about caring, kindness and the nature of our shared humanity.

Another anecdote from Dot described an admission for nose surgery in the hospital where she currently works as:

*the most significant one for me was not the biggest, in the days prior this surgery I had a biopsy, I didn't tell my mother because we were waiting on results ... so very few people knew.*

*I spoke with the nurse when I went in and I said, 'now mum doesn't know and I don't want to bring her in' ... the nurse went out of her way to make sure that*

*my needs were met over my mother wanting to be in the room ...so she completely took mum away from the situation. And mum looked at me and I said, 'oh it's just her way don't worry about it' and I thought just put all the blame back on the nurse. And so it was good that the nurse took control of the situation and gave me the privacy I wanted and respect to my mum. It made me feel safe and it gave me reassurance my confidentiality needs were going to get met.*

In the above anecdote Dot clearly states it was *the most significant, not the biggest* encounter that made a difference for her, suggesting that significant moments of connection are often revealed within small momentary encounters which make a difference.

In Dot's anecdote there are two momentary encounters that are related, the first one when Dot was admitted and spoke to the nurse to explain her situation, making the nurse and Dot collaborators as patient and nurse, which speaks to 'Attending-to' relationally within this moment. This simple action had the appearance of allowing Dot, to have some control in this situation without appearing to be in control to her mother.

The second moment links to when her mother wanted to question why she was being asked to leave. Dot seems to place the responsibility [*blame*] on the nurse.

Alternatively, Dot appeared to give permission to the nurse to act for her, linking back to the first moment when the nurse took her mother away. These small encounters had significant meaning, revealed through Dot's description of feeling safe and having her privacy and confidentiality met which led to her having confidence in this nurse as a trustworthy person. This example again reveals that small actions may appear significant and beyond what is expected of staff, making a difference.

Building on the notion of simple things, Peg enlarged on the unexpected nature of such connections when staff took time with simple, little, everyday things. Peg described an encounter with a staff member when she was unwell and waiting for possible surgery in the operating theatre. Such places are often seen as cold or sterile, which patients perceive as unfamiliar and clinical rather than homely or welcoming, especially when waiting alone there. Peg recollected:

*one guy in that theatre department who kept coming out with these beautiful warm blankets and hell they made a difference... they were just amazing, kept coming out with warm blankets. I don't know if you have ever had them, so*

*toasty... he kept coming back and saying to me "how are you going have those blankets got cold yet?" And he'd come back with a warmer one and take that one away, so it made my half hour or so in there, then they decided they wouldn't do it [operation], bearable.*

Attending-to simple comfort was beyond what Peg expected, the warmth of the blankets was in contrast to the environment and she described them as *amazing*. 'Attending-to' through providing warm blankets was a physical insulator, a buffer against the cold of theatre when very unwell. The giving of warm blankets link to an empathic understanding of Peg as a human being who was waiting alone in theatre at an uncertain time, and also appears to acknowledge Peg's suffering. When the nurse repeated the action it appears to have added significance to the original moment, compounding her sense of being cared for and making things *bearable*; revealing a sense of "reuniting the patient with his or her body and thus make life liveable again" (van Manen, 1999, p. 14).

The word *toasty* relates to the everyday notion of warmth, being sustained and nurtured, which suggests a life affirming aspect of attending-to simple little things. The temporal aspect of this encounter is disclosed through the staff member's inquiry showing an interest in the present; while the word 'yet' goes beyond a single moment to linking possibility, suggesting an acknowledgment that moments pass and new ones present as things change over time. Peg described attending-to simple little things as comforting and reassuring, compounded by being repeated over time.

Once Peg had recovered enough to go to the ward she described being attended-to by another nurse, who brought a can of peaches in to her, as another '*little thing*' that seemed small but in reality had significant meaning for Peg, ensuring she felt considered and remembered. Peg noted:

*a nurse who was also very good at making sure that I was being fed ... what I wanted to eat, there must be something that you want. And I know at one stage it was peaches and she stopped on the way to work and bought some peaches in for me.*

In a similar way to Dot, this anecdote links providing food with the fundamental nature of simple, ordinary, every day little things. As someone who was struggling to return to health after a severe illness, the can of peaches symbolised an unasked for gesture that appeared to nurture or sustain Peg, attending-to both physical and psychological dimensions of care. Adding to this the nurse's action of stopping at the shop on the

way to work could be considered as going beyond what is normally expected of staff in hospital; thereby contributing to creating a memorable moment that made a difference.

While the sections above outline unexpected moments of ‘Attending-to’ little things, the following anecdote describes the embodied nature of being in the moment as associated with little things making a difference. Shaun was an acute admission to hospital following a motor sport injury with suspected torn kidney. This encounter occurred when he was in the ward following surgery.

*The worst thing about it would be, cause everyone knows their own body and what it's doing, and when the nurses or doctors are telling you 'no you can't have that' for something like ice or a blanket to cool you down or warm you up, that makes a difference.*

When Shaun comments on how we ‘know’ our own body, the word *everyone* is associated with a universal knowing of self via the embodied nature of existence. Additionally Shaun implies that he ‘knows himself’ and denial of care altered the mood in-the-moment. The significance for Shaun is discovered through the taken for granted nature of little things that are often not attended to until they have changed somehow to show themselves. van Manen (1999) stated that things happen in the background until we bring our attention to them then they come to the fore and are made visible, only when they are out of ordinary do we attend to them.

Within this anecdote Shaun described his denial of care as failing to change things and this appeared to increase his suffering and compound uncertainty for him, throwing Shaun into possibility and reinforcing the notion of being not-at-home through this encounter. It would appear that when fundamental needs are unattended-to they may become an imperative, linking temporally to the notion of the experience of suffering, will it never end or will I survive this? This suggests that when we fail to Attend-to ‘little things’ by missing or denying them, they are brought to the fore, intensified through the lived body to become a focus for the patient that Shaun describes as: *actually kind of getting painful.*

It appears that little things are related to simple, everyday things that are thrown into focus by the hospital setting. When staff attended to these little things in an unasked for or unexpected way, they acquire a meaning and significance for patients that makes

these moments memorable. The little thing is turned into something significant; thus making a difference for patients in hospital.

### **Ordinariness**

Heidegger describes human beings' existence as a unified experience; it is how we connect to the world and the things we use every day, and it is this relation that creates meaning through a sense of being at-home in the world. The data suggests that hospitals throw patients into uncertainty, whereas behaving in an ordinary way or having ordinary things in hospital provides an increased sense of everyday familiarity or being at-home. Attending-to others in an ordinary way in hospital, such as bringing pillows or blankets, seems to make a difference. Ordinariness appears as simple human actions of care that would apply to any human being anywhere, but find meaning in their appearance in relation to care in hospital.

Don, a man with a long history in civil engineering and an active interest in mechanical engineering, was in the medical ward recovering from a heart attack when he described attending-to ordinary everyday actions as having significance to him.

*When you are compelled to “go and have a shower Don” and when you get back your bed is made up these are all minor events in our ordinary life, but, when you are in hospital they become more important and you look forward to them.*

Don described being directed to shower as a normal everyday action; however, the difference is made when he returns and his bed is made up fresh and clean. He considers this *a minor event* but *important* and that it made a difference to him, suggesting that moments that make a difference are revealed within the ordinary things that are like home. It also speaks to anticipation or expectations; he had a knowing of what the nurse was about and looked forward to the change in his environment, to the possibilities of a fresh start to the day.

In this collection of moments Peg described different ways in which staff made things more at-home through being ordinary. The first anecdote is an account of Peg's birthday in ICU:

*I was in intensive care and I'd had a pretty rough time and my doctor came in and he had a bottle of wine and a bunch of flowers. And you are not supposed*

*to have flowers in ICU and yet he carried them in, waved them to the staff, as he came on by and he stood at the end of the bed and Maurice and the girls were there and he said, 'happy birthday' and gave me the bottle of wine and he said, 'drink it, I've checked your meds it's not going to hurt you, have a drink for your birthday'.*

This encounter occurred after Peg had suffered many complications over a long period of time that had completely removed her from her normal, ordinary world to the ICU. This unexpected encounter shows gifting in a way that would be considered normal or ordinary in Peg's family on such an occasion, revealing that her doctor treated her like a normal person. Furthermore, like her ICU nurse, he encouraged her to step outside her current situation and, to behave as she normally would if she was at home. By reassuring her that he had checked her medications and it was safe for her to have a glass of wine, this moment became a gift that had meaning, the familiar ordinariness, making a difference to Peg.

Peg goes on to describe another example of Attending-to:

*a nurse in the ward who was really good, at making sure that I had everything that I needed. The hospital was falling to pieces and the TV aerial plugs had so much sticking plaster on them that you wouldn't believe it and she was always putting new plasters on it making sure I could watch TV, the news and what's happening outside in the world because by that time I had been in hospital for nearly three months.*

In this anecdote the attending-to that made a difference for Peg during her recovery, centred on the nurse repeatedly putting plasters on the aerial so that the TV would work and Peg could watch the news. This action pointed Peg's gaze to the outside world in a similar way to having her bed turned around in ICU. Such actions revealed the nurses' understanding regarding peoples normal at home routines, increasing Peg's sense of being more at home in hospital. Every time the nurse put plaster on the aerial it reinforced or affirmed Peg's sense of being valued and a part of the world, pointing to hopefulness for the future return to her own world.

Furthermore, the notion that the hospital was: *falling to pieces*, suggests a metaphor for how Peg may have found herself after three months in hospital. It may have even seemed hard to believe that she was still there after being near death more than once.

Returning to ordinary everyday routines like watching the news helped to reconnect Peg with herself as an ordinary person rather than a sick patient.

This also raises a question, in a hospital context, about who is responsible for the standard of care? The staff who delivers care to patients obviously, but also the management and systems that are in place to support such care. Health care organisations have a duty to provide suitable environments and equipment to support the delivery of quality health care in a safe environment for patients and staff which impacts directly upon the care experience for patients as seen in this anecdote.

The ordinariness of attending-to was further revealed by Peg's description of another ward nurse who:

*stopped at the shop on the way to work and bought peaches in for me.*

Even though this formed an unexpected little thing as previously mentioned, the ordinariness of this encounter centred on bringing in a treat to show care, as one might for a friend or relative. This was made more visible/memorable to Peg by occurring in a hospital context between a staff member and a patient, adding significance to the action.

There is a tension for staff who 'attend-to' patients in such ways that could be explored further. There are boundaries to what is deemed professionally acceptable in accepting gifts from grateful patients, but what are the limits to what is an acceptable gift of time, money or self that staff might be able to justify in relation to caring for their patients? Additionally highlighting the potential within health care for staff to fall prey to transference or counter transference when so involved with patients, including the importance of attending to our own health as HCPs in clinical practice settings. It is an area that poses serious questions about where the boundaries for care lie and how we might reflect on these: where do we draw the lines, who pays, who funds time and what are the dangers and limits to such behaviours?

The final anecdote in this collection concerns Peg's initial recovery in the orthopaedic ward. Peg described;

*a good friend of mine ended up in ICU, [Peg's ICU nurse] brought her up to the ward to visit; he put her in a wheelchair and brought her up to see me.*

Bringing friends to see one another for a visit is an ordinary behaviour which attends-to a sense of shared community, connecting patients with their own world beyond the

hospital. Seeing a friend in hospital would normally be associated with the aim of making them feel better and catching up, thereby making a difference. This ICU nurse attended-to these two women in such a way that affirmed them as people and changed the mood of the moment allowing for new possibilities through reconnecting for both women which was perceived as beyond what they expected in the hospital context.

In this group of anecdotes attending-to through being ordinary is revealed as important, as a way of locating how to be, and relating to the moment. It is also a way of finding a sense of being more at-home in an unfamiliar environment. Ordinarity stands in contrast to unfamiliar hospital settings, reminding patients of their connections to their own lifeworld and sense of self.

### **Temporality is life affirming**

The notion of temporality - or time as lived - also appears as a key aspect of attending-to. Many participants used the phrase *take the time*, find the time or *made time* to express significant moments of attending-to which made a difference for them in hospital. This once again supports Heidegger's and van Manen's notions of existence as temporal. Temporality was also revealed by participants, suggesting that being attended-to had significance or value.

Time is revealed in two ways in the data. Firstly, as a way of locating experience in the present while linking to the past or possible future experiences. Providing hope for patients in a way that makes the hospital experience bearable as described throughout the anecdotes in this chapter. Secondly, there is an added dimension of being attended-to at night which appears to relate to being alone in the dark and is described by participants, in this section, as significant.

While time as lived relates to where one finds oneself, another aspect of the temporal nature of moments that matter is disclosed through 'Attending-to' at night time. We are reminded by Iszler (1992) that "we forget how frightening the dark can be. The unknown aspects of falling asleep in the dark alone and not waking up" (p. 12). When we think about hospitals it is not unreasonable to suggest that night time is associated with changes to mood and felt sense of time; things just feel different at night. Alternatively darkness is part of the fundamental experience of living in the world and is often linked to night time and associated with the notions of being alone or isolated,

both emotionally and via the senses, further linking to the notion of being ‘unseen’ or hidden from view. If we accept that hospitals are generally unfamiliar places then being in darkness may suggest added difficulty orienting oneself or distancing oneself from the lived body experiences, especially pain. It seems to suggest the possibility that experiences at night add to patients’ throwness or being not-at-home, as increased vulnerability. As such, it is described in several different ways by the participants.

Don described an anecdote concerning an industrial accident that left him lying ‘*broken*’ for some time before he was taken to hospital with multiple injuries and ended up in the ICU.

*When I fell off the building I broke all my ribs from off my spine and I was black and blue from top to bottom and at night time when the night nurse came around, they used to come in and get pillows and prop me up and get me all organised so I could go to sleep, that was important, they fussed around and they knew I was in a damaged condition, and that was very good. I remember the most was waking up in the middle of the night with the nurse coming out of the dark.*

Don recalled a memorable moment when the nurse comes out of the dark, suggesting a lightening of the situation through being connected together within the light. Fussing about him appears as a showing feeling of concern for his *damaged condition*.

‘Attending-to’ such cares at night suggests both physical and emotional comfort, a human connecting to lessen the sense of vulnerability of being alone in the dark. It also suggests that being touched by other in a way that comforts or provides a sense of safety makes a difference and points to possible metaphors for care (maternal, hands) suggested by Gustafsson and Gustafsson (2013) as hidden in patient narratives.

Similarly Deb described an instance of being ‘attended-to’ at night that provided comfort on more than a physical level when her nurse:

*made sure you are alright in the middle of the night... she sort of rearranged all the bed... she helped me.*

Deb’s description of the nurse coming in the night, also suggests a sense of being cared for or nurtured in a way that is reassuring which made a difference (maternal metaphor).

Another aspect of ‘Attending-to’ at night occurred when Deb wanted to go outside her hospital room at night to get some air. In this instance the darkness links the notion of

being unseen with a private space apart, time was taken beyond the hospital space and routines for Deb and her nurse to connect, not only with each other as human beings but also the greater world. This experience could be viewed as a form of time out for both Deb and the nurse that had a personal quality, adding another layer of meaning to this moment that linked to their relationship.

Furthermore, Deb described being attended-to within this encounter as associated with a sense of guilt:

*you always feel a bit guilty, it was nice that someone had the time to take me outside and stay with me until I had had enough.*

The use of *you* in this anecdote suggests that patients have an awareness of nurses as ‘busy people’ and taking time from nurses for personal reasons seemed like a guilty pleasure. This anecdote further suggests that time in hospital has value to patients in relation to attention from staff, or being valued as important in some personal way.

Deb went on to say:

*it was nice that someone had the time to take me outside and stay with me until I had had enough to go back in.*

In this comment Deb identifies two times, the time taken to go outside for some air, an unasked for and unexpected ‘Attending-to’ her needs. And through staying until she was ready to go back inside suggesting the nurse is also ‘Attending-to’ through accompanying Deb in that moment. Yet the moment was all about Deb’s need, she was the person deciding the time frame, the nurse had put her first making a difference. The difference in Deb’s mood after this moment was described as:

*just all relaxing which was what I needed.*

It can be seen that temporality is an important part of the lived experience of hospital suggesting that time has value to patients, locating their experiences and changing patients’ perceptions and mood when attended-to at night. Night time care appears to be comforting in some primal or fundamental way, to represent an unspoken dimension of human connection that is beyond conscious knowing, a shadow in the darkness suggested but not always visible. Attending-to at night suggests comfort, safety and survival that appear as affirming life. A light in the darkness (night) suggests a possible metaphor for hope and survival that makes a difference to patients in the moment.

In conclusion, ‘Attending-to’ appears as unexpected moments of connection through unasked for things and actions that seem beyond expectation, sometimes bringing ordinariness to encounters which make a difference. Taking time to attend-to flowed throughout anecdotes that involved being of service to other, being affirmed as a person and locating their encounters in time, especially at night making a difference to the experience in the moment.

## **Reflection**

Encounters that attend-to patients are revealed as simple practical actions of care that happen in an unasked for way from staff who demonstrate sensitivity to dimensions other than language, showing a pathic knowing as the foundation of such practices that seem like staff just know what to do. Such moments of care suggest that patients are seen as a person or valued as a human being and this appears to make such moments more bearable. Little things matter as seemingly insignificant things or actions that become visible and unexpectedly important when attended to by staff, as illustrated throughout this chapter. Unexpected moments of connection often arise out of ordinary things in an unfamiliar environment, transformed into something that is meaningful to patients. Participants’ related such actions to feeling their care was beyond what was expected, which suggests such care took them beyond where they found themselves in the moment giving them hope and future possibility. Attending-to *everything* appears associated with patients feeling linked in all their multiple parts back to the whole as experienced in a single moment. It is suggested that such moments constitute encounters that are meaningful and memorable for patients, making things bearable and showing a lived or felt dimension of care that relates to the pathic practices in hospital. Finally, such moments show a reflection of the nature of being-in-the-world as in-the-moment and ‘relating-to-others’ which is unitary and non-divisible.

*Take the time*

*Put me first*

*It’s all about the little things*

*Fuss about*

*Read my mind*

*Surprise me with your actions*

*I feel special*

*When I don't have to ask*

*Everything is taken care of*

*When you go above and beyond*

*In the middle of the night*

*I feel like you understand*

*It makes it all bearable*

## CHAPTER 6: DISCUSSION

*Speech is not the only means of understanding between two souls.*

(Kahlil Gibran, 2007, p. 29)

This chapter represents the place of understanding I have reached in order to uncover the lived experience of momentary encounters with hospital staff that made a difference for patients. Talking about experiences in hospital uncovered an unexpectedness related to the ordinary, simple nature of care. Momentary encounters appear to be what patients remember, talked about and describe as touching them in some way. What made the difference for patients in this study was the unity of the moments of connection that were a visible showing of the interconnected nature of existing as human beings in the world of things together.

The previous two chapters revealed the parts of the whole, a way of being with the data, but always open to how meaning emerged intuitively when the time was right. This discussion presents a synthesis, a weaving of the threads that formed the phenomenon, showing the wholeness of moments that mattered. The thesis of my thesis is that moments of unexpected connection makes things bearable in hospital. The temporal nature of moments influences the connections we form and this interconnectedness, which appears throughout the findings, speaks to the importance of the intersubjective nature of existing in the world of things and people. By attending to the ordinariness and smallness of care patients experience moments which make a difference to their hospital experience; a difference which eased suffering and made things bearable.

The findings raised questions regarding what patients actually expect when in hospital and suggested that patients no longer expect to find caring connections as the norm. This may be attributed to a shift of focus in health from caring to science driven practices within hospitals as part of the nature of modern healthcare.

### **The momentary encounter**

Moments are the thing that formed the focus of this study and are defined as encounters associated with meeting face to face with someone or something new, especially unexpectedly or briefly in present time. Berg, Skott, and Danielson (2006)

and Rosan (2012) support the idea of a brief encounter or moment as a foundation for practice. Adding to this Hawley (2011) described moments in nursing as knowing on the spot, in the moment, what to do or how to act, which Cameron (2014) called an ethical moment when HCPs are attuned to the call of those in need. This is further supported by Gustafsson and Gustafsson's (2013) study of meaningful encounters that described coming together across multiple dimensions that formed moments of life changing insight. Notions such as these suggest that unexpected connections, as described in this study, contain the possibility for change in the 'moment' without prior connection between the patient and the care giver and can appear to happen in an instant.

The findings of this study revealed that a single experience may contain multiple moments, echoing Gustafsson and Gustafsson (2013), who stated that caring moments were a "complex phenomenon that has different attributes and dimensions" (p. 370). These were made visible in Peg's description of her relationship with her ICU nurse. In a single experience Peg was related-to through humour, connected to as an authentic person through everyday conversations about family and becoming familiar to this nurse as a person. Such moments also included maintaining connection with the outside world and often coming back with a positive attitude about the future. This nurse linked Peg with her past, the present and a possible future associated with returning to her lifeworld outside ICU through moments occurring simultaneously, suggesting that moments contain the possibility for change across multiple dimensions at once.

### **Moments in time**

It is the notion that encounters can occur in a 'moment' that points to the importance of time within this study. Time is disclosed as embedded within, and shaping 'moments' with staff in hospital that are perceived as making a difference to the structure and mood of such encounters. According to Heidegger and van Manen existence is temporal and we exist in a state of future projection, "things that might or might not happen" (Fox, 1996, para. 5). Therefore felt time and its effects are fluid and changeable from moment to moment as we respond to the people and environment around us. The moments of this study represent small, seemingly insignificant parcels of time and yet this study clearly shows that it is in the smallness that change occurs. It

is in the ordinariness of our connections that we change the present making a difference: suggesting the possibility for change in an instant. The findings of this study support the view put forward by Watson (2002, 2008) and Jackson (2010) that attending to little things supports the notion that humanity is revealed in the smallest acts, and that these have the power to transform the moment. In addition, lived moments have a felt intensity that affects how we find ourselves in hospital and is associated with experiencing moments of pain, uncertainty and facing the unknown.

The findings outline the temporal nature of moments in hospital using phrases such as: *take the time, find the time or made time* to describe unexpected moments of connection which had significant meaning for participants. Within such moments staff were seen as giving time and taking time to be with patients which had the affect of affirming their worth as persons. Furthermore, momentary encounters with present, compassionate staff compensated for the time pressures felt by patients making the difference (Lovgren et al., 2010; Brown & de Graaf, 2013).

Consequently awareness of time constraints led to patients feeling surprised and grateful when nurses took time to treat them as a real person, confirming that such moments make a difference. It appears that time may be value laden in hospital raising questions about a possible dichotomy associated with time as lived in hospitals between busy doing actions of staff for patients (task oriented) and patients' experience of staff taking time with them, affirming personhood.

Furthermore, when we consider that hospital experiences are often associated with fear or hope with regard to something, it follows that patients' expectations are often anticipatory in that they look forward. However, they are also based on their own past lived experiences or looking back, which are contained in the present moment along with all future possibilities. This was described by Deb in relation to her anxiety about anaesthesia because she had a history of bad responses followed by the unexpected amazement when this did not eventuate which changed her perspective in that moment. Such experiences suggest that memories of the past are connected to how patients find themselves in the present. Therefore when attending to the temporal nature of moments, staff who appear to link patients' past to the present and the present to the future, make the difference by locating patients in time.

Lastly, night forms a further dimension of time, when patients describe staff *coming out of the dark* as memorable, making a difference to them in the moment. It appears darkness forms a fundamental part of existence that also speaks to being isolated or hidden from the world. Literature pointed to the experience of pain or sleeplessness at night in hospital, but fewer studies were found dealing with the experience of what it is like to be a patient alone in the dark from a non psychiatric viewpoint. Participants in the current study stated that things ‘are just different in the dark’. Language used suggested being attended-to in the darkness adds another aspect to the moment. As described in the previous chapter, night time is often associated with an added intensity in the lived experience, which appeared relieved by the nurse arriving with a light in the dark. Such encounters form a metaphor for fraternity, comfort and nurturing that instantly changed the moment. The importance of bringing comfort to patients in the dark appears to have particular relevance to how care is delivered at night.

### **Connections**

The importance of connection was visible and central to momentary encounters for participants in this study. Marshall et al. (2012) stated that “connectedness, involvement and attentiveness were prevalent in descriptions of what patients wanted from their care” (p. 2666). The notion of connection in health care is well researched and forms a visible focus that is confirmed by this study. This study supports literature focused on relationship and personal presence as the key aspects of connection (Brill & Kashurba, 2001; Covington, 2005; Ferrel & Coyle, 2008). Moreover, in a similar way to the current study, other authors described connection as ‘being with’ or ‘being-there’ as a whole person (Davis, 2005; Ferrel & Coyle, 2008; Fredriksson, 1999; Rosan, 2012). Making a difference has been shown to be linked to interpersonal interactions, and this study reiterates the importance to patients of creating a shared experience with therapeutic value (Cassell, 2010; Williams & Irurita, 2004).

As a result of such research the intersubjective, integrative nature of connection is of growing awareness within health care, suggesting that we are more than what is felt, seen and heard. We exist in a complex web of interconnections that create the world in which we live. Gilje (1992) stated that presence is establishing a state of ‘Being’ with a

patient: “as the very personal, individual, unique attribute, quality, or spirit which makes one human” (p. 55). This forms the fabric of reality for human beings and shows the power of Being-in-the-moment. Findlay et al. (2010) stated that how staff connected to patients contributed to the formation of healing relationships, linking connection to possibility for change. As such, the findings of this current study would advocate for returning to more care-full practices which value connecting with patients. When we consider moments of connection, Suchman and Matthews (1988) stated that such moments “offer the possibility of access to unifying experience and a sense of discovery and excitement” (p. 125) suggesting that connection can be disclosed in unexpected ways as revealed in the findings of this study.

### **Unexpected connections**

The unplanned nature of some admissions to hospital due to accident, injury, surgery, anaesthesia, drugs and dependence contribute to a sense of dislocation from self, the lived body and from one’s place in the world with others. Holloway et al. (1998) stated that “time in hospital is time that is lost to patients’ everyday lives” (p. 461).

Accordingly, participants’ experience of dislocation within this study were mediated by unexpected moments of connection with staff which made a difference.

In focusing my thinking on momentary encounters, unexpected connection took shape and formed itself as an important meaning. Findings revealed richly descriptive anecdotes about patients’ momentary encounters in hospital that suggested unexpected connection forms the moment and such moments made hospital more bearable. The quality of the different dimensions of moments that mattered were described as:

*going one step further, above and beyond expectation, noticed, wow, amazing, taken the time and unasked for.*

This language suggests it is not the relationship or the care alone, but the unexpectedness that made the difference.

Unexpectedness was shown through the ordinary smallness of care that appeared to change things. Such moments resonated in the everyday, showing that the things participants’ reported as meaningful and significant were basic and fundamental to ordinary life, made visible by an inability to perform them for oneself.

Attending-to ordinary things unexpectedly brought them forward from the background repositioned them visibly for attention as a foundation of care that matters. Something as simple as getting the pillows right to rest comfortably becomes meaningful when staff attended to such things in unasked for ways. The implications are that simple, normal everyday little things may appear insignificant however, almost universally participants' identified moments associated with little things as having significance and making a difference in the moment.

van Manen (1999) stated that "the patient still expects that primarily this is a healing hand, a caring hand which does not only touch the physical body, it also touches the self, the whole embodied person" (p. 15). It would appear that patients just want a person who is there for them and cares enough to attend to the normal small details of living in a way that honours them as collaborators in their own care. It could also be said that in attending to the little things as HCPs, we attend to the person as a whole and put them first which appears unexpected by patients in hospital.

The findings showed unexpectedly seeing a familiar face revealed being known as instantly providing a link to something familiar which reduced uncertainty in that moment and changed the felt experience. Becoming known over time and building relationship affirmed patients as persons, the unexpectedness of such connections appears to suggest that in busy hospitals patients do not expect the continuity of ongoing connection with staff over time. This may link to how patients perceive staff in hospital as too busy to spend time with them (Davis, 2005).

When staff used ordinary everyday conversation to relate-to patients they were perceived as more like 'normal' people (non-clinical). Ordinarity was revealed associated with finding themselves at home in hospital in relation to connection or communication with staff. This appears to suggest that patients often expect communication from staff to include medical terminology that is unfamiliar or beyond their understanding, making normal conversation unexpected and sometimes surprising. The findings of this current study has built on the knowledge of Andersson et al. (2011), Jeffs et al. (2014) and Williams and Irurita (2004); all of whom contend that engaging in conversation led to patients feeling valued. Moreover, participants revealed that staff who were perceived as interested and friendly led to feeling valued as a person, secure and more at home, becoming constitutive of the larger experience of hospital in a way that was unexpected and memorable to them.

## **Unasked for: A pathic dimension**

In addition to unexpectedness, unasked for cares appeared often in the findings. Unasked for care points to an empathic connection, in the moment, where staff perceive patients' need on a level beyond the conscious verbal dimension. Pathic practices resonate within an intersubjective dimension of existence that has been described as simply being in the world with other together (Heidegger, cited in Brandom, 2005), or what Frie (1997) called a "we-dimension" (p. 96). Further to this, Levinas (as cited in Peperzak, 1993) stated that seeing others face to face by becoming aware of their need and responding practically through caring service we may transcend self for other.

van Manen (2007) described 'the pathic dimension' as a form of knowing that includes "embodiment, personal presence, relational perceptiveness, tact ... thoughtfulness" (p. 20). Similarly Gendline (as cited in van Manen, 2007) stated that the understanding we gain from such knowledge is "sensed or felt rather than thought – and it may not even be sensed or felt directly with attention" and as such, pathic knowledge of self and others is a topic for reflection (p. 20). Such moments occurred on a level beyond; in a pathic dimension of reality which suggests that we are mutually influencing and being influenced by our environment in reciprocal ways as whole persons. Participants described such practices as if the staff were:

*reading my mind, just knew what was needed and above and beyond expectation*

as a showing of the unexpected nature of encounters that made a difference.

van Manen, (1999) stated "there is something deeply personal or intersubjective to the pathic relation" (p. 16). The pathic dimension informs practice through intuition, energy fields and consciousness that are part of existing in the world. The pathic dimension is revealed via non verbal ways of knowing that including body language, a glance, expression, posture and with tone of voice. It speaks to a way of being in the world that Patterson and Zderad (as cited in Hawley, 2011) described as "directly and unmistakably... being with him/her with the whole of oneself" (a moment of being present, para. 8). Moreover, Watson (as cited in Hernandez, 2009) described the intersubjective nature of health care as "maintaining human connection and caring ... allowing us to feel our interconnectedness with all there is" (p. 130). The pathic

dimension attends to the art of identifying and responding to one another on an unspoken or sensed level, to what is intuited in the moment. It is the health care worker that is drawn to enter a room to find that the patient is distressed and in need of help. This view supports an integrated view that people are indivisible, whole entities that exist within a web of complex connections to the world and each other, where things can change in an instant. Shaun illustrated the mutual, reciprocal nature of his pathic 'moment' when he and the doctor shared each other's moment of discomfort as a showing of being called through a face to face encounter. In this instant they saw themselves as like each other and responded with humour to transcend the moment. Such moments transcend and are an expression of being a human that is closely associated with the art and practice of healthcare.

In this study significant moments were associated with care that seemed as if 'staff just knew what to do' in unasked for ways. Like unexpectedness, it is revealed as important by the participants. It appears that attending and relating to patients as a person is linked to intuited moments of care based on how we find our patients as whole persons in the moment that makes a difference.

In addition, other authors have used the term empathy to describe qualities relating to pathic practices that includes: cultivating "a willingness to subject one's mind to the patient's world" (Halpern, as cited in Larson & Yao, 2005, p. 1100). This also involves "being sensitive moment-to-moment to the changing felt meanings which flow in this other person" (Rogers, as cited in Larson & Yao, 2005, p.1102). While Rosan (2012) stated that "empathetic presence is given in the form of joining or being with the other" (p. 131). There is considerable overlap in what appears to be meant in relation to pathic, empathic and empathy as qualities that intuit or perceive how patients are in the moment, suggesting there is a similarity of meaning. Such moments disclose a knowing or understanding of how patients find themselves in the moment; as if staff knew what it would feel like to be the patient in that moment. These views support empathy as a quality of pathic practices that was visible within this study including the felt quality of such moments described by participants as *if they knew what it would be like* and *amazing*, where the unexpectedness of such moments had added significance for the patients.

Rosan (2012) stated that practices that involve empathic presence are memorable and being memorable came through this study indicating a lived quality of moments that

matter such as those described by Peg *who will never forget her nurse*. Peg's memory of unexpectedly receiving warm blankets as making things *bearable*, showed how empathic practices lessen uncertainty or suffering in the moment to become memorable to patients.

### **Surviving the suffering**

Why does this all matter? Berglund et al. (2012) stated that hospitals are places where patients find suffering and it is this suffering that throws them so that they are no longer at-home in the world. While I have talked about the unexpectedness of momentary connections that make things bearable, it is patients' encounters with staff when they are suffering in some dimension of their lives that is disclosed as hidden within moments that matter. Arman and Rhensfeldt (2003) defined suffering as hidden within experiences of pain and anxiety associated with a felt intensity and bearability. Levinas (as cited in Peperzak, 1993) stated we are called by others' suffering and it is practices that make things bearable that disclose suffering.

Literature relating to suffering defines it as an individual, subjective, complex lived experience of a whole person (Milton, 2013; Rodges & Cowels, 1997). Additionally Erikson (as cited in Arman & Rhensfeldt, 2003) stated that suffering is an inner experience that threatens existence. Furthermore, Johnston (2013) stated that "suffering involves the loss of acceptable meaning and nourishing connection" and goes on to say that "how we are present to those who suffer makes a significant difference" (p. 230). The literature suggests that suffering may be hidden within hospital encounters and requires HCPs to refocus our attention when relating or attending to our patients, to 'see' our patients with greater vision to discover the possible suffering in the moment.

Johnston (2013) stated that suffering invites "a reason to care" (p. 231), and this promotes a sense of connectedness to others. This idea reinforces the fundamental reason why we 'do' health care, the focus is to be in service of other, to ease suffering, making things more bearable as described by participants throughout their anecdotes. As noted earlier, when things are not attended-to they appear to become more intensely felt, increasing distress and described in this study by Shaun as almost unbearable, that Halldorsdottir and Hamrin (1997) would call a failure of care.

Heidegger (as cited in Fox, 1996) suggested that we move through existence towards one end, death. Therefore it seems plausible to suggest that the notion of survival is linked to possibility of death. To survive is simply being able to 'be', overcoming uncertainty and the unknown to simply exist, such as Peg's description of surviving adversity and still being alive to celebrate her birthday. Celebrating surviving in the moment affirms being, when we share such moments together, they contain hope for future possibilities. Adding to this a transcendental possibility of going beyond the physicality of suffering to finding meaning through a more spiritual dimension of being human noted by several authors (Deal, 2011; Galvin, 2010; Koerner, 2009, 2012; Perez, 2004). They suggest the importance of a more integrative whole person perspective as an important way to finding meaning in suffering and connect with patients.

The temporal quality of moments of suffering has a felt intensity associated with perceptions of surviving the moment that changes when things become bearable. Hawley (2011) stated that nursing includes the ability to "nourish, sustain, and give life, hope, strength and courage in times of despair and suffering" (a moment of reflection, para.2). I wonder if this fact has faded from view, fallen into the background of current health education to become taken for granted with less attention given to its significance? Have we become so at home with biomedical science and its way of knowing that it has overshadowed the foundational humanitarian quality of healthcare? Galvin (2010), in discussing integrative ideas for a caring science, stated that "there is an increasing overemphasis on predictive research as a suitable and complete knowledge base without equal attention to rich descriptive work" (p. 169). This appears to confirm a need for greater understanding which may be uncovered by attending to patients' descriptions of care, through studies like the current one. It seems timely to turn our gaze back to the foundations, to remind ourselves that the art of 'care' within healthcare is related to concern for others; that we exist in this world together.

### **From thrown to home, a reconnection**

The hospital environment, as previously outlined in earlier chapters, is a felt space described as detached and clinical. Such views of hospital as a place for care points to a distinct lack of reference to patients as participants or as a person in these models of

care which is supported by Berg et al. (2006) who stated that “the patient feels strain because of the lack of a personal caring relationship and perceives the health care as being inaccessible” (p. 48).

Cowling (2000), echoed authors such Watson (2002) and Hernandez (2009), adding that the “clinicalization” (p. 16) of the human experience by the health care disciplines is instrumental in denying important facets of human life, and not fully accounting for the essence and wholeness of experience or the unity and uniqueness of human existence. Em’s description of the moment she walked into theatre as: *frightening [and] daunting* seems to disclose a felt sense of alienation, and vulnerability experienced in that moment. Em’s experience shows how patients appear overshadowed by the scientific paradigm and technology as a way of being in hospitals that Heidegger calls being thrown. It appears that hospitals are still places where patients find suffering and vulnerability; described by Heidegger’s notion of being thrown or being not at-home. As such, human beings seek to find meaning through our interactions in the world, looking for a sense of the familiar, a comfortable place where we fit or find ourselves at-home in the world (Fox, 1996).

It appears that unexpected moments of connection occur when one is removed from the familiar and finds oneself in the unfamiliar world of hospital. Practices which reconnect patients with themselves, their past or to staff, create ways of becoming familiar and feeling more at home in the hospital setting. The unexpected ordinariness of care and attending to the little things was described as being important in bringing the familiar into focus and creating a greater sense of being at home making a difference for participants of this study as already discussed. Consequently, the ordinariness revealed within moments that made a difference stands in contrast to the strangeness of hospital, bringing the ordinary into focus for patients as a way of finding themselves at-home.

Hospital is experienced through care patients receive therefore it makes sense to propose that practices that acknowledge our shared existence link us, forming community with our patients and adding another dimension to care, bringing us closer together as persons and making suffering bearable. According to Berglund et al. (2012), suffering creates a vulnerability that needs to be better understood if we are to

change practices to improve patient experiences through conducting studies similar to the current one.

It could be suggested that patients may in fact call staff to respond to them via an intersubjective connection, through facial expressions, a tone of voice, a posture or just their way of being in the moment that is perceived and attended to by staff. Pathic practices guided by curiosity and interest are described by participants with a sense of wonder and surprise, when staff appeared to act like normal people in a simple, unasked for caring fashion. We find a sense of being when we are with others who 'see' us and relate to us as a person, finding the community in being together as human beings. This suggests that at the heart of healthcare are the health care professionals themselves; the soul of health care is the universal love, respect and awareness of life in the moment. What patients want is a shared experience with another human being who is like them. Making it possible to bear the moment allows patients to move forward to the next moment.

In her Theory of Human Caring, Watson (as cited in Hernandez, 2009) noted that caring is necessary for the preservation of humanity. It appears that what matters most is our humanity – being human with other is what makes the difference. It is not about our technical skills or our scientific knowing, these things enhance a more acute and clinical way of seeing our patients. What matters to patients is about using one's skills and knowing as tools to enhance one's capacity to care as a human being – a whole person who responds and finds the wholeness in others even when they are broken in some way, honouring them through being a genuine interested person. Moments of connection are windows of opportunity to go beyond, to explore what is and to go into relationship together to bring ease and find meaning in the moment that is remembered as making the difference.

### **Why does this matter?**

This study shows that what matters to patients is not specific to the hospital, even though this is the context of the moments of this study. It is a showing of the unitary integrative nature of existing in the world as a human being and would require the same response or care wherever it was discovered. For example, it is assumed one would go to the aid of a lost child, a fallen elder or an injured person wherever they were found to give aid and ease their suffering.

Participants have provided a window through which we can see outside the professional role to what it is we bring to practice that made a difference to them as a person in hospital. It is simple. In the end it is ourselves as human beings that we bring, pathically open and in service of other, making connections that allow our patients to feel a sense of being related to as a whole person, not a body part or a process. When we bring the everyday into the technicality of the hospital world, through attending to the ordinary little things, it shows care in ways that created community, locating patients in the moment. Being there as a familiar person, who returns to re-connect makes life bearable and provides a sense of hope and links us through existing in this moment together as human beings. This appears to be what patients want. To be cared for as a human being by another human being that is what matters to them and has the power to change things in the moment. Can our practice reflect attending to moments of connection in different ways? There is the need for further exploration to discover a greater understanding of how patients and HCPs encounter each other in the context of hospital that can build on the existing knowledge.

### **New Understandings**

I am tentative in highlighting new understandings that might be contained in this study as there is literature I may have not discovered in the research. I have based my focus on a Heideggerian interpretive phenomenology which marries well with a MindBody perspective, suggesting being in the world together is a unitary non divisible experience.

I discovered an enriched understanding of the ordinariness of little things in the participants' experience of moments that mattered as unexpected in some way. While the literature suggests that empathy and relationship underpin the notion of connection, the familiar ordinariness of the moment seem to have been somehow missed over the quality of the whole experience. How is it that fundamental care has become overshadowed by the scientific paradigm to become lost to view, fading into the background of our knowing so as to be unexpected by patients?

This study brings forward a patient voice and presence into healthcare, and findings imply that being present in the moment with patients holds potential for connection,

revealing the patient and HCP to each other. The patient is an expert on his/her own life, the nurse on the healthcare system, and by developing curiosity, sensitivity and willingness to engage and participate in relationship we allow for mutual discovery. Further implications include more flexible practices and greater possibility for discovering moments of connection that have meaning for our patients.

### ***Implications for education***

I believe there is value in adding these findings to undergraduate education programmes for health care professionals who will practice in hospital environments. It offers a small insight into what might have meaning to patients, which in turn helps to inform HCPs to better understand the throwness of hospitals and how we might support patients with finding comfort and easing their suffering in hospital.

An understanding of the ordinariness of things described as making a difference in hospitals may inform support staff education in relation to patient contact. It will enable educators to open up questions about how we might approach care or what might be a beneficial way to practice in this environment with the aim to bringing patient and hospital together in a more unified experience.

### ***Implications for practice***

A focus on who we are as persons informs our practice and is formed by our being in the world involved with patients in some way. This study brings to light questions regarding what patients actually want, and it suggests that it is ordinary, everyday connection with staff in hospital as a person who understands healthcare practices.

Drawing on the notion that moments of connection are brief, and often happen unexpectedly, it is suggested that paying attention and developing a sense of openness towards self and other, a pathic awareness of the unspoken when we encounter our patients may change what we see and hear and may change patients' responses to staff. Such behaviour invites staff and patients to the possibility of connection and is life affirming for all.

In my role as senior surgical nurse specialist in PACU, where time is limited and patients face uncertainty it is important to redefine how we think about temporality. The idea that time is needed to form therapeutic relationships needs to be challenged at both practical and educational levels.

A MindBody journey has enriched my practice through enabling me to approach patients in hospital in a different way. This study, informed by these beliefs, is something I believe is worthy of being shared with colleagues and students as a paradigm underpinning care practices. Finding ways to be with patients that honour them as people and allowing for competent practice rests on being open to be surprised. Anecdotal stories continue to be reported in the medical literature as a representation of Somatic Diseases which “has profound implications for understanding physical disease, moving clinical preoccupations from mainly body toward considering mind, body, family, culture, and environment all in the same clinical time/space” (Broom, Booth & Schubert, 2012, p. 17). These authors describe the possibility of linking story and meaning to physical disease, which is re-presented across multiple dimensions including behaviour, body and language.

Developing conversations about the unspoken and existential dimensions associated with how we construct reality needs to be an overt presence in practice. Containing the suggestion that such other ways of knowing appear to cross boundaries opens new directions for integrating practices that make a difference to how we encounter patients in hospital and make a difference to their lived experience in the moment.

Authors such as Galvin (2010), Watson (2002) and van Manen (1999) outlined the art of reflection in practice as a developing area of clinical competence, rather than something left to the realm of philosophers and theorists, as a tool for enhancing care practices. An integrative paradigm of knowing and practicing, challenges systemic power driven practices to include other ways of knowing in managing patient care. HCPs may need to expand their understanding of practice to include reference to the person who is directly experiencing the living of ill health as a participant in or co-creator of their own care, giving voice to patients in health and increasing discussion in the public domain on how patients and the health system might interact in the future. To bring pathic practices from the unspoken realm into the light, allows for discussion regarding the importance of this intersubjective dimension of practice. Many people practice like this, but not enough research or education exists to allow discussion on what other nurses feel, intuit or give voice to in nursing.

### *Implications for research*

What questions still need answering? This study is a beginning not an answering; many questions remain such as what do patients expect of staff in our hospitals? In this study I have focused on representing patients' unexpected connection in the moment, but further research is needed on negative moments, what do they inform us of the phenomena of making a difference in the lived experience of hospital patients? Is there an expectation that hospitals are places where staff and patients share negative moments of connection?

Furthermore, what is the lived experience of hospital staff when they share moments that make a difference to them with patients in hospital? Are the staff experiences of momentary encounters with patients the same? How is this experience felt by staff and how do they link this to the patients they are caring for? Is it different, is it shared or is it something else? Questions arose out of the findings in relation to patients' lived experience of care in the dark/ night, which could be more fully explored.

Patients belong to family and community so questions arise about how families connect to staff in hospital and who else influences such moments? How many people are touched by unexpected moments of connection with staff?

Further questions remain about how other groups of people might find New Zealand hospitals and the staff that practice in them? How do other cultures respond to being in this environment? What are the things that honour them as people and make the experience of momentary encounters with staff memorable and possible life changing? What would their expectations be?

There seems a coherence rather than confusion about the direction this study points to for building our knowledge about the very people we serve as HCPs and without whom the hospital would be but an empty building. Further research is needed on what is not revealed in the text; the importance of a look, a glance, a word, a touch in unexpected instances of connection that remain unspoken and seemingly insignificant but as I have discovered it is the seemingly insignificant which sometimes speaks the loudest. How do we capture this data and find out what it might reveal?

## **Limitations of this study**

Limitations included that which I did not see, people I did not interview, questions I did not ask. My own limits as a person, my experience of participants might have been different, so interpretations changed with each pass and things came and went like shadows in the mist sometimes out of reach the instant they showed themselves and so not included. The hard bit was the interview, how to do this well and obtain data was an area which I improved at over time. There was a restricted geographic and demographic regarding the participants; all of whom live in a small New Zealand city and were largely all European New Zealanders. What other cultures or locations might add to the ideas put forth in this study is unknown.

A methodological limitation was introduced in an article by Paley (2013) that spoke to the misunderstanding of Heidegger by social science and health researchers arguing that interviews as a method are not consistent with Heidegger's view of existence, which is one of doing and everyday actions and tools. He stated that:

Methods more in keeping with Heidegger's philosophy include observation, naturalistic experiments, some forms of discourse analysis and conceptually associated lines of enquiry involving vocabularies of motive, scripts and the performative aspects of language use. (p. 1520)

There may have been other ways to do this study.

A strength of this study was congruence with underpinning philosophies. The inclusion of different age and gender groups within the limited number of participants meant I obtained the greatest variation possible. I got there with the help of supervisors, the moments of insight and 'ah ha' moments when the data talked to me, driving the process instead of me struggling and wrestling with it was an inspirational moment.

## **What Is**

Unexpected moments of connection in hospitals are about who we are, what we do and how we are in the world. My thinking has deepened regarding how I see the question I originally posed. The question was about existence as human beings, meeting together, in hospital and the difference it made. It seems that in existing we are there and present for self and other. How we are, is uncovered as caring, interested, funny, honest, and positive. What we do is linked to everyday conversation, little things, putting them

first, one-step further, above and beyond. The nature of these interactions seems to be everyday, social, together in the hospital world. When patients call to staff who ‘see’ them as like themselves and respond with caring humanity, it suggests that I would care for you as I would be cared for. It is an acknowledgment of our existing in this world together as human beings, in this place where we connect and form community with each other. We enter a space of joined-ness that is human in nature, recognising the qualities in each other that connect us in the moment. If I let what is not fall away and leave what is, it is hope. My description of the hope this study brings forth is:

*Being there with others is about hope.*

*I hope that you will respond to me,*

*I hope that I can be of service in reducing your suffering,*

*I hope that there will be other times we will connect and build a relationship,  
that we will build this together.*

Existence is mine but it is always shared with others and the world that supports my existence, I am never alone but always relating to. I feel, see, hear and sense things that lead me to choose what to do. In this I am influenced by others and by the very environment I am in. It is a non divisible, shared world that I am connected to. I am open to the hope that life is full of possibilities, moments to share with others, connections that build community that are unexpected. Each moment in life is different from the moment before, I am different, I exist in possibility.

*Let what is not fall away*

*And leave what is*

*Who we are matters*

*What we do matters*

*It's all very simple*

*Be*

*Have a care*

*The heart and soul of the matter*

*Is that we exist in this world together*

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## **APPENDIX A: PARTICIPANT INFORMATION SHEET**



### **Project Title: Patients lived experience of moments/encounters with hospital staff that made a difference**

My name is Dennice Keegan, I am a New Zealand Registered Nurse who works at Southern Cross Hospital. I am also currently completing my Masters in Health Sciences degree. I am interested in natural healing and the idea that we are whole people who sometimes become unwell and may need to use hospitals to help return to better health. I believe that we are all responsible for working together to help each other to healthy. I believe that disease comes from many different dimensions of life such as our thoughts, feelings, environment, food and diet and our beliefs about life. I am interested in finding out who makes a difference to patients in hospital in a normal day.

I am seeking the assistance of members of the public to participate in my research by sharing your story identifying moments that made a difference to your experience of being in hospital. I need to talk to you to gain your story on who made a difference to you in your everyday experience of hospital. Your participation is voluntary and you may withdraw from this study at any time. Your story is yours as will be returned to you at the end of the study along with any findings I have identified from all the participants' stories. Your acceptance or refusal to participate is your choice and will have no effects on you good or bad.

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

This research will be part of my Master's Thesis which will be held in the AUT library upon completion. The results of this research will also be shared with health educators and hospital boards to inform them of patient experiences to improve understandings of how patients experience hospitals, and may be published in a professional journal.

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

If you are over 18, have been to hospital for more than 24 hours and experienced a moment when someone made a difference for you, then you can contribute to this study. Most participants have come by referral from personal social networks (friends, family or workmates)

#### **What will happen in this research?**

If you decide to participate in this study you will need to sign a consent form that gives me permission to include you in my study. The research will require a conversation between you and myself that will be at a time and place that you choose and lasting approx 45- 60 minutes. In the interview conversation I will ask you to tell me your story about moments that made a difference to your hospital stay. The interview will be taped, so I can remember exactly what you said, and later typed word for word for analysis. A shorter version of your story will be written by me and I will call or have a short visit to confirm that you agree with my comments on your story is the way you understand it to be.

#### **What are the discomforts and risks?**

There may be some uncomfortable moments as you recall your hospital experience. So we will take the time needed to allow you to tell your story in your own words. And you may not answer a question or you can stop the interview at any time.

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

If you feel that the feelings you remember are distressing it will be my job to encourage you to have support on hand, or to provide you with support to help you deal with these feelings.

### **What are the benefits?**

Benefits to me may include successfully gaining my Masters in Health Science Degree. Possible benefits to you may include, having your story heard, and thus helping to inform better education or health care in hospitals for other people. You may also get a better understanding of what your own hospital experiences meant to you by sharing them with me.

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

Your name and personal data is confidential for the purpose of this study my research advisers and myself will be the only person to hear the tapes and read any written work produced in relation to your story. You will not be identified by name in the written reports other than by initials or a false first name to maintain your privacy.

All material will be stored in secure cupboard/ computer drive that no one else has access to. At the end of the research your story will be returned to you or destroyed as you choose. Data is kept 6 years then destroyed.

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

There is no financial cost to your participation in the research,

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

I will contact you in a week, if you have not contacted me with your decision about participating in this study.

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

If you choose to participate in my study I will need you to fill in the consent form, which is included in this letter, which we will go over and sign this on the day of our interview. If you have any questions about this form you may ring me and I will answer any questions you have.

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

At the end of my study I will provide you with a short outline of the findings of the research along with a poem that will be created from all the stories, and best represents my interpretation of your experience.

### **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, [annette.dickinson@aut.ac.nz](mailto:annette.dickinson@aut.ac.nz) Ph 9 921 9999 extension 7337

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Dr Rosemary Godbold, [rosemary.godbold@aut.ac.nz](mailto:rosemary.godbold@aut.ac.nz) , 921 9999 ext 6902.

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

**Researcher Contact Details:** Dennice Keegan. E-mail [dennice.keegan@aut.ac.nz](mailto:dennice.keegan@aut.ac.nz) phone 0275523495

**Project Supervisor Contact Details:** Annette Dickinson [annette.dickinson@aut.ac.nz](mailto:annette.dickinson@aut.ac.nz), *ph:09* 921 9999  
ext 7337

**Approved by the Auckland University of Technology Ethics Committee on 26 June 2013, AUTEK  
Reference13/146.**

## APPENDIX B: CONSENT FORM

### *Consent Form*

*For use when interviews are involved.*



*Project title:* Patients lived experience of encounters with hospital staff that made a difference

*Project Supervisor:* **Annette Dickinson, Shelain Zambas**

*Researcher:* **Dennice Keegan**

- I have read and understood the information provided about this research project in the Information Sheet dated \_\_\_\_\_.
- 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 26 June 2013  
AUTEK Reference number 13/146***

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

## APPENDIX C: INTERVIEW PROTOCOL

### Interview Protocol

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#### Before the Interview

Select a suitable participant from those recruited.

Contact participant by phone, introduce myself and notify of selection, and ensure they are still happy to proceed with study and inform them of material you are sending and why. Explain the type of interview you are conducting and its nature. Explain the purpose of the interview. Explain who will get access to their answers and how their answers will be analyzed. Tell them how to get in touch with you later if they want to.

Send information sheet to participant via e-mail or letter inviting them to participate in the study which provides an outline of the study, contact numbers for researcher and support persons and a copy of informed consent to be completed before the interview.

Phone or contact the participant to arrange for a suitable time and place for an interview. Venue: Participants home or venue selected by mutual agreement with participant, inclusion of support person for interview if needed. Ask them if they have any questions before you get started. Address terms of confidentiality, handling and storage of data, state clearly that they have the freedom to withdraw at any time. Test the tape recorder before you get started with the real interview.

#### Interview

Arrive on time, with all of your materials organized. Ensure participant has signed consent and ask for permission to record the interview ensuring the participant is comfortable with the taping process. The tape recorder should be placed so that you can operate it easily, ensure the interviewee is comfortable.

The Interview to be conducted as arranged lasting no longer than 60 minutes. Use informal, conversational open-ended questions, allowing interviewees to respond in own time and choose how to answer the question. Ask questions one at a time and maintain a neutral response to answers.

Questions about how patients feel or experience meaningful moments/encounters may include:

- Tell me about the day you were admitted?
- Tell me about someone who made a difference for you when you were in hospital?
- What was that like?
- What was it like for you to be in hospital?
- Tell me about your experience of being in hospital?

#### After Interview

Verify if the tape recorder, if used, worked throughout the interview. Label and index recordings with the interviewee's name, the date.

Write down any observations made during the interview. For example, where did the interview occur and when, was the respondent particularly nervous at any time? Were there any surprises during the interview? Make notes on the interview, also write about how the things you assumed you might hear, before you left, played out. Did things go as you expected? Or were you surprised? Ask yourself about your interview:

Transcribe the interview word for word, transcription should be a faithful record.

Once original transcript is complete, and initial analysis occurred, return data to participants for verification, and further discussion if needed for clarification of data. Within 1 month of interview.

Upon termination of relationship I will return source of data (interview tapes and notes) including consequent copies of transcript to participants along with a copy of the findings.

## APPENDIX D: SAFETY PROTOCOL

### Safety Protocol

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Aim: Is to undertake each interview in the safest manner and avoid danger to participants and researcher.

Goal: To conduct interviews with minimal risk to the researchers, while having a planned response to any threats or dangers in the situation.

Plan for undertaking interviews in private dwellings of participants include:

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The day before the interview notify support person of intended time and place of interview, including participants' name.

I will carry identification to verify who I am to participants and reduce their anxiety.

I will take precautions to minimise risk in interview situations and ensure that help is at hand, staying in public areas of private homes, keep dress, body language and interactions respectful and low key. Maintain safe social distances with participants to avoid cultural offense.

I will monitor participant's level of response to interview process, recognising effects of discussion on respondents, dealing with and containing strong feelings, decisions about withdrawing from interviews if necessary.

Use de-escalation techniques if necessary to exit situations safely.

I will carry my cell phone on my person at all times with fast dial of support person (G Keegan) on my phone. Notify G Keegan on completion of interview.

Support person to call or txt the researcher if not communicated the conclusion of interview.

Support person to contact the participant using information provided if the researcher has not replied within 1 hour of scheduled interview finishing.

## APPENDIX E: AUTECH APPROVAL



A U T E C  
S E C R E T A R I A T

26 June 2013

Annette Dickinson  
Faculty of Health and Environmental Sciences

Dear Annette

Re Ethics Application: **13/146 Patients lived experience of encounters with hospital staff that made a difference.**

Thank you for providing evidence as requested, which satisfies the points raised by the AUT University Ethics Committee (AUTECH).

Your ethics application has been approved for three years until 25 June 2016.

As part of the ethics approval process, you are required to submit the following to AUTECH:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 25 June 2016;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 25 June 2016 or on completion of the project.

It is a condition of approval that AUTECH is notified of any adverse events or if the research does not commence. AUTECH approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTECH grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please 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).

All the very best with your research,

A handwritten signature in black ink, appearing to read 'M. Banda', with a small flourish at the end.

Madeline Banda  
Acting Executive Secretary  
**Auckland University of Technology Ethics Committee**

Cc: Dennice Keegan [thekeegans@clear.net.nz](mailto:thekeegans@clear.net.nz)