PATIENT & PERSON
To Charles and the person you are
CONTENTS

Foreword ................................................................. vii
Preface ........................................................................ ix
Acknowledgment ........................................................... xi
How to use this book ...................................................... xii
Activities ....................................................................... xiii
Author ........................................................................... xiv
Reviewers ..................................................................... xiv

PART 1 Introduction ......................................................... 1
1 Why interpersonal skills? ................................................... 3
2 The patient–nurse relationship .......................................... 25
3 Nurse as therapeutic agent ............................................. 55
4 Considering culture ..................................................... 95

PART 2 The Skills ................................................................ 115
5 Encouraging interaction: listening .................................. 117
6 Building meaning: understanding .................................... 150
7 Collecting information: exploring .................................. 185
8 Intervening: comforting, supporting and enabling ............. 215

PART 3 Skills in Context ...................................................... 245
9 Transitions through health and illness .............................. 247
10 Challenging interpersonal encounters ............................. 276
11 Building a supportive workplace .................................... 298

Appendix ......................................................................... 328
Index ............................................................................. 337
Patient & Person is a ‘must-have’ for any student, practitioner or teacher of nursing or any health-related discipline. Throughout the world, where there have been government inquiries into poor healthcare, the reports inevitably have noted that patient care had been compromised through poor communication, whether between health professionals or between health professionals and their patients and families. Once regarded by some as a ‘feel good’ or ‘touchy-feely’ part of a curriculum, it has become clear now that interpersonal communication is at the heart of safe and effective practice, and is the critical underpinning of quality care. Used well, the nurse–patient interaction is in itself a potent therapy.

This 6th edition of Patient & Person embodies the very best of educational practice. It is research-based, theoretically grounded and always practice- and person-focused. Such an undertaking requires a great and uncommon skill but one that Professor Emerita Jane Stein-Parbury has developed over many years of bridging excellence in both academic and clinical practice. A dedicated mental health nurse, Jane has a deep understanding of the nature and power of good communication.

This edition is constructed in three meaningful sections. The first introduces the reader to the nurse–patient relationship, its evidence base and the importance of understanding oneself in any interaction; the second delves deeply into the development of the skill components of a nurse–patient relationship; and the third takes the reader into the realities of practice, of using these skills in therapeutic ways to help those experiencing loss, vulnerability and the need to cope. This third section builds skills in dealing with difficult encounters and, with great practicality, takes the conversation into the complexity of the healthcare work environment, looking at the skills of building a supportive workplace and developing personal resilience.

The book is infused with the voices of patients and their families through the use of ‘patient stories’. This brings life and relevance to every aspect of the interpersonal skill development. The practical exercises throughout enable reflection on this development and allow the participant to focus on areas in which they need further refinement in their communication. This enables this refinement to occur in a safe and non-threatening environment. The support for students undergoing this learning is enhanced by the extremely useful appendix, which provides detailed ‘tips’ for facilitators.
Foreword

This book is the product of a professional lifetime of dedicated practice and reflection by Jane. I wholeheartedly recommend it to anyone interested in improving their interpersonal interactions for the benefit of patients and their families. My congratulations to Jane and my thanks for this wonderful contribution.

Professor Jill White AM RN, RM, MEd, PhD, MHPol
Faculty of Nursing and Midwifery
University of Sydney
To some readers, the use of the term ‘patient’ in the title of this book may be interpreted as a reinforcement of the ‘sick role’ in which ill people wait passively to be directed as to what to do next. Such an interpretation is in direct contrast to the meaning of the title. The title Patient & Person is intended to mean that patients should be treated as individual people who play an active role in their healthcare. The basic tenet of the book is that patients should be treated as people whose unique experiences are significant to their nursing care.

In addition to updating references and research highlights, this edition of Patient & Person includes changes to structure and content. Chapter 1 has been restructured in order to orient the focus on patient-centred care. While the concept of caring in nursing is still discussed, the historical background as to its development and refinement has been deleted. Reflection and reflective practice has been substantially revised in Chapter 3. The focus of Chapter 4 is now on how healthcare environments and culture are often at odds with people whose cultural beliefs do not match these environments. Thus the emphasis is now on the influence of culture in relation to healthcare quality and safety. The section on empathy in Chapter 6 has been completely revised and includes contemporary neuroscientific research about how empathy develops. In addition, the concept of compassion is also discussed in relation to empathy. Chapter 11 has been substantially revised. There is now an emphasis on the importance of interprofessional communication. There is less focus on the causes of stress in nursing and more emphasis on caring for self, including mindfulness, resilience and self-compassion.

A major challenge in writing a book about interpersonal aspects of nursing is the tension between capturing the complexity of interpersonal connections and presenting concrete guidelines and general rules for beginning nurses. Beginning nurses, like novices in any discipline, rely on guidelines and rules. In presenting rules and guidelines, there is an inherent danger of a ‘cookbook’ approach. Such an approach assumes there is a rational, objective, ‘right’ way for nurses to interact with patients. Recipes such as ‘Combine three open-ended questions with two empathic statements, add one large tablespoon of support and reassurance, then mix well for 10 minutes during an interaction with a patient’ are simple to understand but inadequate in addressing the intricacy of patient–nurse interactions.

In meeting this challenge, I have tried to avoid an oversimplified approach to using interpersonal skills by including a discussion of the contextual variables
that need to be considered. I have done so in the hope that the guidelines and rules presented in this book will not be interpreted as prescriptions or recipes.

Finally, I want to emphasise that I realise that skills are not learnt simply by reading about them in a book. While this book offers guidelines and suggestions for developing interpersonal skills in nursing, the best way to learn them is by interacting with patients. In listening to and understanding patients’ experiences of health and illness, nurses will come to appreciate that their real teachers are the people who happen to be patients.

Jane Stein-Parbury
Sydney, 2017
AUTHOR

Jane Stein-Parbury RN, BSN, MEd (Pittsburgh), PhD (Adelaide)
Emeritus Professor, Faculty of Health, University of Technology Sydney,
New South Wales

REVIEWERS

Sue Dean RN, MA
Lecturer, Faculty of Health, University of Technology Sydney, New South Wales

Diana Jefferies RN, BA, PhD, ACMHN
Lecturer, School of Nursing and Midwifery, Western Sydney University,
New South Wales

Denise McGarry RN, CMHN, GradCertHEd, BA, MPM, MACN, FACMHN
Lecturer, School of Nursing, Midwifery and Paramedicine, Australian Catholic
University, New South Wales

Yvette M Salamon RN, GradCertPeriopNurs, GradCertOnlineEd,
GradDipNursMang, BEd, MPeriopNurs
Lecturer, Adelaide Nursing School, The University of Adelaide, South Australia
The four chapters in Part 1 reinforce each other by pursuing the same intention – to distil the overall significance of interpersonal relationships in nursing, especially in relation to the potential for nurses to realise their therapeutic agency in helping others. Although similar in intent, each chapter realises its aim through different means. The stories in Chapter 1 engage the reader through identification and serve as illustrations that reassert the subject of this book. The stories are reinforced with relevant research that provides evidence about the importance of interpersonal connections between nurses and patients.

Chapter 2 presents theoretical evidence that reinforces the importance of interpersonal communication, which builds and maintains therapeutic relationships between nurses and patients. The evidence is a synthesis of relevant and meaningful research into the nature of basic psychosocial care in nursing and healthcare. Of particular relevance is the variability in each relationship.

Chapter 3 explores nurses’ therapeutic use of self and the development of therapeutic agency through reflective learning that promotes self-understanding and acceptance.

The importance of culture is discussed in Chapter 4, with an emphasis on promoting culturally congruent care in order to address inequities in healthcare. The system of healthcare as a culture itself is considered. The presentation of stories juxtaposed with discussion of research sets a scene that is carried throughout the remaining chapters in this book.
CHAPTER 1

Why interpersonal skills?

CHAPTER OVERVIEW

• Interpersonal communication and relationship building are essential in delivering patient-centred care.
• Patient-centred care involves active patient participation.
• Current healthcare systems need to be reformed in order to become more patient-centred.
• Interpersonal relationships are central to patient-centred care.
• Nurses need to understand the subjective human health experience and come to know the patient as a person.
• Nurses are morally bound to relate to patients in a caring manner.
INTRODUCTION

Throughout the course of their professional lives, nurses interact with a variety of people in a variety of contexts, and for a variety of reasons. During these social interactions they need to be able to effectively communicate with and relate to other people. As such, nursing is a social activity, and nurses need to be socially competent. They must be skilled in the art of interpersonal communication and human relationship building.

There are professional mandates for nurses to communicate competently with patients in order to gather relevant and useful data for clinical assessment (Nursing and Midwifery Board of Australia 2016; Nursing Council of New Zealand 2007). Furthermore, nurses need to relate to patients as more than simply a source of data. Professional codes of conduct (Nursing and Midwifery Board of Australia 2008; Nursing Council of New Zealand 2009) dictate that nurses are capable of relating therapeutically with patients as more than passive recipients of care; that is, engaging the patient through communicating and relating are necessary to professional nursing practice.

The interpersonal skills of communicating and relating described throughout this book are central to developing the social competence nurses need to demonstrate in their professional role. This is especially true in relation to the people nurses call patients. The word ‘patient’ is used purposely throughout this book. This is not done to perpetuate the problems of treating patients as passive recipients of nursing care, but rather to emphasise that patients should be treated as a person. This is based on a humanistic philosophical belief that humans are capable and competent.

The central premise of this book is that human connection, in the form of a patient–nurse relationship, is vital to nursing. Along with technical capability, the capacity to establish human connection is required for clinical competence in nursing practice. The connection is created by the way nurses and patients interact, and every interaction between a nurse and a patient is placed within the overall context of a relationship. For example, listening without judging and responding with understanding help to create a therapeutic relationship that is based on acceptance and respect.

Interpersonal relationships between patients and nurses humanise healthcare because they are the vehicles through which nurses are responsive to patients’ subjective experiences. The relationship meshes the nurse’s compassion and knowledge with the patient’s experience of health events. Through their relationships with patients, nurses express concern, care and commitment. In the absence of interpersonal relationships with nurses, patients can be viewed as objects, clinical conditions or a set of problems to be solved. Nursing care that is offered without a human connection is impoverished. It lacks a caring connection.

The significance of interpersonal skills in nursing practice is sometimes difficult for beginning nurses to fully appreciate. Completing skill-based tasks often comes to the foreground, as technical proficiency is required for clinical competence. Interpersonal contact may seem like something that happens after tasks are
completed. Focusing on interpersonal aspects of nursing does not mean that attention to task-related nursing functions is diminished. In fact, interpersonal contact increases the therapeutic effectiveness of nursing activities. For example, the restful state of feeling reassured by knowing what to expect and through explanations about details of an upcoming procedure benefits patients. Nurses are often in a prime position to establish interpersonal contact in order to provide such explanations. Nursing care involves making contact with the person who is the patient.

**PATIENT-CENTRED CARE**

There are current efforts in healthcare to reform existing systems in order to make care more patient-centred (Constand et al 2014; Kitson et al 2013; Newell & Jordan 2015; Pelletier & Stichler 2013; Sharma et al 2015). Patient-centred care, also referred to as person-centred care, means that care is not only individualised but also that patients are actively involved in decision making. In order to do so, it is essential that patients’ views, desires, needs and values are at the heart of healthcare. Patients value care that is focused on their individual needs and facilitates their involvement in care (Sidani & Fox 2014).

In a recent analysis of existing reviews of patient-centred care, Sharma et al (2015) identified six key components of this type of care: the establishment of a therapeutic relationship; building trust and respect; knowing the patient as a person, as well as families; shared power and decision making; empowering the patient; and effective communication between the patient and healthcare providers, especially in relation to the provision of meaningful information about their health status and treatment. While the authors concluded that there is no universal definition of person-centred care, there was an overriding theme of the importance of establishing relationships built on partnerships.

The focus on patient-centred care has come to the foreground as a result of increasing evidence that healthcare quality and safety can be improved when patients are included as partners in care (Australian Commission on Safety and Quality in Health Care 2011). There are better outcomes and fewer adverse events for patients when they experience care that is emotionally supportive, respectful and understanding of their preferences, is informative and involves them in decisions (Doyle et al 2013). From a patient’s point of view, emotional support and the relief of distress and anxiety is most associated with care quality (Rathert, Williams et al 2012). This indicates that interactional and interpersonal aspects of care are central to the quality of that care (Dierckx de Casterlé 2015). In addition, patients are more satisfied and experience a sense of wellbeing when care is patient-centred (Rathert, Wyrwich et al 2012). In a review of controlled trials investigating the efficacy of person-centred care, it was found that this type of care not only improves patient satisfaction, wellbeing and quality of care but also objective measures such as reduced cost of care and length of hospital stay, as well as physiological improvements (Olsson et al 2013).
Patient participation in healthcare

The central aspect of patient-centred care that is identified in the literature is that patients need to actively participate in their own healthcare. The notion of patients as active participants in healthcare challenges the traditional ‘sick role’ (Parsons 1951/1987) in which patients are expected to be passive, relinquish their responsibilities and follow the advice of healthcare experts. Such a role prevents people from assuming responsibility for their own health and places decision-making authority in the hands of healthcare practitioners because ‘they know best’. As such, the sick role can disempower patients, thus rendering them more vulnerable. Patient participation alters the power balance such that patients are encouraged to engage in partnerships with healthcare practitioners, with increased capacity to act on their own behalf as a result. It shifts the roles of patients from passive participants to active agents and the nurse from provider of care to partner in care. This requires a change in the traditional culture of healthcare that is characterised by authoritarian and paternalistic attitudes (Snyder & Engström 2016).

Patient participation has its roots in the consumer movement, through which people have rights to be informed, be heard and have choice in matters not only pertaining to their own healthcare but also in the re-design of healthcare processes and systems. Having patients participate in their healthcare is both an ethical ideal and a practical reality. From an ethical point of view, all patients should have a say in their care (i.e. having a legitimate voice in care is a recognised patient right). From a practical standpoint, patients who participate in their healthcare are more likely to commit to that care because the care takes into account their particular circumstances. In this regard, health outcomes are more likely to be successful when patients have input into that care.

In the contemporary world of healthcare there is an international movement to increase patient participation that has been sparked by the recognition that patient participation is not only related to patient satisfaction but also increased care quality and safety (Castro et al 2016; Hudon et al 2011; Mavis et al 2015). Lack of patient participation can result in patients being harmed (Andersson, Frank et al 2015). Furthermore, patients believe they can help to prevent errors by being involved and participating in their care (Tobiano et al 2015). The concept of patient participation is fully explored in Chapter 8.

The challenge ahead: reforming healthcare systems

If the interpersonal skills in this book are to be employed to their best advantage in patient care, then existing healthcare systems need to be reformed. Patient-centred care is only possible when nurses and other healthcare professionals not only have a commitment to such care but also operate in a system that is supportive of such care. At present, healthcare systems in the Western world are driven by
RESEARCH HIGHLIGHT Factors that influence the patient–nurse relationship


Background
Forming productive and caring relationships with patients is essential to achieving person-centred care. Nurses need to attend to the development of these relationships through effective and helpful communication that establishes a meaningful interpersonal connection with patients. Research evidence that provides an understanding of the factors influencing this connection helps to enlighten nurses as to what patients expect and how they can approach establishing a productive and caring relationship with patients.

Purpose of the study
The aim of this study was to examine published literature reviews of research related to the factors that influence the development of caring relationships between patients and the nurses who care for them.

Method
This study was termed an ‘umbrella review’ – an overall examination of the body of published literature reviews that provide evidence about the factors that influence the formation of caring relationships between nurses and patients. Twelve previous reviews of both patients’ and nurses’ perspectives were included in this review. Findings from each of these reviews were categorised then synthesised into six groups.

Key findings
The first group that was identified pertained to the expectation of the relationship. Nurses expected that the relationship would involve knowledge about the patient that was both deep and intimate. Both nurses and patients expected there to be trust in the relationship. The next group related to the values that nurses demonstrated, including being interested, kind and friendly, and acting like themselves (as opposed to acting in a role). The third group highlighted the knowledge and clinical competence of nurses, including their availability and accessibility to patients and their ability to support them. The centrality of communication to the building of relationships was the fourth group, underscoring the importance of it being both ordinary and technical. The fifth group was the organisational culture that was influential on the relationship, for better or worse; for example, a task-focused environment negatively impacted on the relationship. Finally, the impact of the relationship on both nurses and patients was reported, with nurses experiencing satisfaction and patients feeling satisfied, comfortable and safe when relating effectively with nurses.

Implications for nursing practice
This extensive review of the literature demonstrates that both nurses and patients value the relationships that form between them. Nurses need to appreciate that patients want to make interpersonal connections and place their trust in nurses. Focusing on tasks, or behaving in a mechanical, impersonal manner, negatively impacts on making these connections. Technical and compassionate care needs to be blended in order for nursing care to be effective in helping patients.
themselves to nurses selectively, and some relationships will progress to deeply moving levels, while others remain therapeutically superficial. Some patients will require direct aid and assistance with managing their lives, while others will need information and advice in order to cope with and problem-solve challenges related to their health. Still others may simply need the supportive and comforting understanding of another human being. Each has a different level of involvement and commitment that is negotiated. The negotiation process is fully described in Chapter 2.

What makes the relationship therapeutic in nursing spans a range of possibilities, and this is why context-free rules cannot be applied. There are many ways that nurses help through their interactions with patients. According to Benner (1984, p. 48), ‘helping [in the nursing context] encompasses transformative changes in meanings, and sometimes simply the courage to be with the patient, offering whatever comfort the situation allows’. This description provides useful guidance in understanding the range of form and purpose patient–nurse relationships can encompass. It reinforces the notion that ‘being with’ a patient, fully present and involved, is helpful in itself.

Consider the following story, told by a nurse.

A Nurse’s Story

Tony, aged five, was hospitalised as a result of serious injuries he sustained in a car accident. He was a passenger in the car driven by his mother, who also sustained injuries and required hospitalisation in a different facility. Although Tony’s mother was in hospital, her injuries were minor. Because Tony’s injuries were to his head and spine, he was initially admitted to the intensive care unit of the hospital but was eventually transferred to a general medical ward. This is when we first met.

Tony’s father remained by his son’s side day and night throughout the entire hospitalisation. He didn’t say much, and most of our interactions were either non-verbal or limited to brief and factual information about Tony’s condition. I noticed that Tony’s father looked increasingly tired and drained as the days went by. The dark circles under his eyes were noticeable. He walked with a slumped posture.

After five days on the ward, Tony’s condition deteriorated, necessitating a transfer back to the intensive care unit. This setback was overwhelming for Tony’s father. I could see it in his face. Initially, I concerned myself with the details of getting the transfer underway. After the transfer was complete, Tony’s father returned to the ward area to collect his son’s belongings. He didn’t look at me and seemed quite distant. I wanted to say something to him in an effort to offer some degree of comfort but knew better than to deliver a trite cliché such as ‘It will be all right’. After all, how was I to know it would be? Instead, I approached him in the hallway as he was about to leave the ward area and told him how sorry I was that his son had to be transferred back to intensive care. I expressed my genuine sympathy for the turn of events that led to the transfer. He didn’t respond but rather looked at me with a vacant stare, as if he was looking
The situations that nurses encounter often create feelings of helplessness within them when the patient’s circumstances cannot be changed. Nurses may fear that because they cannot change the situation, there is nothing else that can be done. When this happens, nurses may avoid interaction and interpersonal contact, or limit contact with patients to those times when physical aspects of care require attention.

This story illustrates how conveying concern and understanding enables nurses to connect with patients and their families. It also demonstrates that the helpless feelings nurses sometimes experience as a result of clinical realities that are devastating and sad do not mean that they are helpless. Such feelings do not mean that nothing more can be done. The clinical reality of Tony’s injuries was not altered, but the emotional pain that Tony’s father was experiencing was shared by this nurse. The fact that nurses do encounter situations of human suffering means they cannot avoid it. Not only must nurses face such realities but also, on a personal and professional level, they need to learn how to make contact with people who are experiencing human pain and suffering. Being with patients in a manner that is wholly human and caring is more than just something that can be done. It may be everything.

The nature of the patient-nurse relationship

Many professions involve the ability to interact with and relate to people. In fact, good interpersonal skills are needed for successful employment across a range
Consider the following story, told by a patient.

**A Patient’s Story**

As I awaited my coronary bypass surgery I was filled with mixed emotions. I was pleased that technological advances in healthcare enabled such surgery to be performed, but at the same time I was worried about the outcome. When the surgeons explained the surgical procedure, they did so with a detail that I appreciated. Everything I wanted to know had been covered, and they answered each of my questions with patience and complete explanations. But I could still see that to them the procedure was routine. They had successfully completed hundreds, even thousands, of these procedures and approached the explanations with a matter-of-fact manner that would be expected with such familiarity. But, to me, the surgery could never be routine.

After they left my hospital room, the nurse who was caring for me that day, Jan, came in to see me. I had come to know and trust Jan during my stay in hospital. She had been present as the surgical team explained what was to happen during the bypass procedure. Jan also had many years of experience in caring for patients who were undergoing coronary bypass surgery.

I had a few more questions that Jan answered with knowledge and detail. She then sat down next to my bed and explained that sometimes patients need more than factual details. Sometimes, she said, they also have fears related to the surgery that cannot be allayed through information alone. She asked me if I had any fears.

Because I knew and trusted Jan, I told her my greatest fear was becoming a cripple, unable to care for myself and function as an independent person. Some of the possible complications that the surgeons reviewed led me to believe that this was a possibility. I was surprised at how freely the words came out, because I am not a person who discusses feelings easily, especially when these feelings are related to my fears. Obviously, I had some fears and Jan’s concern and interest helped me to express them. I told her that I was not afraid of dying, only afraid of living half a life following the surgery.

She understood what I was telling her. She didn’t try to alleviate my fears by offering me statistics about the probability of my becoming a cripple. The surgeons had already presented the statistics. There is not much consolation in knowing that there is a 10 per cent chance of this complication or a five per cent chance of that complication. Although I was somewhat reassured in hearing these facts, how was I to know whether I’d be the 90 per cent or the 10 per cent?

Instead of focusing on further details, Jan just listened to me. And she demonstrated to me that she understood. When my daughter came to visit me that evening I relayed my conversation with Jan to her. I told my daughter how impressed I was with the fact that Jan initiated this discussion with me. Talking about my interaction with Jan provided an opportunity for me to discuss my fears with my daughter, who also listened and understood. Without the trigger from Jan, I’m not sure I would have discussed my feelings with my daughter. My daughter demonstrated the same level of supportive understanding as Jan. We both felt relieved and a bit closer that evening.
Contrast the above story with the following, also told by a patient.

A Patient’s Story

When Therese entered my hospital room that morning I had the feeling the day wasn’t going to be all that pleasant. She had the manner of an army drill sergeant, moving quickly from patient to patient, not asking how our night had been or how we were feeling. She was one of those nurses who was focused on what she was doing as if we, the patients in that room, were superfluous to her mission. Had she bothered to ask, or even notice the expression on my face, she would have realised how awful the previous night had been for me. I had not slept or even rested for that matter. I could not find a comfortable position in bed because the pain in my hip seemed to be getting worse.

My hip had been badly broken in a car accident six days earlier. When the surgeons described how they repaired my hip, it sounded like carpentry work to me. There were metal pins, screws and plates used to repair and strengthen what would now be a weak part of my body. The pain in my hip was excruciating. During the 21 years of my life, I had not experienced anything like it. In fact, I can hardly recall ever being sick.

The nurses in hospital seemed to come in two varieties – the ones who were sympathetic and understanding about my pain, and the ones who treated me like a sook when I complained. Therese seemed like the latter type. She briskly attended to the other patients in the room before coming to me. I had the feeling she was going to make a big deal about having a shower right now. She did. As she approached me she said, ‘Now it’s your turn, young man. Time to get up. Let’s go.’

I tried to be pleasant when I asked her to let me have my shower after morning tea. I explained that the pain medication I had received earlier was starting to take effect and I wanted to relax and rest awhile before getting out of bed. But Therese was not open to any negotiation on the shower time. She told me that I had to get up and get going now. ‘Part of the treatment,’ she said. She offered no explanation about why the shower had to be now, only that now is what she expected. I felt angry and frustrated but knew better than to try to talk her out of her plans for me. She was in control. She did not seem to care about me.

In the first patient story, Jan demonstrated that she understood what her patient was experiencing in relation to his impending surgery. Jan showed that she knew his impending surgery was more than just another statistic or a routine event. He was facing a major event in his life, and she was there to understand what this event might mean to him. She was concerned about the patient as a person. In the second story, Therese failed to take an individual patient’s needs into account. Had Therese listened to this patient and explored his reasons for wanting to delay the shower, she might have understood his request. Instead she alienated him and gave the impression of only caring about what she believed was best.
often bring person knowledge to the foreground. In an outpatient context where patients are being seen for a routine screening test, person knowledge might not be necessary. For example, in a study conducted in an outpatient endoscopy clinic, nurses identified knowing the patient in a practical sense such as their immediate concerns about the procedure they were about to undergo (Bundgaard et al 2012). It is not always desirable or necessary for nurses to enter into the personal and intimate aspects of a patient’s life (i.e. to have person knowledge). Such entry may even be intrusive or coercive. However, knowing how individual patients are responding to their state of health and healthcare (patient knowledge) is essential in all clinical contexts of nursing.

A combination of patient knowledge and person knowledge encompass what is identified in the nursing literature as the concept of ‘knowing the patient’ (Bundgaard et al 2012; Mantzorou & Mastrogiannis 2011; Zolnierek 2014). Broadly speaking, the concept refers to a process whereby nurses are able to treat a patient as an individual person because they know something about them. ‘Knowing the patient’ means that nurses are able to create relationships based on understanding of the patient’s point of view and therefore is central to patient-centred care.

**Caring and the patient-nurse relationship**

Much of what is said and written about the patient–nurse relationship rests on the assumption that the nature of the relationship is helpful – that is, patients are assisted in some way through their interpersonal interactions with nurses. One explanation of the notion of ‘being helpful’ is found in the concept of caring.

Since the time of Nightingale (1859) caring has been characterised as the essence of nursing (Andersson, Willman et al 2015). Understanding the theoretical construct of caring is akin to understanding nursing itself. This raises a number of questions, not the least of which is the meaning of the word ‘caring’ in the context of nursing. Quite simply, caring means ‘it matters’ (Benner & Wrubel 1989).

If a person cares about their car, then what happens to the vehicle matters to them. In the process of caring about the vehicle, they will also care for it (e.g. by keeping it tuned and running smoothly). To understand a person’s care, it is useful to consider why they care (i.e. the motivation to care). The motivation to care may be because the machine is their sole means of transportation, or it may be because the car is a symbol that boosts the owner’s sense of self and identity. Attention to the motivation to care in nursing is important to consider, especially in relation to the need for reflection and self-understanding (see Ch 3). Nurses who care because it helps them to increase their self-concept run the risk of harming others by confusing their own needs with the needs of patients. The self-awareness required to understand this motivation is considered a requisite for caring.

According to Watson (2011), who was one of the first nursing scholars to explore the essence of caring, caring is both instrumental or action-oriented and expressive or feeling-oriented. Instrumental actions include meeting basic needs
and providing physical care, while expressive caring is related to recognising and acknowledging the ‘personhood’ of the patient.

Patients place value on instrumental actions – for example, giving medications on time, notifying medical staff when necessary and explaining what is physically wrong with the patient (Papastavrou et al 2011; Wiechula et al 2016). They consider that nurses’ technical competence indicates that they care.

A Patient’s Story

At 20 years of age, I was shocked when I received a diagnosis of cancer. Cancer was something that happened to old people, not young uni students like me. The diagnosis did provide an explanation for my fatigue and lack of usual enthusiasm for life but was one that I was not at all prepared to hear. The good news was that the medical staff thought that the diagnosis had been made early enough in the progress of the disease for there to be a good likelihood of remission. But getting to remission required a series of chemotherapy treatments that not only made me feel incredibly sick and very tired but that also resulted in losing my hair.

My family and friends were incredibly supportive throughout the whole ordeal. So were the majority of the nursing staff. It was one nurse who really upset me by her lack of caring concern for my welfare.

Donna worked in the chemo clinic, and I had only met her fleetingly on previous visits to the clinic. Having chemo required daily visits during each course of treatment. When Donna approached me that morning in order to prepare the intravenous line that would deliver the medication, I noticed that she looked very tired and not 100 per cent well. I overheard her talking to one of her colleagues about her big night the previous evening, as she relayed having too much to drink with her friends in the pub. She was complaining of feeling hungover but came to work nevertheless. She didn’t say much to me personally, although she kept talking to her colleagues as she prepared the equipment for me.

It was when she tried to insert the needle that I began to get distressed. Her hands were not that steady as she went about her work. She was fumbling with the equipment. She did not seem to know what she was doing, although I had every reason to believe she was usually a competent nurse. Each attempt to insert the needle was creating more pain and anxiety in me. Side effects of the medications were bad enough. Why did I have to suffer because of this nurse’s lack of skill? After three attempts to insert the needle, she called for assistance. My mum and I just looked on in fear. Another nurse came over to the bedside and assisted. Donna laughed about her inability to insert the needle. I didn’t see the humour in the situation.

Donna’s actions that morning indicated to me that she didn’t care. How could she when she did not arrive for work prepared to focus her energy on her patients? I thought to myself that she should have called in sick, rather than expose vulnerable patients to herself that morning. I received my chemo okay that morning but am still angry about Donna’s actions. Her behaviour seemed like a lack of caring, and I was not impressed.

It’s not that I’m a prude; my friends and I enjoy our evenings in the pub. It was that Donna should’ve realised that she had responsibilities to her patients that morning, and she failed to meet them to the best of her capability.
CHAPTER 1  •  Why interpersonal skills?

This story demonstrates that caring involves technical competence; the patient's distress was created by a lack of demonstration of this. But the real reason for the patient's distress in this story was that Donna's technical capacity was compromised that morning by her own state of health and behaviour. In effect, she was not really ‘available’ to patients that day. To this patient, that meant that she did not care.

Caring cannot be understood as compassion and concern while ignoring physical aspects of nursing. This sentiment was expressed well many years ago by Roach (1985, p. 172), who said:

While competence without compassion can be brutal and inhumane, compassion without competence may be no more than meaningless, if not harmful, intrusion into the life of a person or persons needing help.

Interpersonal skills and caring

The material in this book is concerned with the expressive aspect of caring and the interpersonal skills that are needed for this aspect of nursing to be fully realised. Swanson’s (1993) theory of nursing as ‘informed caring’ provides a useful framework for these interpersonal skills. Swanson claimed that caring occurs in every patient–nurse relationship when that nurse is committed to the wellbeing of the patient (Wojnar 2017). She outlined five processes that are involved in this relationship. The patient–nurse relationship is discussed in full in Chapter 2, and each process of Swanson’s theory directly relates to the interpersonal skills outlined in other chapters of this book, as illustrated in Table 1.1.

The first of these processes is a philosophical grounding of nursing in an inherent belief in people. This is enhanced through self-awareness and reflection, which is emphasised in Chapter 3. Once ‘grounded’ in this philosophical stance, nurses ‘anchor’ their caring through striving to know patients and understand the meaning that they attach to health events, the second process. This is achieved by

<table>
<thead>
<tr>
<th>TABLE 1.1 Processes of informed caring and related interpersonal skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROCESSES OF INFORMED CARING (SWANSON 1993)</td>
</tr>
<tr>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Maintaining belief in people</td>
</tr>
<tr>
<td>Appreciating personal meanings of health events</td>
</tr>
<tr>
<td>Being with patients</td>
</tr>
<tr>
<td>Doing for patients</td>
</tr>
<tr>
<td>Enabling patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maintaining belief in people</th>
<th>Self-understanding</th>
<th>Chapter 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appreciating personal meanings of health events</td>
<td>Understanding</td>
<td>Chapter 6</td>
</tr>
<tr>
<td>Being with patients</td>
<td>Attending and listening</td>
<td>Chapter 5</td>
</tr>
<tr>
<td>Doing for patients</td>
<td>Comforting and supporting</td>
<td>Chapter 8</td>
</tr>
<tr>
<td>Enabling patients</td>
<td>Encouraging participation by sharing information and challenging</td>
<td></td>
</tr>
</tbody>
</table>

The above table shows the processes of informed caring and related interpersonal skills, along with the relevant chapters where these processes are discussed. This table helps in understanding the connection between the theoretical framework and practical application of interpersonal skills in nursing.
‘knowing the patient’, introduced in this chapter and fully explored in Chapter 2, and is brought to life through the interpersonal skills of understanding and exploring in Chapters 6 and 7. The third process in the theory of informed caring is enacted by nurses when they are fully present and available to patients through attending and listening. Referred to by Swanson (1993) as ‘being with’ patients, this process is reviewed in Chapter 5 in the form of attending and listening skills.

Once they are ‘with’ patients and understand their situation, nurses express their caring through actions that pertain to the final two processes in Swanson’s theory, termed ‘doing for’ patients and ‘enabling’ patients to do for themselves. Although the process of ‘doing for’ is predominantly expressed through physical care and skilled clinical performance of nursing care, ‘doing for’ also includes comforting measures that are achieved through interacting with and relating to patients. Comforting measures and supporting actions are discussed in Chapter 8. Swanson’s process of ‘enabling’ includes having patients participate in their healthcare. Such participation, introduced in this chapter, is contingent on patients’ knowledge and understanding of their health status and care. The interpersonal skills needed to inform and assist patients in obtaining this knowledge are also reviewed in Chapter 8.

Although not rigid in the sense that the processes are passed through as stages and phases, there is a sequential aspect to them. For example, ‘doing for’ requires nurses to understand what must be done (i.e. to understand a patient’s frame of reference before attempting to provide psychosocial help).

**Practical know-how in relating to patients**

The skills described throughout this book are designed to enable nurses to develop practical know-how in relating to patients. While it is important for nurses to know that it is important to communicate with patients, they also must know how to do so. The theory of how to relate serves little purpose in the absence of interpersonal skills that promote therapeutic relationships. The skills are techniques that will enable the type of relationships that have been described in this chapter as ‘helpful’ and ‘caring’ to develop.

The techniques are presented in a ‘micro-skills’ manner, meaning they are broken down into component parts. Learning the techniques is supported by experiential activities interspersed throughout the text. This style of presentation has been influenced by writers in the counselling field such as Egan (2014) and Ivey and Ivey (2010). Describing skills in this way runs the risk of it appearing that they can be applied mechanistically. However, the skills cannot be used in such a prescriptive manner.

There are no context-free rules about interacting with patients. Nurses must consider a host of variables when they make contact with patients. Sometimes a discussion about feelings is suitable to the context, while at other times such discussions are inappropriate. Throughout this book, guidelines and theory about how to establish interpersonal contact with patients are presented. However, each interaction, like each patient and each nurse, will be unique and dynamic in its own right.
SUMMARY

Taking the time and expending the effort to understand the world as the patient experiences it results in nursing care that integrates the patient’s experiences. The most effective way to review the material that has been presented in this chapter is through the following nurse’s story, which illustrates the art and science of nursing relationships. It was told by an experienced nurse who was recollecting her time as a student of nursing.

A Nurse’s Story

I was in my second undergraduate year at university when I met Margaret. We met during my clinical placement at a large public healthcare facility that was established to provide rehabilitation services for people with a disability or who were chronically ill. There were more than a thousand patients in this facility, and the sheer mass of this humanity hit me like a tonne of bricks on the first day. We were taken on a grand tour of the entire facility on that day and told that the average age of the residents was 72. It was ‘so young’, we were told, because there were a few patients in their 30s and 40s who were suffering from progressive conditions such as multiple sclerosis. To me the place looked like an enormous nursing home.

Although I had an overview of all patients who lived in this facility, I only came to recognise the 50 who lived in the ward to which I was assigned, and one of these patients became well known to me.

Margaret caught my attention on that first day I was on the ward. She was a frail-looking lady who sat in a wheelchair the entire day, being transported from bed to dining table and back to bed at various times during the day. Margaret captured my attention because she kept repeating the same phrase over and over again. ‘Why am I being chastised?’ she kept saying. The word ‘chastise’ struck me as quaint and curious, as if it was a relic from a bygone era. I had to look in a dictionary to find its meaning. Once I discovered the meaning of the word, I became intrigued by Margaret’s thought that she was being punished. ‘Punished for what?’ I thought. What is making Margaret feel she is being punished? I thought to myself that being a permanent resident of this facility could be perceived as punishment, but there was more than this in Margaret’s experience.

I set out to learn more about Margaret. It didn’t take long for me to get to know her. The fact that I was willing to sit and listen to her was sufficient to establish a rapport. During the two days a week I spent on the ward, I sat next to her and listened, mostly to her thoughts about being punished. For what, I still did not know. I accepted her feelings, although in the back of my mind there were nagging thoughts about the reason for them.

Whenever we talked, I couldn’t get past her expression of the feeling that she was being chastised, so I went to the records to learn more about her. There I saw the words
‘legally blind’ and ‘nearly deaf’. I began to wonder how much sensory input Margaret was receiving and how much this was contributing to her feelings. I located material in my textbooks that described the possible effects of reduced sensory input (in Margaret’s case, near blindness and near deafness). I learnt that one of these effects is suspicious feelings.

I also discussed Margaret with the regular staff working in the ward. They told me that Margaret was a ‘bit crazy’ and ‘definitely paranoid’. Because I thought there was more to Margaret than her suspicion, labelling her as paranoid didn’t satisfy me. Although the label of ‘paranoid’ seemed insufficient to me, I could see how easily such a label could dismiss Margaret’s reality. I still wanted to learn more about Margaret and only she could help me to do so. Week after week I came to Margaret, sat next to her, expressed my interest in her and then just listened.

Eventually, Margaret began to share with me more than just her feelings of being punished. We talked about her family and discussed other things. I learnt more about Margaret, beyond her paranoia. I think me just being there – showing interest in her and listening to her – was enough to enable her to open up and share her thoughts. As I listened to Margaret’s story, I began to piece together bits of what she said.

She mentioned that when she entered the facility her handbag had been taken away and put into a room somewhere. She often spoke of the handbag and the room where it was held. I began to realise that the handbag was significant. I asked, ‘What’s in the handbag?’ She told me it contained a card that had her nephew’s address written on it. Her nephew, who lived in the next state, was her only living relative. Margaret’s husband had died and so had all her brothers and sisters. She had no children. Her nephew was her only link with her family and she didn’t have his address! Margaret wanted desperately to write to this nephew but couldn’t.

Through my perseverance and with the aid of my clinical instructor, I located the room that held Margaret’s possessions. They had been taken from her when she was admitted and placed for ‘safe keeping’ in this room. Fortunately, I was able to retrieve the handbag and, sure enough, inside was a card from her nephew that was sent to her shortly before Margaret entered the facility. Margaret was ecstatic about the find. With it came the possibility of re-establishing contact with her family. I penned Margaret’s words to her nephew and made sure the letter was posted to him. Margaret seemed to settle after this, although she continued to complain about being punished and I continued to wonder why this feeling persisted.

While the contact with her nephew had helped to calm Margaret, she remained quite anxious about being in this facility. So I kept listening. One day she mentioned that sitting near the window hurt her eyes. Her diminishing eyesight was the result of cataracts and the bright summer sun through the window created discomfort for her. Each day after lunch she was wheeled to the window to ‘enjoy the sunshine’. But instead of enjoying this afternoon ritual, Margaret found the experience quite uncomfortable. Could this be perceived by Margaret as punishment? I explored my hunch with Margaret, directing my questions towards the subject of her daily seating near the window. She confirmed my hunch. In Margaret’s mind, the afternoon ritual of being placed in the sun was equivalent to a daily punishment. For what reason, she was not certain. But in her mind...
she thought it was because she had done something wrong and this was punishment for the transgression. With this revelation came my understanding of Margaret’s reality. Her feelings of being punished made more sense to me.

My next plan of action was to try to get the other staff on the ward to appreciate Margaret's experience. I spoke with the nursing staff and they realised what was happening to her. They agreed that placing her in direct contact with the sunshine was counterproductive to what was intended by the move. Placing her near the sun, but not in its direct path, would still help her. No longer would Margaret be placed in the direct sunlight.

When it came close to the time that I would be leaving the placement, I could hardly contain my feelings of sadness. Saying goodbye to Margaret was going to be difficult for me. When the time finally came to do so, Margaret reached into her ‘newly found’ handbag, pulled out an embroidered handkerchief and placed it in my hand. ‘Here,’ she said, ‘this is for you.’ In the back of my mind I recalled the warnings I had heard about accepting gifts from patients. I ignored the warnings, placed the handkerchief in the pocket of my uniform and thanked Margaret. We had shared a special understanding and the handkerchief became a symbol of this understanding. I cherished this gift because it served as a reminder of the importance of being interested in patients, listening to and accepting their reality and, most importantly, understanding their experiences.

The nurse in this story demonstrated concern and compassion for Margaret. In addition, she came to know Margaret as a case, a patient and a person. She used understanding that generated from case knowledge when she connected Margaret’s feelings with her sensory deprivation through loss of vision. She had learnt in her studies that derogatory labels such as ‘paranoid’ could lead to nurses rejecting and ignoring patients. This is an example of patient knowledge because Margaret’s behaviour is viewed in the social context of healthcare organisations. She came also to know the person who was Margaret. Through understanding that contact with her family mattered to Margaret, this nurse came to know something of Margaret’s life value system.

Her relationship with Margaret enabled this nurse to feel the sadness that Margaret was experiencing in relation to the loss of contact with her family. She also felt empathic understanding of Margaret’s feeling of being punished. She then went one step further and functioned, with the aid of her clinical supervisor, as a useful resource for Margaret in locating her family contact details.

In this final sense they both functioned as advocates for Margaret by working through an organisational system that disabled Margaret from contacting her relatives. Although still a student, this nurse functioned with professional autonomy and responsibility because she had come to know the person who is the patient. And she made a difference as a result.