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The Meaning of Patient-Nurse Interaction for Older Hospitalized Women: A Phenomenological Study

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THE MEANING OF PATIENT–NURSE INTERACTION
FOR OLDER HOSPITALIZED WOMEN:
A PHENOMENOLOGICAL STUDY

by
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ABSTRACT

The purpose of this dissertation is to explore how older women perceived their interactions with nurses after receiving care in a hospital setting. Older women are a vulnerable population subject to being overlooked or misunderstood by the nurses caring for them, hence the importance of this study. To gather the data on older women’s lived world of nursing care, I used a phenomenological approach based on a hermeneutic framework that considers linguistic, historical, and social factors to interpret older women’s lived world of nursing care while hospitalized. I personally interviewed seven women between the ages of 66 and 81 after their hospitalizations, and then analyzed the data by means of a theoretical lens derived from critical feminism and adapted to gerontology. I discovered that what the participants found most meaningful was being cared for by nurses who embraced the primacy of caring in such a complete way as to be life giving for them. All seven valued the morally grounded feminine ideal of caring that was exemplified by some of their nurses. They experienced feelings of being in control and of being powerless while interacting with their nurses. When the participants felt in control, their interactions with their nurses were characterized by mutuality, respect, and balanced relational energy. When they felt powerless, their interactions were characterized by lack of voice and agency, and by an imbalanced relational energy. This feeling of powerlessness challenged their sense of personhood. Meaningful, direct interactions with their nurses helped the participants successfully negotiate their terms of care. However, all seven women found that they could not predict when these meaningful interactions would occur. The main implication of this study is the need for further research into 1) ways of increasing nurses’ awareness of what it means to be an older hospitalized woman, and 2) nursing education endeavors that target relational work of nurses with their older generation patients.
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Chapter 1

Introduction

As I sat by the bedside of my own ailing eighty-three year old mother during multiple hospitalizations toward the end of her life, I witnessed the full range in quality of patient-nurse interactions. Some were extraordinarily caring and sensitive. However, in my 30 years as a practicing nurse, I have also witnessed nurses ignoring the assertions of older patients, because they assume that the elderly cannot possibly know best about their own care. As a nurse educator, I have also witnessed ingrained insensitivity and dismissiveness toward older patients on the part of my colleagues. In the course of these observations, I have always been struck by the potential vulnerability of the elderly in their dealings with the health care system.

Older adults will make up an increasing proportion of the population in the future (Vincent & Velkoff, 2010), and if vulnerability accompanies aging, then nurses will be caring for a growing number of vulnerable people. Since women tend to live longer than men, they are more apt to experience chronic disabling conditions (Vincent & Velkoff, 2010; Bamford & Walker, 2012). Hence, older women will more likely spend longer periods interacting with nurses while hospitalized than elderly men. Nurses must therefore understand the meaning of patient-nurse interaction from the perspective of older hospitalized women, if they expect to provide quality care. With this in mind, I have conducted research to clarify the meaning of patient-nurse interaction for older women who have been hospitalized.

Effective and respectful communication is essential to the provision of quality nursing care (Boykins, 2014; Cronenwett et al., 2007) and so professional nurses must attend, listen, and be present to their patients as a means of honoring their values, needs and preferences is a part of a professional nurse’s role (Schuster & Nykolyn, 2010). Unfortunately, patients and nurses do
not always communicate effectively in hospital settings (Jacelon, 2002; Ryan, Anas, & Friedman, 2006; Izumi, Baggs, & Knafl, 2010). Without knowing a patient’s perception of need, cultural preferences, or personal values associated with health and illness, faulty assumptions may lead to inappropriate nursing care.

Moreover, older patients will likely encounter obstacles to communicating their needs, preferences, or values (Larsson, Sahlsten, Segesten, & Plos, 2011). Such obstacles may take the form of ageism, sexism, and negative stereotyping – all of which are ingrained in American culture (Lorber & Moore, 2002; Palmore, 2005). In healthcare settings, older patients may have to contend with paternalism, i.e. an imbalance of power in which healthcare workers are the experts and patients are not (Larsson et al., 2011). Added to these are the stress associated with hospitalization and the anxiety associated with illness (Izumi et al., 2010). Hearing loss or a speech deficit on the part of the patient may also inhibit communication (Schuster & Nykolyn, 2010). In light of these potential barriers, older women can be particularly vulnerable to compromised nursing care especially given the hospital cultural norms under which they might communicate need (Institute of Medicine, 2008; Street, 2002).

To make matters worse, failure to communicate effectively is the principal reason for medical errors in hospital settings (Cronenwett et al., 2007; Institute of Medicine, 1999). Hence, small insensitivities such as ignoring, talking over the heads of, or patronizing older patients may lead to harmful oversights (Larsson et al., 2011; Schuster & Nykolyn, 2010; Ryan et al., 2000).

Furthermore, health care workers tend to communicate differently to patients of different sexes; they tend to be dismissive of women because women are less likely to be assertive (Lorber & Moore, 2002; Street, 2002). For example, a woman complaining of vague symptoms may actually be suffering a heart attack, yet a health care worker may attribute her symptoms to
anxiety (Lorber & Moore, 2002). Thus the nurse’s failure to listen, attend and be present during the interaction could lead to an incorrect diagnosis.

Biomedical narratives tend to equate aging with disease and decline (Calasanti & Slevin, 2001; Phelan, 2010; Twigg, 2004). This tendency, along with the necessary focus of hospital care on illness and disability, can cause nurses to objectify their patients. For example, a healthcare worker may say to a colleague, “Take a look at the fractured hip in bed two.” This form of communication, often referred to as “biomedicalization” (Freixas, Luque, & Reina, 2012, p. 45), comes at the expense of affective and social narratives that contribute to the meaning of everyday health for older adults (Roberto & McCann, 2010). The actual meaning of a fractured hip for this patient has implications far beyond the physical break. Upon return to home after a fractured hip repair, everyday health includes worry about being a burden to family members and regaining the their ability to drive. So when a nurses focus primarily on biomedical aspects, they may fail to address some of their patient’s needs and preferences (Calasanti & Slevin, 2001).

Nurses must also bear in mind that aging is both a physical experience and a deeply social experience and that the identity of older adults is heavily dependent on social interaction. (Phelan, 2010; Twigg, 2004). For this study, the social environment under examination for patient-nurse interactions was across a variety of hospital settings and steeped in paternalism, ageism, gender biases, and “biomedicalization” (Freixas, et al., 2012, p. 45) that I have mentioned above. It was also characterized by “gerontophobia” (Freixas et al., 2012, p. 55) i.e., the fear of looking old or being old which permeates American society. In such an environment older patients run the risk of being stigmatized, or of being treated differently or distantly, especially when their nurse caregivers harbor a personal fear of getting old (Phelan, 2010). Do gerontophobia and other widespread negative responses to aging, affect patient-nurse
interactions? If so, do patients feel more vulnerable as a result? These are important questions for nurses to ask as they encounter greater numbers of older generation patients (Institute of Medicine, 2011). Nurses who develop a deeper understanding of what it truly means to be old, female, and hospitalized can not only reduce such patients’ potential vulnerabilities but also contribute to their overall wellbeing.

Statement of the Problem and Research Question

Older women who have been hospitalized are vulnerable in the sense that they are subject to being overlooked or misunderstood by the nurses caring for them. This study explores how older women perceived their interactions with nurses after receiving care in a hospital setting. More specifically, it seeks to answer the question *What are the feelings, experiences, and expressions of older female patients about their interactions with nurses while hospitalized?* To gather data I used a phenomenological approach, involving personal interviews, to document older female patients’ experiences of interacting with their nurse caregivers. I hope that my research will shed light on the feelings, experiences, and expressions of older female patients and thereby enable nurses to gain greater sensitivity to and a broader understanding of the care needs of older women.

Description of the Study

A phenomenological approach to research is appropriate used for this study in order to illuminate the meaning of patient-nurse interactions for older women who have been hospitalized. The work of Kvale and Brinkmann (2009) informs the overall qualitative methodology I have chosen for this study, which includes sampling strategies, data collection, and analytical procedures. The data was collected through personal interviews with older women after a hospitalization experience. I chose a hermeneutic framework to help me interpret the
linguistic, historical, cultural, and social factors found in conversational transcripts across 8 to 12 participant interviews. The purpose was to find common meanings in the narrative texts about older female patients’ feelings, experiences, and expressions while hospitalized. Finally, I have chosen to use a theoretical lens of critical feminism specific to gerontology because of the socially constructed stereotypes and cultural norms that shape the lives of older women (Freixas et al., 2012). This theoretical lens along with my own personal lens as a gerontological nurse was useful in helping me interpret interview data not only for what women share, but in discerning how their narratives fit into and are informed by larger societal structures and patterns.

**Key Terms**

I have defined below several key terms generated primarily from the text of both the problem statement and research question. In so doing, I hope to avoid ambiguity, eliminate any misunderstanding that might otherwise arise in my presentation of the findings, and thereby increase the validity of the findings.

1. *Expressions.* Body language, facial movements, or sudden changes in demeanor on the part of the interviewees. The subjects’ expressions as they recounted their experiences either illuminated their narratives by providing emotional color or, when the affect expressed seemed incongruent with what was said, called them into question.

2. *Hospitalization.* Acute hospital stay or multiple stays for more than a 24-hour period and within 12 months of the interview. Hospitalization experiences also include time spent in the emergency department, same day surgery, outpatient clinic, or an extended care facility for rehabilitation where interactions with nurses also occur.
3. **Interaction.** Effective verbal communication and/or non-verbal communication (including touch) between individuals that is characterized by openness and respect.

4. **Meaning.** Derived through relationships and connectedness, it includes a search for a sense of coherence and is important for wellbeing (Haugan, 2013).

5. **Nurse/Nurse caregiver.** The holder of the professional credential of registered nurse from either a two-year or a four-year nursing program.

6. **Older women or older female patient.** Patients who were at least 65 years of age.

7. **Vulnerable population.** A social group (in this case older women) that is at greater risk for particular adverse occurrences than the population in general (Bamford & Walker, 2012).

**Limitations and Delimitations**

The limitations of this study are the same as those of any phenomenologically-based research design that uses retrospective interviews as a means of data collection: I have used a small purposive sample of older women, and so the findings cannot be generalized to a larger population. Moreover, descriptions that comprise the lived experiences of hospitalized older women and their interactions with nurses are particular only to the context of this study and its sample population. Finally, the participants’ ability to recall events sufficiently is an inherent limitation of retrospective interviewing.

A delimitation of this study is my decision to interview only women. I have done so because women are likely to live longer than men and are thus more likely to live with illness, disability, and potential hospitalization. Another delimitation is the timing of the interviews with respect to hospitalization. Hospitalization is usually a pivotal experience that generates indelible memories about particular incidents. However, even a one-year gap between event and interview
can adversely affect recall in some instances. Nevertheless, because phenomenology is concerned with the patient’s perception of the meaning of a given interaction, the exact recall of the actual event is a secondary concern of this study.

A final delimiting factor is the decision to interview older women openly, without any type of mental status screening. I have relied on the word of the referring person in determining whether a potential participant would be able to recount her experience coherently. I gathered a sense of the conversational capabilities of potential participants during the initial phone call to set up the first interview. In any event, the phenomenological approach presupposes that the interpretation of the interviewee, regardless of her mental status, determines the meaning of a relationship (Benner, 1995).

**Conclusion**

Some research has been done on nurses’ understandings of their interactions with patients (Slatore et al., 2012). Yet few studies have described the meaning of such interactions from the patients’ perspective, and almost none have considered their meaning for older hospitalized women (Izumi, et al, 2010; Larsson et al., 2011). Until nurses understand the meaning of patient-nurse interactions from the perspective of older women, this population will remain vulnerable to being misunderstood while hospitalized. If both parties cannot communicate effectively their needs, preferences, and values, nurses may make either inappropriate interventions, or no interventions at all. This apparent knowledge gap is therefore worth exploring.
Chapter 2
Review of the Literature

In this study I have sought to clarify the meaning of patient-nurse interaction for older hospitalized women, who are potentially an overlooked, misunderstood, and vulnerable population. This review of the literature explores what is known about the quality of care in hospital settings, including the challenges that medical personnel face in communicating with elderly patients, as well as various perceptions of what constitutes quality care. I have also reviewed literature on older women and their health problems.

I begin with an appropriate starting point: the concept of meaning. Meaning can refer to the search for a sense of coherence, through both self-reflection and connecting and communicating with others (Dwyer, Nordenfelt, & Ternestedt, 2008). Meaning is an important component of wellbeing (Haugan, 2013). Several studies of residents of nursing homes have concluded that the quality of resident-nurse-caregiver interaction actually contributes to the meaningfulness of residents’ lives (Haugen, 2013; Turpin, McWilliam, & Ward-Griffin, 2012). Yet meaning as it applies to the interactions between patient and nurses in acute care settings is not well understood (Izumi, et al., 2010; Schmidt, 2003). Unfortunately, nurses sometimes fail to foster the sense of connectedness that older hospitalized women need to understand the meaning of their experience, thereby leaving them in a vulnerable state and potentially compromising their care (Bamford, & Walker, T., 2012). Since nurses represent most of the hospital workforce, and since older women represent an increasing proportion of the patient population, it is important to clarify the ways in which older hospitalized women understand the meaning of their interactions with nurses.
Quality Care in Hospital Settings

Quality care in hospital settings has become synonymous with effective communication (Boykins, 2014). The definition of effective communication includes attending, listening, and being present in order to show respect for the values, needs, and preferences of another (Schuster & Nykolyn, 2010). Quality care also includes patient-centered care, in which all parties—patient, family, and healthcare providers—share in decision-making. This is easier said than done, since paternalistic models of medical care continue to influence the ways in which medical staff interacts with patients (Matejski, 1981; Ekdahl, Andersson, & Friedrichsen, 2010).

Indeed, physicians have always controlled most aspects of hospital life including nursing (Andrist, 2006). Most nurses have been educated according to this medical model and so they have had difficulty in implementing a more holistic model of care (Huntington & Gilmour, 2001). Moreover, classes in theory and clinical practicums have been arranged around particular pathologies, such as heart disease, cancer, and infectious diseases (Huntington & Gilmour, 2001). Nurses have also borrowed paternalistic power, expecting patients to yield to their advice as they follow physicians’ orders (Larsson et al., 2011). The result has been an understanding of nursing care based on authority (Huntington & Gilmour, 2001). However, the American Nurses’ Association also expects its members to be “concerned with the human response to disease and illness” (American Nurses’ Association, 2014), which often includes fear of pain and fear of death. The emphasis on disease that accompanies the medical model of education has ironically diminished the ability to hear the human response to disease (Huntington & Gilmour 2001, Izumi et al., 2010, Lasiter & Duffy, 2013), a problem that has become more acute with the current trend toward greater patient load per nurse and the consequent decrease in time available for interaction with patients (Lasiter & Duffy, 2013, Institute of Medicine, 2011).
**Communication challenges.** Multiple barriers to effective communication adversely affect the quality of care that nurses can provide to elderly patients. To begin with, 1 in 4 people over 70 have hearing impairments, and 1 in 5 have visual impairments (Dillon, Qiuping, Hoffman, & Ko, 2010). Speech problems, cognitive disorders, and cultural differences compound communication difficulties (Schuster & Nykolyn, 2010). Moreover, people over 65 constitute the least health-literate portion of the population, which is cause for concern, since most patients must understand written instructions for care (Center For Disease Control, 2010). These barriers set the stage for misunderstandings to arise during patient-nurse interactions.

Elderly patients must also contend with communication problems related to ageist attitudes and negative stereotyping (Ryan, et al., 2000). They may be the recipients of offensive, patronizing, and over-accommodating language, which challenges their willingness to engage in interactions. For example, an older woman may not like a nurse calling her “doll” in an extra loud voice, since it presumes that she is both child-like and deaf (Brown & Draper, 2003). Interruptions, and being talked over as if invisible, also set up communication barriers (Ryan et al., 2006). Other obstacles, such as the failure to solicit older patients’ opinions or the presence an intimidating environment prevent patients from speaking up. The eventual outcome could be an incorrect diagnosis or inappropriate treatment (Ryan, et al., 2000; Florin et al., 2008). Hospital staff members place their patients in a potentially vulnerable position whenever they break the link between safety and communication.

**Perceptions of hospital care.** One way of measuring the quality of hospital care is to ask patients for their perceptions, e.g., by means of patient satisfaction surveys. One such survey, the nationwide Hospital Consumer Assessment of Healthcare Providers and Systems, is required by Centers for Medicare and Medicaid, which use survey outcomes to determine the
reimbursement they will pay to hospitals for the care they provide (Isaac, 2010). Nationwide survey results for hospitals, nursing homes, and homecare agencies are available online (Data.Medicare.gov, 2014). Despite their helpfulness, patient satisfaction surveys do not record in any depth patients’ qualitative assessments of care interactions (Izumi, et al., 2010; Coughlin, 2012). One study concluded that patients’ perceptions of care must be better understood before their degree of satisfaction can be meaningfully interpreted (Schmidt, 2003). Indeed, to use satisfaction to measure the quality of care could actually lead to faulty assumptions (Aspinal, Addington-Hall, Hughes, & Higginson, 2003). Apart from patient satisfaction surveys, little in-depth evaluation has been done with respect either to patients’ perception of care or their understanding of the meaning of patient-nurse interactions (Izumi et al., 2010).

Nevertheless, some researchers have attempted to clarify perceptions of nursing care in hospitals from the perspective of both nurses and patients. One ethnographic study (Slatore et al., 2012), describes how patient-centered care, one indicator of quality care, was actualized in an intensive care unit. However, it reports only the perceptions of nurses. Two early comparative studies found that patients and nurses have significantly different perceptions of what care is needed and what priorities hospitals should establish with respect to care (Hudson & Sexton, 1996; Lauri, Lepisto, & Kappeli, 1997). Jacelon’s (2002) grounded theory study revealed that patients and nurses characterized the role of nurses very differently. Patients believed that nurses primarily administered medication and gave direct care; nurses believed that their main role was to educate and to provide emotional support (Jacelon, 2002). More recently, an ethnographic study (Coughlin, 2012) described both patients’ and nurses’ perceptions of hospital care and found that patients’ perceptions of care differed significantly from those of nurses. These
differences suggest the need for further research about the relational aspects of patient-nurse interactions in hospital settings.

Hospitals emphasize the care of the physical body, and so caregivers can easily overlook the psychosocial aspect of patient care (Freixas et al., 2012; Phelan, 2010; Twigg, 2004). Lasiter and Duffy (2012) noted that research has tended to stress the physical aspects of safe patient care, and so little is known about the emotional aspects of feeling safe while hospitalized. However, they did discover that patients felt safe and less stressed when nurses gave oversight, were predictable, provided personalized care, and acted as advocates (Lasiter & Duffy, 2012).

According to Jacelon (2002), paternalism and power show up as common themes in patients’ accounts of their perceptions of hospital care. Coughlin (2012) also uncovered a negative theme: “patients have no control” (p. 2331), which is corroborated by Jacelon’s (2002) finding that hospital patients claimed nurses were often “very directive or dictatorial in style” (p. 231). A qualitative analysis that used inpatient focus groups found that the subjects often used the phrase “the hospital as an institutional power” (Ekdaahl et al., 2010, p. 236). This perceived imbalance of power also affects the relational quality of patient-nurse interactions (Kitson, Athlin, & Conroy, 2014). However, patients believe that nurses, in their caregiving, mostly ignore the issue of power (Tarlier, 2004).

Chinn and Falk-Rafael, who are among the leading researchers on the subject of relational power imbalances, contend that “Power is the energy from which human action and interaction arises” (2015, p. 64), and that the energy generated within patient-nurse interactions is relational power. Relational power can be “peace power” that is shared and nurturing, or “power over power” that is hierarchical and driven by rules (Chinn & Rafael, 2015, p. 66).
Nurses have usually operated from a position of power over power, which puts patients at a
disadvantage in a patriarchal system (Chinn & Rafael, 2015; Kitson et al., 2014).

**Older Women and Health Problems**

Because women tend to live longer than men, they also tend to live longer with disabling
chronic conditions (Profile of Older Americans, 2013; Vincent & Velkoff, 2010), such as
Alzheimer’s disease (Bamford & Walker, 2012). Women are thus also more likely than men to
spend a portion of their later years in hospital. For example, women are 1.8 times more likely to
be admitted to the hospital after being injured in a fall than men (Stevens & Sogolow, 2005). As
Bamford and Walker (2012) have noted, “The adage, ‘men die and women become disabled’ is
still widely considered to ring true” (p. 123). Nevertheless, little research has been done into
older women’s perception of hospitalization (Izumi et al., 2010; Ekdahl et al., 2010).

Research on older women with chronic health conditions suggests that women do not
define the meaning of everyday health in terms of illness and disease, but rather in terms of their
functional ability, i.e., the ways in which their social roles as wife, mother, and grandmother are
altered (Charmez, 2005; Roberto & McCann, 2010). Hence older women equate quality care
with improved function or with the renewed ability to perform the activities of daily life, such as
walking and personal hygiene. They make their health related decisions on the basis of
“everyday health” (Roberto & McCann, 2010, p. 99) rather than medical diagnosis. For
instance, if the unpleasant side effects of a medication detract from her everyday health an older
woman may decide to stop taking it, without taking into account the original reason for the
prescription. Nurses who are oriented to the medical model of care or who are not listening,
attending, and being present during interactions can fail to discover important information about
such patients (Huntington & Gilmour, 2000; Phelan, 2010).
A hospital environment fosters dependency, and many elderly patients have difficulty being dependent on others (Calasanti & Slevin, 2001; Twigg, 2004). For women in particular, lifelong social inequities can exacerbate dependency in the later years. For example, a lifetime of unpaid caregiving and/or low-paying work can lead to economic dependency. Moreover, lifelong social inequities or a sudden catastrophic event, such as widowhood, may induce stress-related illness (Freixas et al., 2012), and constrained financial resources can limit health care options (Calasanti & Slevin, 2001).

The terms “third age” and “fourth age” (Twigg, 2004, p. 64) are social gerontological descriptors that refer, respectively, to persons 50 to 75 years old and to those older than 75. The majority of older patients who live past their third age into their fourth age are women (Vincent & Velkoff, 2010). In their fourth age, women experience the accumulated impact of their dependencies as the focus of care shifts to factors related to the deterioration of the body, such as poor mobility and problems with elimination (Twigg, 2004). To make matters worse, very old women continue to be socially marginalized to the point of being perceived as an outright problem or burden (Freixas et al., 2012; Street, 2002). This pervasive devaluing of older women in American culture fosters self-stigmatization that is ultimately disempowering (Freixas et al., 2012). Critical feminist gerontological theory maintains that older women are not only disempowered and marginalized, but may also be subject to health care disparities because of these realities (Dillworth, Anderson & Hilliard, 2012; Hooyman, Browne, Colette, & Richardson, 2002). For this reason I have used feminist critical theory in this study as a hermeneutical key to understanding what hospitalized women say about their experiences of interacting with nurses.
Conclusion

As I have mentioned above, older women are living longer than they did in previous generations and are thus more likely to spend their final years dealing with disabling chronic conditions that increase the likelihood of hospitalization (Vincent & Velkoff, 2010). As patients, they may have different understanding than nurses about what constitutes quality care. These differences can lead to a misunderstanding of roles and expectations (Schuster & Nykolyn, 2010). Moreover, the typical social climate in hospitals tends to be paternalistic and to be characterized by an imbalance of power between patient and nurse that can adversely affect communication and contribute to a perception of powerlessness on the part of patients (Coughlin, 2012; Schuster & Nykolyn, 2010). When a nurse fails to foster connectedness or to understand the meaning of an older woman’s hospital experience, care can be compromised (Haugan, 2013). Taken together, these factors suggest that elderly women are likely to have negative experiences as patients. Hence my desire to take a closer look at the ways in which older female patients experience their interactions with caregivers. Since little research has been done in this area, my study has the potential both to provide significant clarification with respect to the meaning of patient-nurse interaction, and to contribute to a critical feminist understanding of this interaction.
Chapter 3

Methods

In this study I explore how older women perceive their interactions with nurses after receiving care in a hospital setting. To facilitate the interpretation of these perceptions, I used a phenomenological approach based on a hermeneutical framework that takes into consideration linguistic, historical, and social factors (Rogers, 2005). The works of Creswell (2013), Morse (2011), Kvale and Brinkmann (2009), and Van Manen (2014) informed my overall qualitative methodology. I used personal interviews to provide the data with which to answer my research question: What are the feelings, experiences, and expressions of older female patients about their interactions with nurses while hospitalized?

The importance of the study stems from the reality that older women are a vulnerable population subject to being overlooked or misunderstood by the nurses caring for them (Ryan et al., 2006). As older women are likely to experience marginalization, I approached the research question through the lens of feminist critical gerontological theory as applied by Freixas, Luque, and Reina (2012), who have encapsulated their point of departure as follows: “The exclusion of elderly women from academic research, from the media, and cultural spaces of visibility and power, is illustrative of the gerontophobia in our culture” (p. 55). If gerontophobia also contaminates the ethos of hospital care, then older female patients are marginalized in the very settings that have been created to support their wellbeing. By compiling personal narratives about patient-nurse interactions, I hope to provide the nursing field with alternative perspectives that would enable caregivers to gain a better understanding of and a deeper sensitivity to the plight of elderly women. I have set forth below factors related to my research, such as research design, ethical considerations, and my role as researcher. I also present the potential contributions of my findings.
Research Design

I have used a qualitative phenomenological methodology so as to illuminate the meaning of patient-nurse interactions for older hospitalized women. To this end I have had to make decisions about participants, sampling strategies, screening, data collection, and analytical procedures.

Participants and sampling strategy. I interviewed a purposive sample of women aged 65 and older within 6 months of their hospitalization. I initially decided to select as my subjects women who had been hospitalized for more than 24 hours, and I expected that some would have more than one hospital experience to share with me. I was also willing to consider partial or entire stays in an emergency department as hospitalization, because patient-nurse interactions frequently occur there (McClosky, 2011). However, I found that my selection criteria were too narrow for the realities I encountered.

Most of the women who ultimately participated in this study had chronic health challenges that required more than one hospitalization and contact with nurses in multiple settings. These settings included outpatient clinics, same day surgery centers, emergency departments, and in-patient hospitalizations. Some of the visits lasted less than 24 hours. When participants relayed information about patient-nurse interactions in these additional settings, I recognized the need to include them as a part of their unfolding stories. I also discovered that some significant interactions with nurses had occurred more than 6 months prior to the interviews, and so I decided to include these as well. I found evidence to support this latter decision in the work of qualitative health researcher Janice M. Morse (2011). Morse found that patients tended not to forget events such as illnesses and hospitalizations, and that those who had
time to reflect on the impact of an event often moved from suppressing their emotions to expressing their emotions, thereby yielding rich descriptive data (Morse, 2011).

I used convenience sampling to recruit participants, i.e., I used contacts from my professional and personal community to locate women aged 65 or older who had recently been hospitalized. I also anticipated using snowball sampling, i.e., getting referrals from participants living in group housing. This indeed was how I came to interview one of my participants. Initially, I anticipated interviewing 8 to 12 participants. I began my analysis after the first interview and continued until I had enough rich information to perform a reflective phenomenological analysis (Van Manen, 2014). I had more than enough experiential anecdotal material after interviewing 7 women.

I also selected participants on the basis of their ability to carry on an intelligent conversation without undue fatigue. I decided not to use a mental status screening examination because the elderly find it to be uncongenial, and so it would have been a potential barrier to building rapport. This type of screening would also have been redundant, since it deals with empirical truth and not the feelings, experiences, and expressions that were the focus of the study. As far as other criteria are concerned, I chose subjects who could speak English and I did not screen for race, sociocultural background, or any other factors. Table 1 indicates the demographics and health events of my participants, who ranged in age from 66 to 81, with a mean age of 71.
Table 1.

<table>
<thead>
<tr>
<th>Interview date</th>
<th>Name</th>
<th>Race/Socio-economic status</th>
<th>Age</th>
<th>State</th>
<th>Date</th>
<th>Condition</th>
<th>Time in hospital</th>
<th>Related events</th>
<th>Record- ing minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/12/14</td>
<td>Laurie</td>
<td>White/Middle class</td>
<td>68</td>
<td>OR</td>
<td>9/14</td>
<td>Post-knee replacement infection</td>
<td>4 days</td>
<td>Three hospitalizations due to infection occurred in year prior to study. Anticipating fourth surgery to replace a temporary knee implant. Interview referenced an inpatient hospitalization.</td>
<td>19.19</td>
</tr>
<tr>
<td>11/18/14</td>
<td>Bertha</td>
<td>White/Middle class</td>
<td>67</td>
<td>NC</td>
<td>8/14</td>
<td>Hysterectomy</td>
<td>30 hours</td>
<td>Multiple provider visits before and after surgery including diagnostic procedures. In-patient overnight.</td>
<td>15.25</td>
</tr>
<tr>
<td>11/19/14</td>
<td>Ann</td>
<td>White/Middle class</td>
<td>66</td>
<td>NC</td>
<td>8/14</td>
<td>Uterine and cervical biopsies</td>
<td>12 hours</td>
<td>Multiple provider visits before and after surgery, including diagnostic procedures. Same day surgery unit.</td>
<td>35.28</td>
</tr>
<tr>
<td>11/19/14</td>
<td>Minerva</td>
<td>White/Middle class</td>
<td>68</td>
<td>NC</td>
<td>7/14</td>
<td>Surgical repair shoulder rotator cuff</td>
<td>12 hours</td>
<td>Multiple provider visits before and after surgery, including diagnostic procedures. Extensive physical therapy before and after surgery. Same day surgery unit.</td>
<td>29.36</td>
</tr>
<tr>
<td>12/10/14</td>
<td>*Eutelia</td>
<td>White/Middle class</td>
<td>84</td>
<td>OR</td>
<td>10/14</td>
<td>Stroke</td>
<td>4 days</td>
<td>Emergency department and inpatient hospitalization.</td>
<td>---</td>
</tr>
<tr>
<td>12/18/14</td>
<td>Jean</td>
<td>White/Middle class</td>
<td>81</td>
<td>OR</td>
<td>6/14</td>
<td>Total knee replacement</td>
<td>3 days</td>
<td>First hospitalization for knee replacement nine months prior. This interview was regarding a hospitalization for a second knee replacement, followed by two weeks in a rehabilitation center.</td>
<td>33.14</td>
</tr>
<tr>
<td>1/9/15</td>
<td>Penny</td>
<td>White/Middle class</td>
<td>77</td>
<td>NY</td>
<td>1/14</td>
<td>Urinary tract infection/Allergic reaction to medication</td>
<td>4 days</td>
<td>Emergency room event due to a reaction to a sulfa-based antibiotic, which resulted in four-day in-patient stay.</td>
<td>33.41</td>
</tr>
<tr>
<td>1/9/15</td>
<td>Sue</td>
<td>White/Middle class</td>
<td>70</td>
<td>NY</td>
<td>5/14</td>
<td>Open reduction surgery for wrist fracture</td>
<td>10 hours</td>
<td>Had a fall resulting in an emergency department event, provider visits with diagnostic procedures, and the surgery in a same-day facility two days later.</td>
<td>26.37</td>
</tr>
</tbody>
</table>

* Communication compromised during interview

My interview with Eutelia, who was recovering from a stroke, was conducted in the presence of her daughter-in-law. However, on the day of the interview she was confused and
unsure of why I was there, so we kept the interview light and brief, with talk of family pictures and the upcoming holiday. Eutelia relied heavily on her daughter-in-law for conversational assistance and her interview was therefore excluded from the data.

**Screening procedure and interview guide.** I requested that my contacts use the following prompt to briefly screen potential participants for their interest in participating in the study: “A George Fox University graduate student conducting a study would like to talk to you about what it was like to receive nursing care while you were in the hospital. Is it OK if I give Darcy Mize your name and number? She happens to be a nurse and she would love to hear your story. She will call you to set up day and time.”

If a participant was willing, I made an initial phone contact to schedule an appointment. In this first phone conversation I wanted to be clear about my intentions and so I was prepared to answer a few questions about the nature of the study and my interest in the topic. I also stated the expected length of time for an interview and explained that I would keep the conversation confidential. I also explained that their interview would be recorded. If the participant was willing, I scheduled an interview appointment in the course of this first conversation. At the end of the call, I left my name and phone number in case the participant needed to change or cancel an appointment. Fortunately, all scheduled appointments were kept.

**Data collection.** I employed a “semi-structured life world interview” process, a standard Phenomenological methodology, using criteria delineated by Kvale and Brinkmann (2005):

This kind of interview seeks to obtain descriptions of the interviewees’ lived world with respect to interpretation of the meaning of the described phenomena. It comes close to an everyday conversation, but as a professional interview it has a purpose and involves a specific approach and technique; it is semi-structured – it is neither an open everyday conversation nor a closed questionnaire. It is conducted according to an interview guide that focuses on certain themes and that may include suggested questions. The interview
is usually transcribed, and the written text and sound recording together constitute the materials for the subsequent analysis of meaning (Kvale & Brinkmann, 2005, p. 27).

Using a semi-structured interview helped me explore patient-nurse interactions from the patient’s perspective. It also allowed me to guide the conversation to ascertain relevant information and stories without being excessively informal or controlling. As the interviewer, I proceeded with a posture of “deliberate naïveté” and avoided presuming any knowledge of meaning, while at the same time remaining opened to unique descriptions of the phenomena (Kvale & Brinkmann, 2009, p. 30-31).

I conducted one interview per participant for 60 minutes, including time necessary for introduction, actual recording, pauses and breaks in the conversation, and conclusion of the visit. I was sensitive to signs of fatigue and made sure I conducted the interviews in a comfortable, distraction-free setting of the participant’s choosing. In our face-to-face meeting, I explained the consent form and the interview process and obtained a signature before starting. The consent form included permission to audio-record the interview (see Appendix A). If the participant was accustomed to using some form of hearing amplification, I checked to see if it was in use. Then I proceeded with the interview, keeping in mind the standard practices about communicating with older adults set forth by Gerontological Society of America (GSA) (see Appendix A).

My interview guide (Appendix B) included a briefing for the start of the interview. It also incorporated a debriefing process at the conclusion of the interview in which I summarized key points and allowed the participant to offer feedback or clarification. During the interview, I took observational notes as needed, to help myself recall the particulars of the setting, the mood of the conversation, the individual’s demeanor or facial expressions, and thoughts for further elaboration. After the session, I offered a small thank you gift to each participant as a gesture of
appreciation. I interviewed 8 participants between November 2014 and January 2015. Meetings averaged 50 minutes in length, the recorded interview time, 27 minutes.

**Analytical Procedures.** I analyzed the data by means of a process of coding, condensation, and interpretation of meaning that was similar to the qualitative research interviewing process described by Kvale & Brinkmann (2009). Figure 1 presents a flow chart of the data analysis process from interview to theme creation.

Figure 1. Flow Chart of Analytical Procedures

I listened to each audio recording twice and then I personally transcribed the interview. To organize the data, I uploaded the audio recordings into NVivo version 10 computer software (QRS International, 2014) and began transcribing directly. While transcribing, I listened to the salient points of the conversation multiple times, paying careful attention to any difficulties that arose in translating the oral word to the written word. For example, I reviewed multiple times words that were inaudible or affected by background noise and I also used NVivo to slow down the playing speed of the recording.
I then began a process of meaning condensation and decontextualizing text segments in order to find natural units of meaning (Kvale & Brinkmann, 2009). This process was entirely data-driven, as opposed to being organized according to my own presupposed themes, insights gained from my experiences, or the literature. My next step was to do a general coding and memoing (analytical note writing) of the natural units of meaning in the first 4 interviews. At the same time, I also composed 4 memos in which I analyzed the codes I was discerning and reflected on their appropriateness. For the first 4 interviews, this analysis resulted in 15 different codes, each of which was composed of multiple units of meaning. Figure 2 is a screenshot from NVivo of the code “excusing behavior,” which is representative of the process of accumulating units of meaning in a particular code.

Figure 2. Code “Excusing Behavior”- NVivo Screenshot
At this stage, I began doing more detailed meaning condensation and coding using hard copies of transcripts, as opposed to using the software’s coding system. This additional step served as a mechanism for self-checking. This recursive move was an attempt to be faithful to the meaning that was coming directly from the words of the participants, rather than the meaning that I might impose from my own self-knowledge and preconceived notions. In addition, moving back and forth between coding in NVivo and coding with paper and pencil kept me alert to possibilities as the data accumulated. I treated the remaining interviews in the same fashion: listening, transcribing, coding and memo-making in NVivo, coding again on hard copies of transcripts, and recoding into NVivo. I composed a total of 11 memos and 69 codes for the 7 interviews.

I highlighted the codes in different colors to help with the condensation process. Eight categories emerged from this process. The category entitled “acquiescing” resulted from the merging of several codes, including “be good,” “excusing behavior,” “self-image,” and “self-deprecating.” Table 2 displays the 8 code categories condensed from 69 different codes.

Table 2.

<table>
<thead>
<tr>
<th>Categories From Coding Condensation Process</th>
</tr>
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<tbody>
<tr>
<td>1. Mother reference</td>
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<tr>
<td>2. Nursing care-poor</td>
</tr>
<tr>
<td>3. Nursing care-neutral</td>
</tr>
<tr>
<td>4. Nursing care-good</td>
</tr>
<tr>
<td>5. Feelings</td>
</tr>
<tr>
<td>6. Power/agency</td>
</tr>
<tr>
<td>7. Acquiescing</td>
</tr>
<tr>
<td>8. Functional concerns</td>
</tr>
</tbody>
</table>

I then took a closer look at the units of meaning in each category. A directionality in the patient-nurse interaction seemed to be emerging: patient to nurse, nurse to patient, reciprocal; so I took this into account when it seemed evident. Table 3 shows my analysis of one of these units of meaning.
Table 3.
Meaning Unit Condensation

| Meaning unit | I had a very kind nurse that bent over backward, always thought ahead, even what I was thinking, and when she knew I was going home that day, she said why don't you take off your stockings and I will clean them so they will be nice for you when you get home. And after physical therapy I wanted to walk and I asked her if there was another person to walk with me because I knew I had to have someone to walk with me, and she said she would walk with me. She took the time away from what she was doing to walk with me . . . That's meaningful to me because if you don't keep your legs strong you have lost a lot of the beginning of the battle. |
| Condensed transcription | A caring nurse that was kind, went the extra mile, took the time, acknowledged that her rehabilitation activity of walking was vital for her overall well being. |
| Directionality | Patient-Nurse ↔ |
| Codes | “Good nurse” and “functional concerns” |
| Category | Nursing care-good |
| Theme | Caring with primacy |

The next step in the analysis was the interpretation of meaning (Kvale & Brinkmann, 2009). In order to do this I re-contextualized the categories into themes using a hermeneutical framework that takes into account language, history, and social factors (Rogers, 2005). My use of critical feminist gerontological theory, in combination with my own personal interpretive lens, influenced the re-contextualization of the meaning of participants’ interactions with nurses. In other words, my interpretation work was not “presuppositionless” (Kvale & Brinkmann, 2009, p. 211). I worked through the audio recordings, transcripts, codes, and memos in a spiraling movement with the intention of co-creating a deeper understanding of the phenomena (Van Manen, 2014). At one point, I engaged a nurse colleague to serve as a peer auditor. She listened to 2 segments from the transcripts of different participants and verified the accuracy of the transcription. She then read the meaning condensations to verify consistency between the
transcripts and the condensations. Together we discussed potential interpretations. The peer
auditor confined her activities to ensuring the integrity of the data and to helping me prevent bias
(Creswell, 2013). Ultimately, I determined that the participants’ feelings, experiences, and
expressions about their interactions with nurses while hospitalized could be encapsulated in two
major themes: “experiencing caring” and “maintaining personhood.”

Research Ethics

Each participant signed a consent form at the start of the interview session, and I assured
each participant, both orally and in writing, that what she said would remain confidential. I also
gave her my word that I had no affiliation with the hospitals in which she had received care and
that she was free to comment without fear of repercussion if she anticipated treatment in the
same hospitals in the future. The consent form included permission for audio recording. If a
participant had wanted to terminate an interview at any given point, I would have turned off the
recorder, deleted the recording, and ended her participation in the collection of data. None of the
patients made such a request.

Protection of data. I asked each participant to choose her own pseudonym to honor her
preferences for how she would be identified and to assure her anonymity. In addition, I ensured
that any computer used in the data collection process was password protected. I kept transcripts
and documents related to the interviews in a locked filing cabinet for the duration of the project,
and I plan to keep them for 5 years after the date of the first interview and then dispose of them
in a secure fashion.

Since older women are potentially a vulnerable population, I took another ethical
precaution: if a participant had a caregiver, such as a spouse or a child, I told her to feel free to
inform the caregiver about the research process. As I mentioned above, Eutelia took advantage of
this offer and asked that her daughter-in-law be permitted to stay with her during the interview. The final precaution is standard for any research involving human subjects: the Institutional Review Board at George Fox University had to approve research proposal before I could proceed with my research. In short, I made every attempt to protect the identity and stories of the women who were willing to share their stories with me.

**Benefits of the research.** A potential benefit of the study for the participants was the opportunity to reflect on their experience and possibly thereby to gain an insight that would lead to a sense of peace or bring closure to their hospitalization event. According to Eide & Kahn “The making of meaning is an inherently therapeutic activity” (2008, p. 200), and from my experience as a nurse in conversation with older patients, I can attest that some form of therapeutic outcome often does occur in such situations. To ensure that the sessions would have at least the possibility of being therapeutic, I was ready to change the course of the interaction or terminate the interview, if any participant experienced distress on recalling aspects of her hospitalization. Hence I terminated the interview with Eutelia after she became confused about my questioning her, even with her daughter-in-law present. In all such research, the benefits to the participant must outweigh the potential distress, and as a qualitative researcher I respected the boundary between beneficence and distress during the course of the study (Kvale & Brinkmann, 2009; Eide & Kahn, 2008).

I hope that my findings will illuminate what patient-nurse interactions might mean for hospitalized elderly women. The literature makes clear that during hospitalization elderly women are often vulnerable due to the illness, pain, and stress that are innate to the acute care environment. Because of this, they do not function at an optimal level and may be especially prone to not communicating well with their caregivers. I also wanted to learn what nurses are
doing to meet the special needs of elderly women. This was one reason why I used retrospective interviews. I also hoped that, if I allowed time to pass for reflection on the overall experience, the participants would be free of stress as they attempted to ascertain the meaning of those experiences.

**Role of the Researcher**

I undertook this research as a partial fulfillment of the requirements for the Ed.D. degree from George Fox University. I have been a professional nurse for decades, having received a B.Sc. in Nursing from Michigan State University and an M.Sc. in Nursing from the University of Illinois. I have practiced primarily in contexts involving the provision of nursing care to older adults, such as home care, community health organizations, long-term care settings, and acute care hospitals. I have also been a nurse educator at various times throughout my career. I recently completed 6 years as an Assistant Professor of Nursing in an undergraduate B.Sc. in nursing program, teaching primarily on the care of the older adult, so this research project was pertinent to my life and work. My current professional memberships include The Gerontological Society of America (GSA) and The National Gerontological Nursing Association (NGNA).

Because I am committed to the care of the older adult, I acknowledge that I am in a position of potential bias while interpreting the findings, and so I took measures to remain critically aware and reflective throughout the research process.

**Potential Contributions of the Research**

Since nurses constitute the largest number of healthcare workers (Institute of Medicine, 2011), and since older women represent a growing percentage of overall health care consumers (Vincent & Velkoff, 2010), understanding the meaning of a patient-nurse interaction ought to be seen as essential for the provision of quality nursing care. However, the literature says very little
about this topic, and older women’s stories about their hospitalization experiences have not been heard (Izumi, et al, 2010; Larsson et al., 2011). Several important implications of this research are therefore obvious. First, my findings will help to raise awareness of the potential vulnerability of older women who are navigating a complex health care experience that is liable to challenge the most adept consumer. Second, they will help to stimulate nurses to come alongside their patients and either encourage self-advocacy or be a strong advocate when the patient’s capacity for self-advocacy is limited. Finally, since nurses often have little time to spend with their patients, my finding should help provide nurses with advance knowledge and heightened sensitivity about what their elderly female patients must be thinking and feeling. This increased empathy should serve to increase the possibility of nurses communicating well with and expressing care for such patients, and it should also reduce the possibility that such patients will become invisible.
Chapter 4

Results

Introduction

The results of this qualitative study came from my analysis of richly revealing interviews with 7 older women. I conducted the interviews from November 2014 to January of 2015 in order to answer my research question: “What are the feelings, experiences, and expressions of elderly female patients about their interactions with nurses while hospitalized?” I chose the place and time for each interview according to each participant’s preferences. The participants ranged in age from 66 to 81 (mean age = 71). All were white, middle class women known either to my professional colleagues or to my personal associates, with the exception of one woman, whom I selected as a result of a snowball sample in an apartment complex in central New York.

The interviews proceeded in a semi-structured style (see Appendix B). The meetings averaged 50 minutes in length, which allowed me time to explain the interview process, review the letter of consent, answer questions, and close the meeting. The average audio recording time was 27 minutes. All seven 7 participants willingly engaged in this process that because it offered them an exclusive opportunity to share their stories. The conversation flowed easily. After personally transcribing audio recordings of these interviews and analyzing them thoroughly, I discerned 2 major themes related to the meaning of patient-nurse interactions: 1) experiencing caring, and 2) maintaining personhood. Each theme had two sub-themes with defining
characteristics. During my analysis of the patient-nurse interactions I also discovered patterns of relational energy that characterized the patient-nurse interactions.

Figure 3 depicts the themes, sub-themes, defining characteristics, and relation energy pattern found in patient-nurse interactions. A solid arrow on the left of each theme represents equal partnership and energy balance in a nurse-patient relationship. In the middle, the dotted arrow represents unidirectional relational power and energy imbalance from nurse to patient. The dotted arrow to the far right depicts the patient’s relational energy directed by the patient toward the nurse to try and accommodate the power asymmetry (see Figure 3 below).

Figure 3. Themes, Sub-themes, Defining Characteristics

Some of the nurses that the subjects encountered provided exceptional care, were knowledgeable, competent, and attentive, and had highly developed relational skills that engendered connectedness (Defrino, 2009). They embodied “everyday ethical comportment” that was respectful, supportive, and patient-centered (Benner, Tanner, & Chesla, 2009). The relational energy these nurses developed with their patients was synergistic, empowering, and
necessary for healing (Halldorsdottir, 2012; Watson, 2008). The conjunction of all of these positive characteristics indicated that the nurses in question made caring for their patients their primary objective.

The participants also had to deal with uncaring nurses who were relationally distant, incompetent, insensitive, and untrustworthy, similar to what was found in the works of Wiman & Wikblad (2004) and Doane & Varcoe (2007). In addition, the relational energy between patient and nurse was unidirectional in such cases: care was done to the patient and not with the patient in mutuality. This kind of energy elicited relational indifference or distress in the participants.

According to Halldorsdottir (2008), personhood thrives when patient-nurse interaction is characterized by mutual acceptance that allows both persons to retain their dignity, agency, and self-worth. The participants’ accounts of their experiences indicated that some nurses did a better job than others of fostering their patients’ sense of personhood. Nurses who were able to neutralize power asymmetry in their dealings with patients created spaces where personhood remained intact (Delmar, 2012). In these situations, they treated their patients as full partners in care planning, allowing them the opportunity to voice concerns and influence outcomes. The resulting balance of relational energy facilitated this process.

Conversely, when nurses tried to exert control, their patients became distressed. The relational energy flowed from the patients’ attempts to overcome the domination. Those participants who adopted acquiescent strategies, such as being good or remaining silent, were able to manage stress and protect their sense of personhood.

In this description of themes and sub-themes, the phenomenon of maintaining personhood overlaps at times with the phenomenon of experiencing caring. For example, a caring nurse will be sensitive to the use of relational power as a means of helping a patient
maintain personhood, whereas an uncaring nurse will use power over a patient to expedite care. I should mention here that my understanding of relational power derives from Chinn and Falk-Rafael’s (2015) definition of power, namely, “Power is the energy from which human action and interaction arises” (p. 64). The social nature of patient-nurse interactions compels an additional analysis of relational energy to define more precisely the themes and sub-themes in the meaning of these interactions.

The following results present all of the themes and sub-themes I derived from my analysis of the data, along with supporting excerpts from the interviews. I cite references from the literature in order to situate the findings in both the nursing world and the larger world of today’s health care system. Finally, I offer personal observations from my experience as a nurse and as a nurse educator as a commentary on the findings.

**Results**

**Experiencing caring/uncaring.** Caring is one of the foundational values of professional nursing. Ideally, the “everyday ethical comportment” of a practicing nurse will demonstrate the “primacy of caring” (Benner, Tanner, & Chesla, 2009, p. 279). Although the concept of caring has many definitions, most practitioners would agree that it includes the following characteristics:

- alleviation of vulnerability, promotion of growth and health, the facilitation of comfort and dignity, or a good and peaceful death, mutual realization, and the preservation and extension of human possibilities in a person, a community, a family, or a tradition. (Benner et al., 2009, p. 280).
When experienced nurses give primacy to caring, their everyday practice is characterized by an ethical comportment that cherishes respect and patient-centeredness and thereby promotes true healing (Benner et al., 2009).

Several researchers have contributed to the health care profession’s understanding of caring by examining the patient’s perception of patient-nurse interactions. From the patient’s perspective, good nurses embody genuine concern, competence, wisdom, attentiveness, communication, and connectedness (Halldorsddottir, 2012). Patient–nurse interactions have the capacity to affect healthy outcomes through empowerment, the reduction of stress (Doane & Varcoe, 2007), and the activation of a protective immune system that can be “life-giving” (Halldorsddottir, 2008, p. 646). Conversely, patients perceive uncaring nurses to be relationally distant, incompetent, insensitive, and untrustworthy (Wiman & Wikblad, 2004; Doane & Varcoe, 2007). The participants in my study recounted experiences of both caring and uncaring nurses.

**Caring held in primacy. Bertha – “Whatever I needed, they were there.”** Bertha was a sixty-eight-year old retired dental hygienist who continued to do work for the county dental program. Bertha was effervescent and was a joy to interview. She had been lucky. She was diagnosed with uterine cancer, underwent a hysterectomy, and was pronounced cancer-free without the need for further treatment. When I asked her if she could recall a time when a nurse had provided exceptionally good care, she responded as follows:

> Whatever I needed they were there—but really I didn't need that much. But they were always right there when I needed something . . . the nurses were very attentive, I didn't have any problems at all with their care . . . no, no if I called them, they came quickly (Interview with Bertha, 18, November, 2014).

As a nurse and nurse educator, I found this anecdote encouraging, although I wondered whether Bertha’s account might have been overly positive because she was still feeling euphoric from her reprieve from cancer. I also thought she might simply be telling me what she thought I
wanted to hear. However, Bertha was not alone in her assessment. Of the 7 participants, 6 used “attentive” to describe nurses with whom they had had positive encounters, which confirms that their nurses’ attentiveness had been meaningful to them.

Ann, a former elementary school principal, was more serious in nature than Bertha. She had been hospitalized due to suspected cancer and had undergone a uterine biopsy. Ann seemed to have given the interview considerable thought before we met. She chose her words carefully. When I asked her the same question—“Can you recall one moment with a nurse that was exceptionally good?”—I received a thorough response:

The first thing that happened with the nurse was she said ‘Now I am going to go back and get you some warm blankets, because it is chilly here and they won't be back to get you for about 30 minutes.’ So that was a kindness that, you know, it just made you feel very comfortable, and then when she came back she just made . . . you would call it small talk . . . except that it was particular to you. Asked what I retired from—hobbies, children—and I am certain she could have found some of that information off the chart, but it was a conscientious effort or a conscious effort to make certain that I was relaxed. However embedded in all that were the questions that made sure you knew exactly what was going to happen—‘Will you please tell me your address and telephone number again?’—and to make sure there wasn't anything out of sorts that would cause problems with the procedure (Interview with Ann, 19, November 2014).

The nurse tended to Ann’s comfort immediately, using purposeful small talk to relax her. Competence was evident as she wove her duties into a pleasant interaction. For the nurse, this event was probably nothing extraordinary; it could be characterized as everyday practice. For Ann, the result was a sense of comfort, security, and being cared for during a time of health related stress.

Ann continued:

She [the nurse] was very personable, and it of course came up in the conversation that my fears stemmed around what happened with my mother, and then that led to the conversation about my mom living with me for the last 4 years, and my taking care of her, and just so happened that this nurse had taken care of an aunt with the same type of
thing, and so it felt as though we had some common ground, and it just made you feel very secure, very secure, and very cared for (Interview with Ann, 19, November 2014).

A common bond developed between Ann and the nurse through their sharing of family caregiving experiences. Ann’s mother had a history of uterine cancer and dementia. The nurse initiated this opportunity to connect, and Ann was receptive. Nell Noddings’ description of the participants in a caring relationship—the “one-caring” and the “one cared-for” (Noddings, 2005, pp. 16-21)—applies here. The nurse, as the one-caring, is involved the act of moving away from self and simultaneously becoming engrossed in the interaction. The patient, as the one cared-for, feels the concern and sincere interest and enters the interaction in a meaningful way (Noddings, 2003). Such reciprocal interaction creates a synergy that supports the healing process (Halldorsdottir, 2008; Doane & Varcoe, 2007).

Laurie, who had undergone several hospitalizations to address an infected knee replacement, spoke of a nurse’s caring in the following way:

I had a very kind nurse that bent over backward, always thought ahead, even what I was thinking, and when she knew I was going home that day, she said, ‘Why don't you take off your stockings and I will clean them so they will be nice for you when you get home?’ And after physical therapy I wanted to walk, and I asked her if there was another person to walk with me, because I knew I had to have someone to walk with me, and she said she would walk with me. She took the time away from what she was doing to walk with me. That's meaningful to me because if you don't keep your legs strong you have lost a lot of the beginning of the battle (Interview with Laurie, 12, November 2014).

Laurie had had many interactions with this particular nurse and had developed a rapport with her. Her account describes a nurse who has achieved a high degree of interpersonal competence. Fosbinder (1994) formulated a theory of interpersonal competence after exploring the patient-nurse relationship from the perspective of the patient. She found that the patients focused on the nurses’ comments, and not on the tasks they were performing. These comments took the form of translating (explaining), getting to know you (personal sharing), establishing trust (anticipating
needs), and going the extra mile. Laurie found her nurse’s interactions meaningful, because her nurse had taken the time to “walk the extra mile” with her, thereby acknowledging the anxieties Laurie had with respect to the restoration of her lost mobility.

Sue had been hospitalized 7 years before the interview, in the course of seeking a second opinion for the treatment of her uterine cancer. She recalled an interaction with a nurse who had demonstrated “concern” and the “right feelings”:

But I remember the kindness of his [oncology doctor] nurse . . . and I mean, she was older than me at the time, she was a lovely lady, she would go out of her way for you, she was very, very, concerned, above and beyond what you would expect. She had the right feelings, I guess, and of course in oncology, its a different area, and a lot of the people were a lot sicker than I was, but I always remember Ann, she really seem to make an effort . . . And I remember her to this day. Because, y’know, every time I went in to the office, she really seemed to go out of her way, something a little extra (Interview with Sue, 9, January 2015).

These interview excerpts from Ann, Laurie, and Sue describe caring in a way that corresponds to the descriptors of caring found in the literature cited above. Each nurse with whom one of the subjects had had a positive encounter had the capacity to touch the patient in a memorable way, regardless of the duration of the interaction or the point in time at which it had occurred. Ann interacted with a nurse in same-day surgery, Laurie had the same nurse for several days over a number of hospitalizations, and Sue recalled patient-nurse interactions that had occurred 7 years before. Jean Watson in her book, *Nursing: The Philosophy and Science of Caring* (2008) describes a “caring moment”:

two persons (nurse and other) together with their unique life histories and phenomenal field (of perception) become a focal point in space and time, from which the moment has a field of its own that is greater than the occasion itself (p. 61).

Others have concluded that effective patient-nurse interaction can occur in 30 seconds, 15 minutes, or over a long period of time (Kitson et al., 2014). The patients in this study did not
judge the degree of care they received by the amount of time their nurses spent with them. Rather, what they found meaningful was being with a nurse who could express caring in a life-giving way.

I turn now to the opposite end of the spectrum, from the primacy of caring to the uncaring acts experienced by patients under nursing care. These acts reveal the underside of nursing care and illustrate the vulnerability of older hospitalized women.

Uncaring. Sue – “She wasn't rude, she was just like a nonperson.” The participants could switch, almost without missing a beat, from recounting interactions with caring nurses to telling stories of other nurses whose uncaring interactions were characterized by incompetence, insensitivity, untrustworthiness, and relational distance (Wiman & Wikblad, 2004). Sue, for example, had had an unfortunate interaction with an emergency department nurse after being admitted with a fractured wrist and discovering that she would need to have surgery to repair 4 different fractures. The following excerpt from the interview describes the incident:

Interviewer: Can you recall one moment with a nurse that seemed difficult for you? Let’s go back to the initial visit to the Emergency Department . . . an interaction with a nurse where you were left feeling—well she isn't really listening to me.
Sue: I didn’t even remember there was a nurse involved, until I thought about it afterwards, because we made no connection whatsoever. Usually, I think that, you know, I have always been in customer service all of my working life. And usually, I connect with most people, I go anywhere, I can talk with them, you know—but this particular woman. . . . I didn't even remember, she wasn't rude; she was just like a nonperson. I had to think, I thought, but there must have been a nurse in the emergency room, but I don't remember anything about um. . . . The only thing I remember is she asked me if I wanted a pain pill, and I said no . . . and she helped me take off my blouse and put on the robe. And she asked me questions . . . took my blood pressure . . . and nothing (remarkable) at all . . . but our interaction had no connection (Interview with Sue, 9, January 2015).

In an emergency department, it is expected that trauma care take precedence. Ideally, relationship building happens simultaneously, but nurses may provide strictly instrumental and
technologically oriented care in order to tend to the traumatic injury. This well-intentioned intervention can come at the expense of a connection between patient and nurse (Delmar, 2012). This was certainly the case in the incident that Sue recounted.

During the interview, Sue seemed still to be pulling together the pieces of the fall she had experienced: injured wrist, emergency room visit, visits to a new surgeon, hospitalization for repair, difficulties with immediate post-op support, and physical therapy. Her lengthy discursive answers included unfinished sentences. Later in the interview she returned to her negative experience with the emergency department nurse:

Sue: And then when she came in after he [doctor] had set my arm, she helped me back on with my blouse. Then she told me I was lucky because most people that day had broken their hips. I didn't exactly consider myself lucky, because I was kinda surprised by the comment. Then I thought I would rather have a broken wrist instead of a hip, even though I am right handed. You know, but I think that was the only thing she said . . . that made her . . .

Interviewer: (pause) Stand out?
Sue: Yes. (Interview with Sue, 9, January 2015).

For Sue, the nurse was only memorable for her enigmatic comment about a broken wrist versus a broken hip. This left her wondering how lucky she truly was. She was right-handed, living alone, and still driving her own car. How was Sue going to function with a broken wrist beyond the emergency department’s doors? If the nurse had taken another minute to talk about her injury in the context of managing day to day, she might have closed the relational gap and preserved a caring moment—even in an emergency department setting (Doane & Varcoe, 2007).

Maybe the nurse did, in fact, attempt to contextualize Sue’s misfortune with concern about her daily function. Was Sue too stressed to hear what was being said? Was this comment a clumsy attempt to make Sue feel better? Was it a thoughtless comment that objectified Sue by equating her with her injured body part? Phenomenological analysis considers all such
possibilities. As a nurse and a nurse educator, I believe that the deconstruction of this patient-nurse interaction provides an opportunity to build communication skills with listening at the center (Van Manen, 2014).

Minerva had had an experience that altered her ability to function as a mother, grandmother, and household manager. At the time of the interview, she was several months into an arduous recovery and rehabilitation from a rotator cuff repair. After I had prompted her several times to think of a nurse that stood out in her hospital experience, she was hard put to select one over the other. Her comment at several points in the conversation was that, “I think they were all special” (Interview with Minerva, 19 November 2014). This comment was delivered with an unenthusiastic tone and flat affect, suggesting either dutiful replay to the nurse interviewer or uninspired nursing care. Ultimately, the one interaction with a nurse that she described was brief, but telling:

Minerva: When you are ready to be cut on, you are a wreck . . . y’know, ‘cause when they started the IVs and all that, the nurse that was doin’ it dropped something, and it spilled all over the floor. Ha! My medicine bottle! I am going ‘Uh, oh, oh my god, ha ha’ . . . accidents happened, but I mean that is the thing I can remember before the anesthesiologist came in.

Interviewer: What did she say when she dropped it?
Minerva: ‘Oh my goodness . . . I just got the dropsies today.’ And, you know, that wasn't terrible or anything—but I was kind of shocked that she would drop a medicine that was going into an IV. She was an older woman; hate to talk bad about older women, ha. Other than that, ok, I was put to sleep (Interview with Minerva, 19, November 2014).

Minerva acknowledged the unavoidability of the accident, but it had occurred at an unfortunate time, at an anxious pre-operative moment, and it led her to feel lack of confidence in nursing care “I waited for that surgery for 7 years because I didn't want to be cut on” (Minerva, 2014). She also echoed a stereotypical sentiment that associates age with incompetence (Freixas,
Luque, & Reina, 2012; Ryan, Anas, & Friedman, 2006). Hence this older nurse that had the “dropsies” was deemed untrustworthy at a crucial moment.

Laurie, aged 68, was pleasant but serious. She walked with a walker and carried a pack attached to an intravenous pump with antibiotics. I could hear the soft whirring and clicking of the pump in the background as she recounted one of several experiences of insensitive treatment at the hands of a nurse after knee surgery:

Laurie: One nurse told me after I came out of surgery, it was the same nurse that did those three things, she said, ‘Can you scooch down and sleep on your side?’ After you have knee surgery, that’s the first thing, you do not want to sleep on your side.
Interviewer: Can you scooch down and sleep on your side?
Laurie: I said ‘No, let me just stay like this,’ because I kept falling asleep the way I was. After surgery, you do not want your leg pushing on the other, or this leg pushing on that. . . you can't. She said, ‘Well, you cannot stay like that this whole time you are here, I know you just got out of surgery, but you have got to think about moving around.’
Interviewer: Did she offer any solutions?
Laurie: No (Interview with Laurie, 12, November, 2014).

This was Laurie’s memory of one post-operative interaction with a nurse that she had come to dislike. For Laurie, this nurse made an unreasonable request that could be considered hard-hearted and inappropriate. Sue, Minerva, and Laurie had all experienced uncaring on the part of practitioners of a profession that is supposed to have caring at its nexus. Their accounts suggests that there is something inherently immoral about uncaring.

*A morality of caring.* – “It’s very stressful when you’re taking care of your own; you wanna do everything right for them.” Women often define themselves as providers of care and 5 of the 7 participants spontaneously talked about being caregivers for parents and family members. For them, providing care had always been a moral obligation as can be seen the following excerpt from my interview with Jean:
Jean: I took care of my mom even while I was working, about the last 7 years of her life. I mean, she was competent and all that, but she had terrible rheumatoid arthritis and she needed a lot of care . . . and ah, you know, you just do it. My dad, too, he had a circulatory problem, he lost part of his leg, I didn't take care of him physically, I took him to doctors’ appointments and all that stuff and got him into a nursing facility but, um, it’s very stressful when you’re taking care of your own; you wanna do everything right for them, you get tired; we didn't have as much support. It’s hard taking care of your parents and trying to keep up with your kids and all that stuff. Then when my husband had Alzheimer’s. It was bad for a while, but I survived, hnghhn (Interview with Jean, 18, December, 2014).

Perhaps the participants wondered whether the uncaring nurses they encountered personally embraced a morality of caring that went beyond just doing a job. Sue put it this way:

I think that perhaps they [nurses] have forgotten what their real goal is, to be a comfort to a person, to be an assist to a person, and I think it’s like a lot of people, it’s just a job, and they are just there and they don't really care much, and it’s unfortunate, and I haven't suffered because of it, but I didn't like it (Interview with Sue, 9, January, 2015).

From the perspective of the cared-for, the one-caring presents herself in the form of an attitude (Noddings, 2003), and Sue identified an attitude of indifference in the one caring for her. Thus, the relational energy between the one-caring and the cared-for, or the nurse and the older hospitalized woman, cannot necessarily be strong or healthy if characterized by indifference. My findings shed further light on the phenomena associated with older women maintaining a sense of personhood in a hospital environment.

**Maintaining personhood.** Personhood, or the state of being human, thrives when mutual acceptance of personal uniqueness characterizes a relationship (Halldorsdottir, 2008). Personhood is closely tied to dignity, agency, identity and self-image. When personhood is disregarded, ill feelings are generated; humiliation, lack of control, and low self-esteem are possible outcomes (Watson, 2008).
Patient-nurse relationships in institutional settings, such as hospitals, are subject to power imbalances (Ekdahl et al, 2010; Jacelon, 2002). Hierarchy, rules, and expediency influence the direction in which power flows (Chinn & Falk-Rafael, 2015). Delmar (2012) maintains that the balance of power inevitably remains in favor of the nurse in this setting and that it builds on a potential sense of powerlessness innate to a person with poor health status. When patients find themselves in a situation of dependency in an unfamiliar hospital culture, they must maintain a degree of control to retain a sense of personhood. They are liable to have diminished control over bodily functions, choices regarding their care, and the expression of thoughts and feelings. Patients can easily doubt their own capabilities and often prefer to avoid expressing their thoughts and feelings. In the course of my research I discovered two sub-themes with respect to patients maintaining the meaning of their personhood during their interactions with nurses: negotiating care terms and acquiescing.

Nurses who treated the participants as full partners in planning for their own care, or who took pains to provide a thorough explanation of the care they were providing, respected the participants’ dignity and uniqueness. This respect resulted in a balance in relational energy and facilitated any negotiations about change or continuation of care. Sometimes, though, the participants had difficulty voicing concerns and influencing the planning of their care, and so they had to expend relational energy to maintain a sense of personhood. At times they had to adapt to a stressful care situation by employing strategies of acquiescence.

*Negotiating care terms. Penny – “That was the most aggravating thing, they just would not listen to me.”* Penny, aged 77, is quite short, with beautiful white hair, a smiling face and a twinkle in her eye. She liked to laugh and to punctuate conversations with witty
comebacks. She was proud to report that she had gone parasailing with her grandchildren when she was 73.

Penny had to be rushed to the emergency department in the middle of the night. Earlier that day she had visited a walk-in clinic to receive treatment for a bladder infection and was prescribed an antibiotic. She took the first dose just before bed, and later woke up feeling dizzy and sick from what she thought was an allergic reaction. She ended up spending 4 days in the hospital. Penny reported that she had received responsive nursing care on the inpatient unit and that she had had no need to negotiate extensively for what was needed:

Because I had a bladder infection and I had not, um . . . I still had the same underwear on . . . and I mean I wanted to take a shower, but I knew they wouldn't [let me] because I had an IV in me, but they did suggest . . . I said, ‘Can't I do something? I still don't have any clean underwear.’ So they went right away and said, ‘You can take a wash off right here.’ So right away they got me paper undies and towel and washcloth and soap, so that I could wash and take care of myself. They did it right away. It wasn't like, ‘Oh, we'll be back,’ they just did it (Interview with Penny, 9, January, 2015).

As I have already mentioned, having control over one’s bodily functions is important to maintaining personhood; poor control over bowel and bladder is socially stigmatizing and causes older adults to feel humiliated (Twigg, 2003). Penny, perhaps embarrassed, found the response for help with personal hygiene mercifully expedient. However, she had a different experience in the emergency department:

Penny: I called my friend, and I said, ‘We need to go to the hospital. I am having a reaction from this medication.’ They [emergency room nurse and doctor] would not listen to me. I just have an allergy to the medication. And I had the medication with me, so I knew what I was talking about. Now keep in mind, all the questions they asked me, I could answer, I walked in under my own power—as far as I know I didn't stagger—all the questions in an emergency room, I answered. I gave my list of medications. They see this white hair, and ‘God, you must be having a stroke or a heart attack, that is a definite.’ So that much I gleaned out of it. So that, and I have very good insurance (Interview with Penny, 1, January, 2015).
Penny was given medication to counteract her allergic reaction to the antibiotic. She also underwent diagnostic testing for a possible cerebral vascular accident or a heart attack. In the course of the interview, after talking further about her inpatient experience, she came back to her time in the emergency department: “What I felt more, and what I was really annoyed about, was when I was downstairs [in the emergency department] and they would not listen to me. . . . That was the most aggravating thing; they just would not listen to me. . . .”

In all likelihood, the hospital care team in the emergency department was following protocol for further testing. It has been well documented that women’s symptomatology can elude diagnosis, especially in the case of cardiac problems (Dillworth-Anderson, Pierre, & Hilliard, 2012). In Penny’s instance, serious health events in addition to the allergic reaction to the antibiotic may have been occurring. Ultimately, she was diagnosed with a bladder infection and an allergic reaction to the medication, and not a stroke or a heart attack. Months later, her overriding sentiment about this experience was not appreciation for the responsiveness of the health care team, but annoyance over having been dismissed, and suspicion of the hospital’s overuse of diagnostic testing in the emergency department. She felt, though, that in calling her friend, reporting her symptoms, and bringing her medicine with her she had been in control. However, in her compromised condition, Penny felt that the treatment plan was done to her, not with her.

Penny’s account indicates how it feels to have one’s voice ignored. Even though her white hair was beautiful and her zest for parasailing was remarkable, she is likely to have her agency and personhood challenged even more with each passing year (Twigg, 2003).

Along the same lines, Laurie had a confusing moment while negotiating the terms of her care while she was hospitalized with an infected knee:
Laurie: And she [nurse] wanted me to always use the walker. I could walk without the walker because I am so long; I could hold on to things to get there. And there was very little room in the bathroom for the walker, and I couldn’t move around it. It was more trouble. The person that replaced that nurse came in quickly when I had to go to the bathroom and said, ‘You don't need to use the walker; I saw how you got to the bathroom and had no problem.’ So I wasn't far off; I wasn't thinking I could do more than what I could.

Interviewer: So the second nurse acknowledged your capability to make that judgment?
Laurie: Yes (Interview with Laurie, November, 2014).

Looking closer at the exchange in relational energy between Laurie and the two nurses sheds further light on the dynamics of negotiating the use of the walker. The “rules are rules” nurse was not necessarily wrong in her instructions, but she may simply have found it easier to insist than to negotiate, in terms of the expenditure of relational energy. The observant nurse came from a posture of patient-centeredness and consideration of Laurie’s unique abilities. Rules may have dictated differently, but this nurse took into account what was right for Laurie. The observant nurse empowered Laurie in decision-making. The relationship between Laurie and the observant nurse was likely less stressful and it likely also provided greater opportunity for healing (Halldorsdottir, 2008).

Jean had spent 20 years as a surgical nurse in a local hospital and so had a distinct pre-knowledge about the complex world of health care. Now aged 81, she was soft-spoken, tall, and slim. She also had gray hair and wore glasses. She had had her first knee replacement the year before to relieve the pain of rheumatoid arthritis. The operation was a success, and so she had a second knee replacement 6 months later. She walked with a walker and also had a brace on her lower leg due to foot drop. She had had 2 contrasting experiences in the course of negotiating her care with a health care team. The following interview excerpts describe her second hospitalization:
The first time [knee replacement] for 2 or 3 days after the anesthesia, I got very sick to my stomach, so I stressed this to the anesthesiologist, and I think they gave me something else. I did much better, I still felt queasy and didn't have much appetite, but I didn't vomit and lose so much weight, and so forth; they listened to you. I told the nurse and the anesthesiologist, and they all got together and decided I better have something else.

(Interview with Jean, 18, December, 2014).

She made specific mention of the respectful treatment she had received:

Well, they treated me like I was relatively intelligent, and they explained things very thoroughly . . . but I felt like the nurse was talking on the level of any person my age and that I understood perfectly what she was telling me (Interview with Jean, 18, December, 2014).

What seemed important to Jean was that she was included in the planning, engaged respectfully, and afforded full explanation. Having been a nurse in the past, she was perhaps expecting this sort of interpersonal competence in her nurse.

Jean also mentioned that she had had episodes of post-operative confusion during her second hospitalization. Competent nurses are knowledgeable about post-operative confusion, since it is not uncommon, especially in elderly patients. Nurses sometimes mistake post-operative confusion for dementia, and in such cases may treat the affected patient in a less-than-respectful manner. This particular nurse did not make this mistake, and Jean appreciated being treated “relatively intelligently” (Jean, 2014). The common social identity as nurses that filled the relational space between both Jean and her nurse and Jean and myself added a reflexive significance to this account of a successful negotiating of terms of care.

After she was discharged, Jean spent time recovering in a rehabilitation /long term care center. In this situation her pre-knowledge of the hospital world failed to help her receive respectful treatment, as the following episode illustrates. It occurred during a two-week rehabilitative stay, when a male certified nursing assistant (CNA) was sent in to give her a shower:
Yeah, and to give me a shower, and I went along with it for a while, then I thought, huh, I am not going to get undressed in front of this guy. He's not a nurse, he is not professionally [trained] . . . who I think should be. They should send me a girl. I guess I made some comment that, ‘Really, isn't there a female nurse that can give me a shower?’ and he said, ‘Well, we are pretty short handed and I am supposed to get you up to the shower.’ Like that’s the way it is [Jean’s emphasis], ha-ha. So, all in all, I was not satisfied . . . I don't know, maybe, I was kinda cranky, so maybe, one time I was like, ‘I really want out of here.’ That might have influenced my thinking a little bit, but my family also noticed they had some problems with the staffing and so forth. And so they weren't as considerate of my age and my sensitivity to . . . they sent in a male, he wasn't a nurse (Interview with Jean, 18, December, 2014).

Jean summed up her experience in the rehabilitation center as follows: “It was awful . . . I asked my daughters to get me out of here” (Jean, 2014). When Jean described this incident, she abandoned her normal soft-spokenness and raised her voice for emphasis. The caregiver in question was not a nurse, but most likely a CNA. Nevertheless, in a rehabilitation/long term care center registered nurses are ultimately responsible for the delegation of work to CNAs and the supervision of their performance. She felt the treatment she had received was inconsiderate and insensitive for a person of her age, but rehabilitative practices have changed significantly since Jean was a practicing nurse:

Because I know they used to do hip surgery when I worked in the hospital, and they would, I think it took about a week before they had ‘em go home. And now one of the gals I used to work with said they do it as a day surgery (Interview with Jean, 2014).

In today’s world of expedited care, recovery times are being delegated to transitional care facilities, such as rehabilitation centers (Kitson et al., 2014). Yet Jean thought her dignity had been violated and that she had been denied agency over her own care.

The excerpts from my interviews with Penny, Laurie, and Jean suggest that elderly women can have difficulty negotiating care terms in a hospital or care center. Not only their
words, but also the visibly tense way they held themselves as they relived these moments, communicated the challenges they had to face in order to maintain a sense of personhood.

*Acquiescing. Laurie – “And you just tried to bend with whatever you could bend.”*

During the interviews several examples came to light of participants using acquiescent behavior to salvage a sense of personal integrity in their interactions with nurses. To acquiesce means to give in to or go along with something without protesting, even if you don't really want to (mydictionary.com). In the course of the interviews I heard participants excuse lapses in care by nurses. They attributed these lapses to new developments in hospital culture, such as chronic understaffing (Bertha, 2014; Jean, 2014) and policies requiring nurses to give paperwork precedence over direct care (Laurie, 2014). I also heard participants wonder aloud whether they themselves had contributed to lapses in care. For example, Jean was disappointed that her nurses did not give her a bath after she had spent four days in the hospital but wondered whether her own condition had contributed to the lapse:

Well, there was one thing: I think I was hoping they would give me a bed bath type thing to clean up. And about all they did after this last surgery, they gave me a washcloth and something to brush my teeth with. But they didn't make an attempt to get me up. Now maybe because I was not doing quite as well like I should be, maybe because I was a little nauseous and a little weak in the head, you know. But I always thought that would make you feel good, if you cleaned up a little bit (Interview with Jean, 2014).

Jean’s self-deprecating remarks are consistent with what the literature has indicated, namely that older women tend to be less assertive and more submissive as patients (Ryan, et al., 2004) and that their self-blame leads to disempowerment (Freixas, Luque, & Reina, 2012). Jean may not have felt like making a fuss about this lapse in care, or maybe she did not have the energy to do so.
Laurie experienced a slightly different challenge when she was hospitalized again for her infected knee:

My knee had to be drained, because they were taking all the infection out, and she [nurse] was changing all that and doing all these things around me, probably changing the IV and then she said, ‘OK.’ Then I said, ‘I think I have to go to the bathroom.’ She said, ‘Why didn't you tell me that before I did all this other...?’ I had a hard time urinating, so I was always afraid to say I had to go, because if I got in there and didn't go, I got ‘chkkk’ (she made a gesture to suggest she was being scolded) (Interview with Laurie, 12, November, 2014).

Laurie’s hesitancy to ask for help to get to the bathroom suggests that she was afraid of being identified as a problem patient. If her fears had been great enough, she might even have soiled herself and needed to be cleaned up and to have her bed linens changed. The social labeling of patients affects the quality of nursing care they receive such that it could even be termed a violation of dignity in a health care setting (Jacobson, 2009). Nurses who label patients as “difficult” are more likely to distance themselves from such patients and to provide less supportive care (Shattell, 2004). Laurie describes a strategy of acquiescence she used to avoid being labeled difficult:

Interviewer: Now that you have had time to reflect on your hospitalization, what was meaningful about your interaction with nurses?
Laurie: Well, like I said, some of them [nurses] were more considerate than others. And you just tried to bend with what ever you could bend, and try not to ask for too much.
Interviewer: So by the word “bend?”
Laurie: I mean emotionally requesting, ask for as little as possible.
Interviewer: Be good?
Laurie: Yes, be a good girl (Interview with Laurie, 12, November, 2014).

Laurie gained status as a patient potentially worthy of care by “bending,” being compliant, and refraining from protest. The 2 excerpts from Laurie’s interview also demonstrate the asymmetry of power that characterizes patient-nurse interactions (Shattell, 2004; Stoddart, 2012). In the first excerpt, the nurse held power over her for the most basic of human needs—
elimination, and Laurie kept quiet for as long as she could. In the second interaction, Laurie figured out that the best way to negotiate hospital culture from a position of powerlessness is to “be a good girl.”

Sometimes this power imbalance is unreasonable, as Sue experienced after her wrist surgery while she was interacting with the nurse assigned to discharge procedures:

Sue: I asked the surgeon, ‘Dr. F, can I go home after the surgery; I live alone,’ and he said, ‘Sure Sue, you can go home.’ So, um, we’re [Sue with her neighbor] getting dressed, so I don't know, and she [nurse] overheard us talking. So she said, ‘You can't go home alone because of the nerve block.’ She said, ‘You have to keep your shoulder elevated above the level of your heart for three days’ . . . she didn't do nothing, she kept staying there . . . insisting . . . that I could not go home alone, and that I had to find alternate means, ‘No we can't admit you to the hospital; we will keep you here until 5 o'clock then. . . .’ You know. . . . (Interview with Sue, 2015).

Sue moved on to a different topic, but eventually the interview returned to the unresolved problem about her discharge from the hospital:

Interviewer: OK, so let’s go to the nurse that gave you the information that you can't go home by yourself. Tell me how that made you feel?
Sue: Well she was kind of like very insistent. It was like her way or no way. I was thinking, ‘What am I going to do now?’ Now, in retrospect, she maybe had a misunderstanding from the doctor; I don't know, but I just felt that like she . . . I suppose if I felt a little more alert, I suppose I might have said, ‘I want to speak to somebody above you,’ or I might have said, ‘I think you could find the doctor; and I mean she just was tyrannical in that ‘You can't go home alone; you can't be admitted to the hospital; we can't find the doctor. You have to do something.’ But her attitude was she was the commanding general; I was her subordinate (Interview with Sue, 9, January, 2015).

If the discharge nurse had been asked to recount her perception of the interaction she would likely not have given the same account. But this was Sue’s perception of the incident, of being placed in an untenable position by an authoritative nurse that held institutional power. This interaction caused distress for Sue immediately after her surgery, which was problematic,
because an asymmetrical power relationship between patient and nurse does not promote healing (Delmar, 2012).

**Conclusion**

I have organized my findings from the 7 interviews with older hospitalized women into themes that represent the essence of their interactions with nurses. The participants shared their experiences of both caring and uncaring nurses. They also shared what it was like to have their voices heard. At times they felt empowered in their relationship with their nurses, thanks to their nurses’ patient-centeredness. The participants also recounted their fear of being labeled difficult and their experience of powerlessness with respect to their own care, both of which sometimes resulted in a loss of dignity.

These privileged stories by hospitalized elderly women gained further meaning when I filtered them through the lens of critical feminist gerontological theory and through my own personal lens as a nurse, nurse educator, and woman. With these lenses, light rays diverge and converge to form images. These images include a feminine ideal of caring with moral underpinnings as well as a picture of older women with the ability to maintain dignity and personhood in the face of an impersonal health care system.
CHAPTER 5

Discussion and Conclusions

As I listened to the audio recordings of the interviews over and over again, I was reminded of Twigg’s (2004) assertion that “age and aging are deeply social” (p. 70). With this in mind, I began to visualize the highly social experience of a dance between patient and nurse. For instance, I imagined the patient not knowing the dance steps or not being able to keep up with her partner. I saw the nurse take the lead, while the patient worried about stepping on the nurse’s toes. Then I saw the patient and the nurse flowing in a beautiful partnership. This dance metaphor highlights the social closeness of a patient-nurse relationship and the need to read a partner’s rhythm and spirit. If a patient is new to dancing or too ill to participate fully, the rhythm and spirit are lost, and toes get stepped on. The elderly women I interviewed for this study expressed the “dance” or interaction in the form of 2 broad themes: “experiencing caring” and “maintaining personhood.” These were the themes that emerged from the answers to the research question, “What are the feelings, experiences, and expressions of older female patients about their interactions with nurses while hospitalized?” In this chapter I discuss these 2 themes and sub-themes through the lens of critical feminist gerontological theory, as well as from my own personal perspective as a nurse, nurse educator, and woman.

Feminism deals with the advantages and disadvantages that follow socially constructed gender archetypes throughout one’s life span. Feminism as applied to gerontology addresses these advantages and disadvantages in the context of aging (Twigg, 2003). For instance, it would indicate that the socially accepted definition of feminine beauty fails to consider the possibility that the deep lines in a woman’s aging face represent the beauty of wisdom. The critical feminist approach to research “aims to correct the invisibility and distortion of female
experience in ways relevant to ending women’s unequal social position” (Lather, 1991, p. 71). The participants in my study experienced their unequal social position as elderly women within the patriarchal culture of health care (Huntington & Gilmour, 2001).

I use the metaphor of a lens to accommodate the participants’ diverse perspectives on their lived experience of hospitalization. A metaphorical lens shapes perception and comprehension in somewhat the same way as a literal lens causes light rays to diverge and converge to form an image. Thus, in applying the lens of critical feminist theory to gerontology, I have been able to filter the multiple perceptions and interpretations of one particular story and to make it possible to see new meaning in the lived experiences of the hospitalized elderly women who participated in the study (Kvale & Brinkman, 2009). Figure 4 represents the lens of critical feminism. When of patient-nurse interactions were filtered through this lens, the main themes of “experiencing caring” and “maintaining personhood” diverged into sub-themes of “caring held in primacy,” “uncaring,” “negotiating care terms,” and “acquiescing” (see Figure 4).

Figure 4. Themes and Sub-Themes Through the Lens of Critical Feminism

I felt honored to listen to participants’ stories. I believe the participants perceived the act of interviewing as an act of caring. As I listened to them share their personal feelings and
expressions, I realized that this care was being reciprocated in my own feelings of identification with these women as a nurse and nurse educator. I noticed the interviewees’ thoughtfulness in wanting to “get it right” for me and for the greater purpose of the research. I wanted to listen carefully and to be a reflexive researcher. This caring nature that is socially constructed as a feminine quality also carries with it a moral leaning (Noddings, 2003). When viewed through a lens of critical feminism, older hospitalized women were situated in a disadvantaged and vulnerable position when the morality of caring was distorted by uncaring nurses. To be a caring nurse requires ethical comportment, consistent with standards of professional care. When caring nurses bring their own moral leanings and professional ethic comportment to bear on their work, they elevate their interactions with patients from simple caring to care held in primacy.

A particular moral problem that all participants mentioned was the dialectic of experiencing both caring and uncaring nurses. I sensed a tension in their reporting as they retold their stories about nurses who were exceptional and about those who were insensitive, uncaring, or distant. To explore this dialectic linguistically, it is important to understand that opposites take meaning from what the other is not (Ray, 1996). By knowing what caring involves one discovers what uncaring involves, and, as a result, acquires greater understanding of the nature of caring.

Each participant in this study had a narrative about both caring and uncaring nurses. In retelling these experiences, the participants expressed a range of responses, ranging from pleasure and satisfaction to bewilderment, disappointment, and outright anger. However, they were not content to let their stories rest. Rather, they applied a moral filter to them in an attempt to reconcile the tension between their good and bad experiences and to bring the two ends of the caring spectrum together peaceably (Palmer, 1998).
The dialectic of experiencing caring became stronger when the participants reflected on their own personal experiences as caregivers. According to Noddings (2003), being involved in caring unleashes a weight of memories and feelings. In this study, 5 of the 7 participants recounted memories of and feelings about their own experiences of caring for their mothers and other family members. Their stories described caring motivated by love and obligation, and involving personal and family sacrifice, stress and hardship, and self-doubt on the part of the caregiver. Often the circumstances in which they exercised their caring were beyond their control, which left them feeling guilty. In my role as researcher, I, too, had to acknowledge the significance of my own memories of caregiving.

As a result of listening to these stories and analyzing them, I believe that being conscripted into a position of “one-caring” (Noddings, 2003, p. 16) provides an undeniably unique perspective on being cared for. The participants attributed a multiplicity of meanings to their experiences of being cared for by nurses. Any tension I observed while they were recounting their stories arose not only from the paradox of caring/uncaring they had experienced as patients, but also from the memories and feelings of questioning the rightness or wrongness of the ways in which they themselves had provided care for family members. This important finding shed significant light on the feminine ideal of caring and situates the participants’ experience within a wider moral context.

These elderly hospitalized women, who had their own memories of one-caring and experiences of being cared-for, remind us of the intrinsic morality of caring; and their negative experiences of being cared for in an authoritarian environment by nurses lacking in beneficence also raise questions about what it means to maintain personhood in such a context. I have defined personhood as encompassing health, dignity, identity, agency, and self-regard. This kind
of personhood is often associated with the term patient-centeredness. A patient-centered relationship implies mutuality, inclusion, and trust (Clissett et al., 2013; Olesen, 2011). The participants in this study believed that the nurses they perceived as being uncaring lacked this patient-centeredness and that this deficiency caused the participants to struggle to maintain their personhood.

Institutional authoritarianism also contributed to this diminished sense of personhood. Indeed, as healthcare systems struggle to keep up with rapidly changing technology and rising costs, they tend to stress expediency in all things, and especially in patient care. Reduced staffing and an increase in computerized systems have reduced the amount of inpatient care, and so the sick tend now to receive treatment as outpatients or to spend their recovery time in rehabilitation centers. The result is a reduction in patient-nurse interactions. To cope, some patients are using the internet and social media to become more knowledgeable about health care and are taking advantage of the increasing tendency of hospitals to grant patients full agency. However, elderly patients have not necessarily been socialized to acquire knowledge from sources other than physicians, or to expect to take part in decision-making about their own care. In fact, some older patients still prefer to relinquish control to those in power (Ekdahl et al., 2009). However, the participants in this study wanted their voices to be acknowledged, their unique situations to be understood, and their agency to be granted. They did not want to relinquish their personhood.

The participants spoke about the frustration of being in an unfamiliar environment, or “another world” (Penny, 2015). In this other world—a clinic, an emergency department, or a hospital—someone else dictated the rules of care. The women described feeling both in control and without control. Nurses have knowledge of this other world and are capable of carrying out
the interventions necessary to facilitate recovery and health. They often turn this taken-for-granted knowledge into power-wielding energy (Delmar, 2012; Kitson et al., 2014) thereby sacrificing their patients’ personhood.

In this study, the participants indicated that the relational power between patient and nurse affected their ability to maintain their personhood while hospitalized. Some felt included in this world and thereby had agency to negotiate the terms of their care. This sense of inclusion stemmed especially from interactions characterized by trust and respect that offset the imbalance of power between nurse and patient. Both partners in the dance shared its rhythm and spirit. Some women resorted to silence, self-doubt, and acquiescence in order to maintain a semblance of agency in their dealings with nurses. As long as power resided with the nurse, the patient experienced self-doubt, humiliation, and anger. In such cases the patients’ dance partners either ignored the rhythm and spirit of the moment or they failed to teach their patients the steps. The participants who felt less agency in their interactions with their nurses essentially recounted the strategies by which they had survived, rather than thrived, in care. In such instances health care systems become another world that cannot possibly be life giving.

Conclusions

The participants recounted that what made their stay in hospital most meaningful, was the time they spent with nurses who embraced the primacy of caring so completely that it became life-giving. They found such caring to be characterized by a respect that allowed them a dignified social identity and nurtured positive self-regard. Three findings from this study, which I have filtered through a lens of critical feminist gerontological theory, are summarized in the following paragraphs.

First of all, the participants have a unique perspective on the experience of caring. Their
expressions include stories of being cared for themselves by nurses as well as stories of being the one caring for family members. In these combined stories, the contrast between the nurses who held caring in primacy and those who were distinctly uncaring brings out the moral nature of caring. Indeed the meaning of the patient–nurse interactions in this study sheds light on the importance of cultivating a feminine ideal of caring based on distinct moral underpinnings.

Second, the participants sometimes felt in control and sometimes felt powerless in their interactions with nurses. When they felt in control, their interactions with nurses were characterized by mutuality, respect, and balanced relational energy, which enabled them to negotiate the terms of their care. When they felt powerless, they lacked voice and agency. They also experienced an imbalance of relational energy that made them feel distress and forced them to adopt strategies of acquiescence in order to survive care and maintain personhood.

Finally, in the evolving world of health care, technology and expediency may support the hegemony of the health care system but they may not bring life to the very people the system is intended to serve. This is particularly true for the vulnerable population of older women, such as those in this study, who potentially face increasing disability requiring hospital care, and who must rely on direct, meaningful, interactions with health care workers to successfully navigate the healthcare system. The findings suggest that patients do not have consistent access to such interactions.

**Recommendations**

After reflecting on the outcomes of this study, I would reconsider my approach in any follow-up study. To be specific, I would include an additional age category among the participants, interview both male and female patients, and take into account the importance of the support of family and friends.
This study included participants in one age category only, that of 65 years and older. Twigg (2004) believes that both the biological and the (highly variable) socio-cultural aspects of aging are important. Hence third age (50-74) participants would likely have a different understanding of the meaning of patient-nurse interactions than their fourth age (75+) counterparts (Twigg, 2004). Comparing and contrasting the responses of patients from these age ranges could contribute new insights about the meaning of nursing care in a hospital setting.

I would also consider interviewing both women and men in a future study, since feminist theory can be used to understand the experiences of elderly patients of either sex (Meleis, 2012). The experiences of the potential inequities in health care may be the same or different for older men as opposed to older women. The application of a feminist qualitative approach to understanding meaning could clarify these similarities and differences. Such an expansion of research would be timely, since increasing numbers of older men have been taking on what has traditionally been regarded as a feminine role, namely that of caregiver for disabled spouses and significant others. Would this in any way affect their own experiences of being cared for in a hospital setting?

My interest in assessing the supporting role played by family and friends stems from observing the spouses, daughters, and friends who visited the participants in the present study, but whose role in providing support was beyond the scope of this study. The participants’ voice and agency may have been strengthened, diminished, or left unaltered as a result of their interactions with family members and friends. Nor is it clear whether or not these supportive individuals affected the participants’ perceptions of the meaning of their interactions with nurses. The support family and friends (or lack thereof) likely plays a critical role in the lived experience...
of hospitalization, and to study it would provide a greater understanding of what may be an underutilized resource in our struggle to care for an increasingly aging population.

**Implications for Future Study**

The obstacles that stand in the way of better health outcomes for older hospitalized women are partially biologically determined. Bodily aging most certainly results in chronic illness and functional disability, and more research into these realities of getting older needs to be done. However, these obstacles are also socially determined, and this social dimension resides in the spaces in and around patient-nurse interactions. The dehumanizing interactions recounted by the participants in the present study compel us to improve the experiences of hospitalized older women. I believe this improvement cannot begin until we gain a heightened awareness of the social and relational spaces between and around patients and nurses.

The women in the present study experienced caring and maintained a sense of personhood by participating in life-giving interactions with their nurses. On the other hand, they experienced degradation of personhood when their nurses’ relational energy expressed itself as power and control over them. This caused distress and compromised healing. Nurse educators and practicing nurses alike could use these findings as a springboard for creating awareness-raising activities that would transcend the rote “therapeutic communication” chapter that has inhabited nursing textbooks for decades.

Pedagogies that would facilitate a heightened awareness of what it means to be an older hospitalized woman are either available or waiting to be created. I believe that a simulation laboratory with either fidelity mannequins or standardized patients in role-play would facilitate the teaching and learning of the appropriate relational skills. I also believe that simulation would introduce nursing students to knowledge-specific and respectful care for older adults while
dispelling the common myths and stereotypes of aging. Finally, the awareness of the social and relational spaces between and around older patients and nurses will grow as the nursing profession commits itself to education, scholarship, and research.

What is known about older women’s lived experiences in the hospital world has not been well articulated in the literature (Izumi et al., 2010). The patient satisfaction surveys that are commonly used fail to capture the qualitative expressions of interactions that lead to a deeper understanding of patients’ perceptions of care (Schmidt, 2003). In the present study I have thematized, through the analysis of the data, a quality of relational energy in patient-nurse interactions. When filtered through the lens of critical feminism, this relational energy echoed the institutional power that dominates the world of patient care (Ekdahl et al., 2010). The participants felt exceptionally cared for by their nurses when relational energy was balanced and power was shared. In an environment of shared power, measures of quality care move beyond indicators of patient satisfaction and into the realm of life-giving care. When balanced relational energy, caring, and respect for personhood filled the spaces in and around patient-nurse interactions, these older hospitalized women became advantaged and visible.
References


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doi:10.1016/j.pec.2009.10.026


NVivo qualitative data analysis software; QSR International Pty Ltd. (Version 10) [computer software].


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Appendices
Appendix A

Recommendations for Communicating With Older Adults

General Tips for Improving Interactions With Older Adults

1. Recognize the tendency to stereotype older adults, then conduct your own assessment.

2. Avoid speech that might be seen as patronizing to an older person ("elderspeak").

General Tips for Improving Face-to-Face Communication With Older Adults

3. Monitor and control your nonverbal behavior.


5. Face older adults when you speak with them, with your lips at the same level as theirs.

6. Pay close attention to sentence structure when conveying critical information.

7. Use visual aids such as pictures and diagrams to help clarify and reinforce comprehension of key points.

8. Ask open-ended questions and genuinely listen.

Excerpt from:

Appendix B

Interview Guide – The Meaning of Patient-Nurse Interaction

Date: ________

Time ________

Pseudonym__________

<table>
<thead>
<tr>
<th>Interviewer</th>
<th>I am interested in understanding what it is truly like to be a patient in a hospital receiving nursing care. I am most curious about the viewpoint of elderly women. Specifically, I would like to understand what it felt like when you were talking with a nurse. This is about your story while hospitalized, so no response is right or wrong. I am hoping this may help nurses gain insight into better care practices. The interview will be recorded, and I might take a few notes, as well. You may refuse to answer any question, and you can ask me to stop at any time. Also, you will not be personally identified in any report of this study. At the end of the interview, I’ll ask if you can think of a pseudonym you might like for me to use to give you time to think about it. (recorder on)</th>
</tr>
</thead>
</table>
| Question 1 | Would you tell me the events that led up to your hospitalization?  
• Were you alone or with somebody when admitted?  
• Did you feel like the nurse understood you?  
• What was your emotional reaction to this event? |
| Question 2 | Are you able to describe a particular time when you were talking with a nurse during your time in the hospital?  
• How was that experience?  
• Did the nurse take time with you?  
• Did you feel like the nurse heard your message?  
• What happened as a result of this interaction? |
| Question 3 | Can you recall one moment with a nurse that seemed difficult for you?  
• Would you say this was a bad experience?  
• How did this make you feel? |
| Question 4 | Can you recall one moment with a nurse that seemed exceptionally good?  
|           | • Was there a special quality about the nurse that made the difference?  
|           | • Can you tell me more about this? |
| Question 5 | Now that you have had time to reflect on your hospitalization, what was meaningful about your experiences and interactions with nurses?  
|           | • Were you mostly alone while talking with nurses or did you have family members or friends with you most of the time?  
|           | • Did you feel you could express your needs?  
|           | • Did you ever feel vulnerable? |

**Interviewer**  
Summarize aloud the main points articulated during the interview.

**Question 6**  
• Are these main points that I have summarized appropriate conclusions from what you have shared with me?  
• If I have misrepresented your words, please feel free to clarify this for me.

**Question 7**  
• I have concluded my questions for you. Do you have anything more you would like to share?

**Interviewer**  
Thank you very much for your time and for sharing your story (recorder off).

End Time: __________  
Total: __________
Appendix C

Letter of Consent

You are invited to participate in a research study conducted by a nurse educator, Deborah(Darcy)Mize, from the George Fox University, Department of Graduate Education. I hope to learn what it is truly like to be a patient in a hospital receiving nursing care. I am most curious about the viewpoint of older women. Specifically, I would like to understand what it felt like when you were talking with a nurse. I am hoping this may help nurses gain insight into better care practices. You were selected as a possible participant in this study because of your recent hospitalization experience.

If you decide to participate, I plan to conduct a single interview to last for sixty to ninety minutes with necessary pauses and breaks in conversation to prevent fatigue during the interview process. A comfortable, distraction-free setting for the interview is of your choosing. This interview will be audio-recorded.

Your participation is voluntary. Your decision whether or not to participate will not affect your relationship with the hospital system you entered. If you decide to participate, you are free to withdraw your consent and discontinue participation at any time without any consequences. If in the unfortunate event that discussion about your past hospitalization proves to be too distressing for you, the interview will be stopped and I will assist you in contacting your primary health care provider as needed.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. Participant identities will be kept anonymous by use of a pseudonym.
assign to your transcript. If you have any questions about the study, please feel free to contact my dissertation chairwoman, Dr. Susanna Steeg, Assistant Professor of Education, George Fox University, steeg@georgefox.edu, 503-554-2839. If you have questions regarding your rights as a research subject, please contact the Institutional Review Board (IRB@gfu.edu). You will be offered a copy of this form to keep.

I cannot guarantee that you personally will receive any benefits from this research. It may be that the opportunity to reflect on your hospital experience helps you in some way. At the very least, know that by sharing your story, you are contributing to nursing education scholarship and potentially the positive practice patterns of nurses.

Your signature indicates that you have read and understand the information provided above, that you willingly agree to participate, that you may withdraw your consent at any time and discontinue participation without consequences, and that you will receive a copy of this form.

Signature
Date