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Nurse–patient interaction: a review of the literature

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Abstract:

Aims. The aims of this paper are to review a theoretical model useful for developing nursing knowledge related to nurse–patient interaction, review the literature on nurse–patient interaction, and discuss areas for further research.

Theoretical model. Goffman’s theory of face work.

Results. Nurse–patient interaction is a central element of clinical nursing practice. This paper shows how Goffman’s model can be used as a theoretical framework for understanding nurse–patient communication.

Relevance to clinical practice. Issues such as power, the social and cultural context, and interpersonal competence are shown to be important in the quality of nurse– patient interactions and nurses need to take cognizance of these factors in their interactions with patients.

Key words: nurse–patient communication, nurse–patient interaction, nurse–patient relationship

Introduction

Article:

Society views nurses favourably, often as benevolent, virtuous and admirable. Nurses have been positively stereotyped as ‘ministering angels’ or ‘angels of mercy’ (Muff, 1982). Nurses

frequently experience this positive view of the profession first hand in clinical practice. How often have you heard statements such as these? ‘They [the nurses] are so nice’, ‘Oh, honey, you are so sweet’, ‘you are the best nurse’, ‘the nursing staff is very nice’. Nurses reading this paper will probably be familiar with nurses’ stations overflowing with candies and treats that have been sent from appreciative patients and/or their families.

An existential phenomenological study of the hospital environment found that nurses were prominent in patient’s descriptions of the hospital (Shattell, 2002). Participants in Shattell’s (2002) study were asked what they were aware of in the hospital environment. In addition to positive statements about ‘nice nurses’, strong negative statements about nurses and nursing care were also present in their descriptions of the hospital environment. One participant who was hospitalized on an oncology unit said this of her hospitalization and of the nursing staff collectively:

The patients’ views of nurses illustrated above clearly demonstrate a paradox. These patients’ overall experiences of their nursing care appear inconsistent with their initial representation of the ‘nice’ nurse. While nurses may be seen as ‘nice’, patient participants in Shattell’s (2002) study of the hospital environment longed for more and deeper connections with nurses. They experienced the hospital environment as disconnecting and actively sought ways to connect with nurses. Patient’s dependence on nursing staff as well as perceived powerlessness to the nurse’s power, created a situation where patients believed they had ‘actively’ to find ways to solicit needed nursing care. In addition to these factors, nurses were viewed as overworked and overwhelmed, leading to even greater patient needs and hence, more active strategies to get these needs met. Nurse–patient interaction was central to this tactic.

The aim of this paper is to review a theoretical basis for nursing knowledge development for nurse–patient interaction, review the literature on nurse–patient interaction, and discuss areas for further research. Goffman’s theory of face work will be reviewed followed by a review of the literature categorized into the following subgroups: nurse communication within nurse–patient interaction, nurse–patient interaction, patient perception of nurse–patient interaction, and patient care-seeking communication. Following the literature review will be a discussion including implications for practice and future research.

Goffman’s theory of face work

Nurse–patient interaction can be conceptualized from the theoretical perspective of symbolic interactionism. Symbolic interactionism is a philosophical perspective that originated from George Herbert Mead in the early 1900s at the ‘Chicago School’, specifically, the Department of Sociology at the University of Chicago. Symbolic interactionism is a social psychological approach to studying the meaning of human action (Schwandt, 1998). Accordingly:

A person’s sense of self emerges through social interaction... a sense of self develops as people (a) imagine themselves in other social roles (seeing themselves as through the eyes of others and internalizing the attitudes of the generalized other), (b) anticipate the responses of others, and (c) act in accordance with the meaning that things (other people, ideas, events, objects, or situations) have for them (Powers & Knapp, 1995, pp. 166–167).

In other words, the individual interprets the environment based on symbols and meaning and then acts accordingly. Symbolic interactionism views human-to-human interaction not according to response and stimulus but through interpretation, and meaningful and purposeful action and interaction.

Goffman's theory of face work, consistent with symbolic interactionist thought, describes a theory of interaction whereby both individuals interpret and act in order to maintain the face of self and other. An individual presents to the other with a particular evaluation of how the self is to be portrayed. Goffman (1955) coined the term face work to describe the interaction ritual in human-to-human encounter. He defined the term face as 'the positive social value a person effectively claims for himself [sic] by the line others assume he has taken during a particular contact' (Goffman, 1967, p. 5). A line can be described as a front, which is presented through verbal and non-verbal behaviour that conveys the individual's appraisal of both participants, especially of him/herself. A purpose of the face work is to manage the impressions, or face, of both self and other. This management of impressions of and by self and others were described in terms of a theatrical performance (Goffman, 1959). Goffman (1967) theorized that people interacted in a cooperative dance.

Participant's descriptions simultaneously representing nurses as both 'nice' and cold and distant, demonstrate the patients' contradictory accounts of their relationships with nurses (Shattell, 2002). The coexistence of two opposing views of nurses can be considered through face work theory. The patient's use of flattery may be an attempt to maintain the face of self and other in the care-giving/care-receiving interaction. The patient strives for a favourable impression by the nurse, simultaneously attempting to maintain self-esteem and autonomy.

Spiers (1998) advocates the use of face work theory in nursing research on nurse–patient communication as current communication theories used by nursing (stemming from the discipline of psychology) are inadequate fully to 'explain how communication is directed by basic human and cultural needs' (p. 25). The use of face work theory can:

illuminate how communication in interaction is negotiated and mutually constructed and how specific verbal strategies function in multiple ways to respond to the instrumental demands of the situation as well as the interpersonal needs of both participants (Spiers, 1998, p. 26).

What we do know about nurse–patient interaction will be reviewed in the following section of this paper.

Review of literature

To access literature for the review, the following databases were used: CINAHL, Medline, and PsychInfo. Search terms used were nurse–patient interaction, patient communication, nurse–patient relationship, and nurse–patient communication. Literature relating to the nature of nurse–patient communication was included. Appropriate references listed in other articles were also used to inform this discussion. Most of the articles were data-based studies, however, theoretical and discussion articles were included if they were germane to the topic. English language publications from the United States, United Kingdom, and other European countries were

included. There was no preset time period; all studies relevant were included.

The literature will be reviewed from the following perspectives, identified from this body of literature: (1) nurse communication within nurse–patient interaction, (2) nurse–patient interaction, (3) patient perception of the nurse–patient interaction, and (4) patient care-seeking communication. This literature review will not include literature on help seeking, doctor–patient communication, patient satisfaction, autonomy, mutuality and empowerment.

Nurse communication within nurse–patient interaction

Most of the research on nurse–patient interaction focuses entirely on the nurse’s communication in the encounter, assuming the power position in the relationship:

Traditional sociological theory on professions awards power to the professional based on knowledge acquired through academic training and leavened by a service orientation toward the client (Haug & Lavin, 1981, p. 212).

This professional power over patients is well documented in Parson’s (1951, 1975) work on the sick role. In the sick role, a patient is a willing passive recipient of care provided by a knowledgeable health care provider. The patients freely give up their power to professionals because they have specialized knowledge that the patients do not have; professionals willingly accept this power. In comparison with Parson’s sick role, Roth’s (1963, 1972) studies of doctor–patient relationships in tuberculosis hospitals found that patients were less likely to remain passive and used negotiation and bargaining to increase their interpersonal power; never, however, to the point of attaining equality. Studies that were found which examined this social context of unequal power were related to patient decision-making (Taylor et al., 1989) patient autonomy (Martin, 1998), and mental health service needs of psychiatric mental health patients (Jackson & Stevenson, 2000). Hewiston (1995) and Johnson and Webb (1995) studied power dimensions in nurse–patient interactions.

In their ethnographic study of social judgement and the social processes of care as experienced by nurses and patients in a medical hospital setting, Johnson and Webb (1995) found that nurses exerted power over patients and that interactions were filled with conflict and struggle, resulting in ‘acquiescence of patients to the nursing and medical goals of care’ (p. 83). Johnson and Webb (1995) described how one patient negotiated the social judgement of the nursing staff; a patient interrupted nursing shift report, knowing that this was a ‘violation’ of social norms. To combat the possibility of being labelled a ‘bad patient’, he later acquiesced to having X-rays that he did not want, yet agreed to, in order to mitigate his failure to follow the rules (interrupting report). His social skills, awareness, and previous experience enabled him to successfully manage his social standing in this environment of care. This social process of care could be viewed from Goffman’s theory of face work. The patient in this example acted purposefully and knowledgably in his interactions with the nursing staff. What happens when patients are too ill or have inadequate social skills? Their ability to assess and negotiate the social environment of care is then seemingly limited.

Patients are aware that there is a nursing agenda, that they are expected to follow that agenda, and that there are consequences if they do not. This awareness is shown in the words of an older hospitalized patient, ‘I have to do as I’m told. I’m 94 next week and I still have to do as I’m told’ (Hewiston, 1995, p. 80). What happens when patients do not ‘do as they are told?’ The negative social labelling of patients as ‘bad’ or ‘difficult’ is an example of a consequence of patients who disregard the nurses’ agenda. As the quality of patient care is in part determined by the social labelling process, it is understandable why patients would try to avoid being labelled ‘difficult’. According to face work theory, patients in this study wanted to be viewed positively and put forth that front; through their self-evaluation and their perceived evaluation by the other, they were able to maintain their presentation of the ‘good’ or ‘easy’ patient.

Harrison et al. (1989) found a difference in communication behaviours based on nursing-related work experience (such as working as a nurse’s aide, licensed practical nurse, or volunteer involved with patient care). Nursing students who had nursing-related work experience realized when others did not understand them, used facial expressions and meaningful gestures, and were sensitive to others feelings more so than those nursing students who did not have nursing-related work experience. In addition, the nursing students who had nursing-related work experience were less likely to use deception, gossiping, blaming and judging. However, the students with the most nursing related work experience used threats to gain compliance or cooperation, disagreed frequently, and interrupted more than those in the group of nursing students who had no nursing-related experience. Harrison et al. (1989) also found that the group that had no nursing-related experience were better listeners and less critical than those with nursing-related work experience. It appears that as nursing students gain more experience and education, communication behaviours become less desirable. Harrison et al. postulated that students may have learned appropriate communication skills but did not fully incorporate them into their usual communication patterns. It has been suggested that the health care environment prevents the integration and utilization of therapeutic communication behaviour (Mathews, 1962; Mynatt, 1985). Further research in this area is warranted to deepen our understanding of these processes.

In another study of nursing students, Baer and Lowery (1987) examined the effect of patient characteristics and helping situation on nursing students’ like or dislike of caring for patients. Baer and Lowery (1987) found that students liked best to care for persons who were cheerful, communicative, accepting of their illness, and accepting of nursing care. According to Garvin and Kennedy (1990), ‘the findings from this study (Baer & Lowery, 1987) highlight the fact that patient communication characteristics are important variables to consider when examining the nurse–patient relationship’ (p. 27). The use of Goffman’s face work theory to investigate the nurse–patient relationship is reasonable as it actively includes both patient and nurse, thereby addressing Garvin and Kennedy’s stated point.

Caris-Verhallen et al. (1998) used Roter’s interaction analysis system to analyse nurse–elderly communication in home care and institutional long-term care based in King’s nursing theory. Interestingly, Caris-Verhallen et al. (1998) found that communication related to nursing and

medical topics occurred with greater frequency in home care than in the institutional long-term care setting and that communication related to relationship building was found more frequently in institutional care than in home care. Limitations of this study include self-selection (where nurses selectively recruited patients for participation in the study) and performance bias (where the presence of a video recorder could effect the communication of the nurse). While this study adds to the theoretical research-based knowledge of the types of nurses' communication and differences in when they are used, it does not increase the understanding of the nurse–patient relationship or consider the patient's role in the encounter. In addition, it is unlikely that multifaceted nurse–patient communication can be categorized into discrete predetermined quantifiable units to illuminate the complexity of nurse–patient interaction.

Gibb and O'Brien (1990) studied 10 Registered Nurses' 'speech acts' and 'speech style' with older clients in two different nursing homes. The authors found that most of the nurses' communication elicited little verbal elaboration from the patients, requiring only 'yes' or 'no' responses. They also found that nurses rarely gave up control of patient care procedures.

Nurse–patient interaction

Nurse–patient interactions were the focus of studies in the context of life-threatening or terminal illness (Aranda & Street, 1999), primary care (Johnson, 1993), inpatient chronic illness (Savage, 1997), home care and care of older people (Trojan & Yonge, 1993), labour and delivery (Beaton, 1990), and psychiatry (Altschul, 1971; Cleary et al., 1999; Cleary & Edwards, 1999).

An early United Kingdom study on nurse–patient interaction was conducted by Altschul (1971) who studied nurse–patient relationships using participant observation and interviews in four inpatient psychiatric units. In the 1970s, there was controversy about whether or not nurses should form relationships with patients, some believing that nurse–patient relationships were 'dangerous' (to patients and nurses). In an attempt to examine this concern, Altschul observed nurse–patient interactions, interviewed both nurses and patients about their experience of a nurse–patient relationship (if they claimed to be in a nurse–patient relationship), and interviewed patients who described themselves in a nurse–patient relationship as to whether they considered the relationship therapeutic.

Altschul (1971) found that patients in nurse–patient relationships believed that these relationships were therapeutic, however, nurses 'frequently expressed doubt about the value of their relationship with the patient' (p. 185). The researcher did not judge the relationships to be therapeutic because they did not seem to be 'purposeful or goal-directed' (p. 185). Nurses interviewed by Altschul ridiculed colleagues who had therapeutic relationships with patients. Interestingly, these same nurses were themselves involved in nurse–patient relationships.

Altschul (1971) found that both nurse and patient were aware of being in a nurse–patient relationship; however, nurses were often unaware of the patient's view. This study quantified the number and duration of nurse–patient interactions and found that nurses 'were not observed in frequent or prolonged interactions with the patients' (p. 184). This finding, however, did not preclude nurses from forming relationships with patients; in fact, in three of four examples (on

one psychiatric unit) where both nurse and patient claimed that they were in a nurse–patient relationship, the researcher only observed one interaction of a short duration (that incidentally was initiated by the patient). Therefore, the nurse–patient relationship was not dependent on many interactions of long duration. While the interviews with nurses indicated that they believed they spend considerable time with patients, this was contrary to the researcher’s observations. These findings challenge the long-held belief that time is essential in order to develop a satisfying nurse–patient relationship. A recent reconceptualization of the nurse–patient relationship by Hagerty and Patusky (2003), which is consistent to the findings here, suggests that extensive time is not necessary to form a relationship.

In contrast to the findings of Shattell (2002) on the hospital environment, Altschul (1971) found that some patients, when asked what had helped them while in the hospital, spoke at length about certain nurses. They not only revealed the nurse’s name, but that ‘each nurse was described in vivid terms and it became obvious how much detailed information patients had about each of the nurses on the ward’ (Altschul, 1971, p. 183). Findings common in Altschul (1971) and Shattell (2002) are that patients want nurses who are genuine, do not seem to be in a hurry, and are available and willing to talk to them.

Patient perception of nurse–patient interaction

Only three studies were found that explored patient perceptions of nurse–patient interaction. These studies sought to explicate the patient’s perspective on the interpersonal competence of nurses (Fosbinder, 1994), the patient’s experience of exclusion and confirmation through nurse–patient interaction (Drew, 1986), and the patient’s experiences of care when labelled ‘difficult’ (Breeze & Repper, 1998).

Fosbinder (1994) developed a ‘theory of interpersonal competence’ based on a qualitative ethnographic study of the patient’s perception of nurse–patient interaction. Study participants included 40 patients and 12 nurses from orthopaedic and cardiac care units in a private teaching hospital in the United States. Patients were asked what happened when the nurse took care of them and how they felt about what went on with their care. Overwhelmingly, patient participants talked about the interpersonal interaction instead of other aspects of nursing care. The themes as they emerged from the data included the following: translating (informing, explaining, instructing and teaching), getting to know you (personal sharing, humour/kidding and being friendly), establishing trust (being in charge, anticipation of needs, being prompt, following through and enjoying the job), and going the extra mile (being a friend, and doing the extra) (Fosbinder, 1994). Fosbinder (1994) acknowledges the importance of the patient’s role in nurse–patient interaction and suggests this as an area for future research:

interpersonal competence is assumed to carry a reciprocal nature, where characteristics in the patient have important influence. Such issues need further study to expand the model proposed here (p. 1092).

Goffman’s face work theory could further our understanding of the reciprocal nature of nurse–patient interaction by helping us understand communication behaviour.

Another study that explored the patient’s perspective of nurse–patient interactions was a

phenomenological study of the experience of exclusion and confirmation in hospitalized patients (Drew, 1986). Exclusion is defined as ‘to be excluded, that is, to experience one’s feelings’ being disregarded by another on whom one depends’ (Drew, 1986, p. 40); confirmation is ‘having one’s feelings acknowledged by an important other’ (p. 40). Participants were individually interviewed and asked to describe one positive and one negative experience with a caregiver. Exclusionary experiences of patients (through their interactions with caregivers) in the hospital were characterized by experiences of caregivers who were emotionally ‘cold’, hurried, and who avoided eye contact. Caregivers who were energetic and enthusiastic, made eye contact, were physically relaxed (i.e. moved slowly) and willing to talk about their own lives were characterized as confirmatory.

Drew’s (1986) study illuminates the patient’s experiences of the caregiver as exclusionary and confirmatory. This study shows that caregiver communication and behaviour has an impact on patients in the hospital setting. Patients who were negatively affected by exclusionary experiences reported feeling like energy was being taken away. Confirmatory experiences were described as energy giving. The effect of nurse–patient interaction on the experience of the patient can be helpful or hurtful, confirmatory or exclusionary. Although not all of the findings can be entirely attributed to nurses as caregivers, some participants in their descriptions included nurses. These findings are consistent with those of Shattell (2002) and Plaas (2002). Shattell (2002) found that patients experienced the hospital environment as disconnecting and disconfirming. In a phenomenological study of the patient’s experience of the outpatient health care environment, Plaas (2002) found that patients expressed feeling like they were treated like objects. Studies of inpatient and outpatient health care environments have findings consistent with those of Drew (1986) that exclusionary and confirmatory experiences are present in both settings.

Based on early studies on deviance (Tannenbaum, 1938; Becker, 1963; Lemert, 1972), moral evaluation and social labelling of patients is well outlined in the literature (Lorber, 1975; Jeffrey, 1979; Stockwell, 1984). This negative social process of labelling patients as ‘difficult’ affects patient care in the hospital environment. The label ‘difficult’ or ‘bad’ has been associated with patients who are ‘demanding, uncooperative, and ungrateful... [who] make staff feel ineffective’ (Finlay, 1997, p. 440). This description of the ‘difficult’ label derived from symbolic interactionism is different from earlier research that used patient characteristics such as medical diagnosis, physical attractiveness, race, gender, and age to define the ‘difficult’ patient. Current research shows that nurses who label patients as ‘difficult’ often avoid or distance themselves from these patients (Carveth, 1995; Finlay, 1997; Breeze & Repper, 1998) resulting in less supportive nursing care (such as responding promptly to patient requests for assistance, providing privacy, informing the patient, providing comfort measures, and using the patient’s name) (Carveth, 1995).

In an ethnographic study of the mental health patient’s experience when labelled difficult, Breeze

and Repper (1998) used focus groups and unstructured interviews to study patient perceptions of care experiences. The researchers used a focus group of nine mental health nurses to examine patient characteristics that they regarded as ‘difficult.’ This focus group yielded the following characteristics: does not respond to intervention, does not conform, primary or secondary diagnosis of personality disorder, long-term mental health problem, multiple and complex needs, demanding (of staff, time or resources), disruptive and aggressive (Breeze & Repper, 1998). The researchers then interviewed six patients who met the ‘criteria’ of the ‘difficult’ label.

Apparently, the researchers initially had a list of 17 patients who met the criteria, but the patients who were labelled ‘difficult’ by the nursing staff, were also difficult to interview by the researchers. Many of the potential patient participants were unavailable, too ill to consent, or were unwilling to participate. Even patients the researchers did interview were not easy to contact. For example, one participant was visited four times just to explain the study and give consent.

Breeze and Repper (1998) analysed data obtained from the interviews using a stage-by-stage method adapted from grounded theory. Findings included three major themes – control, patient response and nurse intervention. Patients described feeling like they had no control over their treatment and were coerced or forced into certain behaviours that the staff thought more appropriate. The participants responded to this control with anger, which led to a ‘struggle for control’ (p. 1306). Positive nursing interventions included the following: ‘a good nurse–patient relationship ... treating the patient with respect...as a valued person... displaying empathy and holding ‘normal’ conversations with the patients; enabling the patient to have meaningful control over their care ... listening to and, especially, believing in the patient’ (Breeze & Repper, 1998, p. 1306). The participants expressed a desire to be respected and valued as a person. This finding is consistent with Plaas (2002).

Patient care-seeking communication

There has been little research on patients as active participants in the nurse–patient interaction.

As stated by Russell (1994):

one implicit assumption, among many others, inherent in the focus of most research efforts in this area is that the caregiver has the power to make changes and influence the care giving situation (p. 308).

Subsequently, we know much more about how nurses communicate with patients than how patients communicate with nurses. There were only five studies found that addressed patient communication specifically. The context of these studies was pain management (Pettegrew & Turkat, 1986; McDonald et al., 2000) and care seeking of elders in a continuing care community (Russell, 1994, 1996).

Two empirical studies reported in one article examined how patients communicated with their providers and how that communication contributed to the patient–provider relationship (Pettegrew & Turkat, 1986). Both studies were performed at a low back pain clinic at a university medical centre. In the first study, all clinic patients (n = 96) were mailed three measurement tools – Patient Communicator Style Measure (PCSM) and Illness Behaviour

Inventory (IBI), and a tool to measure utilization of medical treatment. The sample was comprised of 50 patients, yielding a high response rate of 52%. The PCSM measured the construct communication style, which has been found to be reliable and valid. Communication style is defined as how people communicate. The PCSM consists of nine subconstructs: dominant communication style, open communication style, attentive communication style, friendly communication style, relaxed communication style, precise communication style, dramatic communication style, contentious communication style, and animated communication style. The Illness Behaviour Inventory measures how people communicate when ill and contain two subconstructs: work illness behaviour and social illness behaviour. Pettegrew and Turkat (1986) found a correlation between social illness behaviour (such as frequently bringing up one's illness in conversation, giving off non-verbal cues about one's illness, and acting more ill than one feels) and assertive communication styles (such as open, dramatic, contentious, and animated) and increased visits to the health care provider.

In the second study, Pettegrew and Turkat (1986) videotaped seven patient–provider interactions to study the difference between the participants' self-report of communication style and that of an independent raters' assessment. The interactions were on the patients' initial visit to the clinic, in a meeting with a physical therapist. The same physical therapist was used for all seven interactions. There were no significant differences found between patient self-reports and the independent raters assessments of communication behaviour. While there were no statistically significant differences in the two groups, it was interesting to note that with the patients who reported having an assertive communication style, the independent raters found to be contentious, uncooperative and inappropriate. How do patient communication variables affect nurse–patient interaction and health outcomes? How does the power differential impact the interaction? How could the use of face work theory impact the nurse–patient relationship, both in research and practice? Further study is warranted and as Pettegrew and Turkat (1986) aptly conclude, 'patients may have a far greater impact on and responsibility to the health-care relationship than previous provider-patient research has revealed' (p. 391).

In another study about patient communication and patient care seeking, Russell (1996) used participant observation and semi-structured interviews with older patients in a long-term care facility to examine care-receivers' insight into 'successful care interactions' (p. 309). Symbolic interactionism was the theoretical framework that guided Russell's (1994) study. The phenomenon was viewed, the study was framed, and the data was analysed all from this perspective. Russell (1994) found that elders used their prior interpersonal experience, labelled 'insight', to manage future interactions with caregivers. Russell (1994) describes a care-seeking process, which consists of two phases: care eliciting and care engaging. This care-seeking process emerged from experiences with both formal and informal caregivers and was sequential and developmental in nature. Russell (1994, 1996) labelled patient communication the 'care-seeking process' for elders in a continuing care community. It is appropriate to more fully explore what it is that occurs when patients seek care. Goffman's theory of face work would be

an appropriate framework for use in this endeavour.

Discussion

Goffman's theory of face work was reviewed and proposed to further our understanding of nurse–patient interaction. Threats to face may be greater in situations in which patients and nurses interact and vulnerability is threatened. For example, nurses are frequently in the position of asking very probing questions about intimate personal matters. Patients in a highly vulnerable health crisis are forced to depend upon nurses for basic needs. Both of these situations are illustrations of common nurse–patient interactions where the potential for the patient's loss of face (autonomy, self-esteem) is high. An understanding of nurse–patient interaction through the use of face work may 'provide an alternate lens for examining social phenomena of interest to nursing within the social construction of verbal conversation' (Spiers, 1998, p. 45).

Research on nurse–patient interactions has increased our knowledge on how nurses communicate in nurse–patient interactions, how patients perceive nurse–patient relationships and how patients perceive nurse–patient interactions. Nurses were found to exert power over patients. Nursing students' communications skills did not improve with communication skills training and nursing related work experience. Nurses distanced themselves from patients who were labelled 'bad' or 'difficult' thereby decreasing the quality of care. Nurse–patient relationships were able to be formed after very few nurse–patient interactions and of relatively short duration. Patients believed that these relationships were important in their care, and in fact, more important than other aspects of care. Patients wanted nurses to be genuine, not in a hurry, available and willing to talk to them. Patients wanted to be valued and respected as individuals and believed that social interaction was important. Patients did not want to be treated like objects.

The findings from this literature review have many implications for clinical practice. Nurse–patient interaction can have a major influence on the patient care experience and should be vigilantly considered. In a descriptive study of how patients communicate their need for pain medication after surgery, McDonald et al. (2000) found that some patients avoided or delayed communicating needs because of not wanting to complain. In an effort to manage their desire to be liked, do patients communicate with nurses in patterned ways? Do nurses recognize the more subtle ways in which patients communicate their needs?

Most of the body of literature on nurse–patient interaction explores the communicative action of the nurse thereby ignoring the contribution of the patient (May, 1990). Although most would agree that nurse–patient interaction is central to nursing practice, there are few studies that address patients as equal partners in nurse–patient interaction. Morse et al. (1997) assert that: the patient's behaviours have been relatively ignored when nurses have been examining the nurse–patient relationship. Additional research is urgently needed to examine the patient's contribution (p. 341).

The majority of studies that have examined patient communication have used an atheoretical linguistic, content-based communication orientation leading to a limited understanding of the patient's role in nurse–patient interaction. Many research questions remain: How do ill patients communicate with nurses? How do communication styles of patients affect nurse–patient

interaction and health outcomes, patient satisfaction and quality of care? Does a dominant or assertive communication style lead to greater satisfaction with nursing care? Does patient communication behaviour account for a significant difference in patient satisfaction? What are the best ways to access the ‘difficult’ patient for research purposes? How do these methodological complexities impact research findings on negative social labelling? Why do nursing students fail to incorporate therapeutic communication into their nurse–patient interactions subsequent to more education and nursing related experience? What variables contribute to this phenomenon? How does the consumerist culture impact professional power and the nurse–patient relationship? Does consumerism affect empowerment? Does oppressive group behaviour apply to patients? The literature reviewed in this paper has presented the existing research on nurse–patient interactions. Much about the patient’s contribution remains unknown. Utilization of face work theory could help us narrow this gap.

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