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A grounded theory study of patient/nurse interaction in a
community practice setting.

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~~04/06~~

Abstract

This thesis is about patient/nurse interaction in a community practice. My aim is to advance sociologically informed understandings about patient/nurse interaction. The key areas of inquiry in my grounded theory study are:

The meanings and understandings expressed in patient/nurse interaction.

The influence of socio-cultural characteristics in patient/nurse interaction.

My study was conducted in a community practice setting using the traditional discovery methodology of Glaser and Strauss (1967). The community practice setting is four health centres with social and geographical differences. The participants in the study are patients attending those health centres and practice nurses who work there. Research methods are observations, informal interviews and semi-structured interviews. Constant comparative analysis supports my research process. My substantive theory is constructed from the generation of two categories: Investment and Experience.

The category of Investment relates to the social assets and resources brought to patient/nurse interaction. The category of Experience relates to the historically crafted meanings and understandings that individuals bring to patient/nurse interaction. Together, these categories contribute to understandings of patient/nurse interaction in a community practice setting.

I argue in this thesis that the meanings and understandings that patients and nurses bring to interaction provide the social dimension that is quintessential and foundational in their relationship. I also argue that the social construction of reality of being a patient or a nurse is related to the socio-cultural characteristics that they bring to their performance in patient/nurse interaction. I show that performance as a patient or a nurse is initiated and achieved via processes of acting and reacting to each other in relation to socio-cultural characteristics. I demonstrate that the meanings and understandings patients and nurses generate from experiences beyond and including their situated need/care interaction are pivotal in the negotiation of their relationship. Empowerment plays a central role in processes of negotiation and is connected to the social construction of reality in patient/nurse interaction.

My substantive theory contributes to understanding of patient/nurse interaction and raises the visibility of negotiation, empowerment, and the influential role of socio-cultural characteristics. The implications of my substantive theory relate to the involvement and participation of stakeholders in health care practice and delivery. In nurse education, the standards of proficiency for eligibility to register with the NMC should be revised to include the social dimension of patient/nurse interaction as a domain of practice. I conclude by arguing that sociologically informed understandings need to be expanded and applied in health care and nursing with contemporary social policy and current priorities for health in mind.

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Chapter 1 Introduction

This thesis is about the interaction between patients and nurses in a community practice setting. It examines the social meanings and understandings expressed in patient/nurse interaction, including the influence of socio-cultural characteristics. It uses grounded theory in the tradition of Glaser and Strauss (1967). A substantive theory about patient/nurse interaction is constructed from two categories, Investment and Experience, which are generated through data analysis.

I argue in the thesis that the meanings and understandings that patients and nurses bring to interaction provide the social dimension that is quintessential and foundational in their relationship. I also argue that the social construction of reality of being a patient or a nurse is related to the socio-cultural characteristics that they bring to their performance in patient/nurse interaction. I show that performance as a patient or a nurse is initiated and achieved via processes of acting and reacting to each other in relation to socio-cultural characteristics. I demonstrate that the meanings and understandings patients and nurses generate from experiences beyond and including their situated need/care interaction are pivotal in the negotiation of their relationship. Empowerment plays a central role in processes of negotiation and is connected to the social construction of reality in patient/nurse interaction.

This opening chapter introduces the natural history and conceptual approach of the thesis. The principal areas of interest and the aims of my study are presented in 1.1. A description of the construction of my substantive theory follows in 1.2. As a guide to the thesis, I summarise my key findings in 1.3 and describe the presentation in 1.4.

1.1 Aims and background of the research

The aim of my thesis is to examine patient/nurse interaction in a community practice setting. My intention is to contribute sociologically informed understandings about patient/nurse interaction. The key research questions are:

What happens when patient and nurse meet and interact?

What meanings and understandings can be identified in patient/nurse interaction?

What is the influence of socio-cultural characteristics in patient/nurse interaction?

How can the meanings and understandings and the influence of socio-cultural characteristics identified in patient/nurse interaction be explained?

My grounded theory study pursues these questions in a community practice setting.

The community practice setting is health centres located in a neighbourhood or centre of population. The health centre in the community is the place where people interact purposefully to address health and illness needs. Providing services to meet the needs of people living locally and the communities they live in is the purpose of health centres in the community. The four health centres that comprise my field of study are located in areas with geographic and social differences. I argue later in the thesis that my study locations are representative of the health status of communities in Scotland.

Sociologically informed understandings will contribute to insights into shared issues, resources, opportunities or dilemmas in patient/nurse interaction. In this way, my study reflects traditional concerns with the social relationship between individuals in the context in which they interact purposefully, in this instance patients and nurses in the community practice setting. The theories of social interaction that informed my work are examined in 3.2.

Previous research that informs my study revealed that the social dimension in patient/nurse interaction is often overlooked or lacks depth of consideration in present theorising. Several key perspectives provided the rationale for my study and where it was conducted as follows.

Patient/nurse interaction has most often been addressed in other care settings and linked to specific contexts of care, for example, peri-operative or palliative care. Because of this, the patient's illness and/or the nurse's professional speciality have provided the focus of research attention. Whilst a focus on context specific care and practice in this way is understandable, it has been at the expense, not only of sociologically informed understandings, but also of examining patient/nurse interaction in community settings in particular. I elected to conduct my study in the community practice setting to redress this imbalance. Additionally, the community practice setting is distinctive in that it is the interface of public health and primary health care services sited in localities of population, rather than in centralised institutions that focus primarily upon illness services.

Age, gender, socio-economic status (SES) and ethnicity are defining characteristics of individuals in society. These characteristics relate to, and link with, the social identity and experience of individuals. Socio-cultural characteristics are factors of inequality and as such continue to be concerns that underpin morbidity and mortality in Scotland and the rest of the United Kingdom (Acheson 1998, Hanlon *et al.* 2001, Blamey *et al.* 2002). Furthermore, Bradley (1996:19) argues that age, gender, SES and ethnicity 'cannot be separated in their effects' as lived relationships that interact and create the dynamics of social inequality. Persistent inequalities related to age, gender, SES and ethnicity are critical concerns in the priorities of public health in Scotland and the United Kingdom (Baggott 2000, Blamey *et al.* 2002, Watterson 2002).

The minority ethnic population in the terms defined by the Registrar General is very small at 1.9% in the central area of Scotland where I conducted my study (Registrar General, 2001 Census of Population). However, I have included ethnicity because it is a fundamental socio-cultural characteristic of every individual and could not be excluded in seeking the cultural meanings and understandings of patients and nurses. The role of age, gender, SES and ethnicity in interaction is a central interest in my study. I conceived these socio-cultural characteristics to be central to an individual's navigation and negotiation in the social world.

My research participants are patients and practice nurses in a community practice setting. I refer to the interaction of the participants as patient/nurse interaction throughout my thesis. Their interaction is also referred to throughout as need/care interaction because the term best reflects the *raison d'être* of patients and practice nurses meeting purposefully in the community practice setting. Need/care interaction transpires when the patient presents with needs (health or illness) and the nurse responds with care.

I draw upon the work of several prominent interaction theorists to inform my analysis and substantive theorising. The work of Strauss (1978) regarding negotiation contributes helpful concepts related to understanding *modus operandi* in interaction.

'The social construction of reality' as conceived by Berger and Luckmann (1967) is helpful in understanding the diverse meanings and understandings that participants brought to interaction. Finally, the work of Garfinkel (1967) regarding social performance is useful in examining processes of navigation in interaction. The links between navigation and negotiation processes in *modus operandi* are explored in my findings chapters.

My role and characteristics as researcher are influential throughout the research process. Denzin and Lincoln (1998a: 24) identify that the prospect of value free inquiry is mythical and indeed undesirable:

Any gaze is always filtered through the lenses of language, gender, social class, race and ethnicity.

It is manifest that my socio-cultural characteristics interact with the entire research process. I address the complex issues arising from the relationship between the research, the researched and the researcher in my thesis.

1.2 Construction of theory

My systematic approach in using grounded theory to 'discover' is consistent with the original work of Glaser and Strauss (1967) and the subsequent work of Glaser (1978, 1992). Glaser and Strauss (1967:105) describe their constant comparative method in four stages which are:

- (1) comparing incidents applicable to each category
- (2) integrating categories and their properties
- (3) delimiting the theory
- (4) writing the theory

Grounded theory is characterised by the constant comparative analysis of data which is driven by theoretical sensitivity with emergence of theory in mind. Later, I identify the nature of theoretical sensitivity as responsiveness to meanings in my data. I also show later how I have integrated the stages Glaser and Strauss (1967) propose in my study.

The emergence of my substantive theory is connected with the direction of progression of analysis and follows the process of understanding set out by my participants. My analytic approach in the construction of theory is informed by drawing on the conceptualisations of Glaser and Strauss (1967) and Glaser (1992). My theory is constructed in the following way:

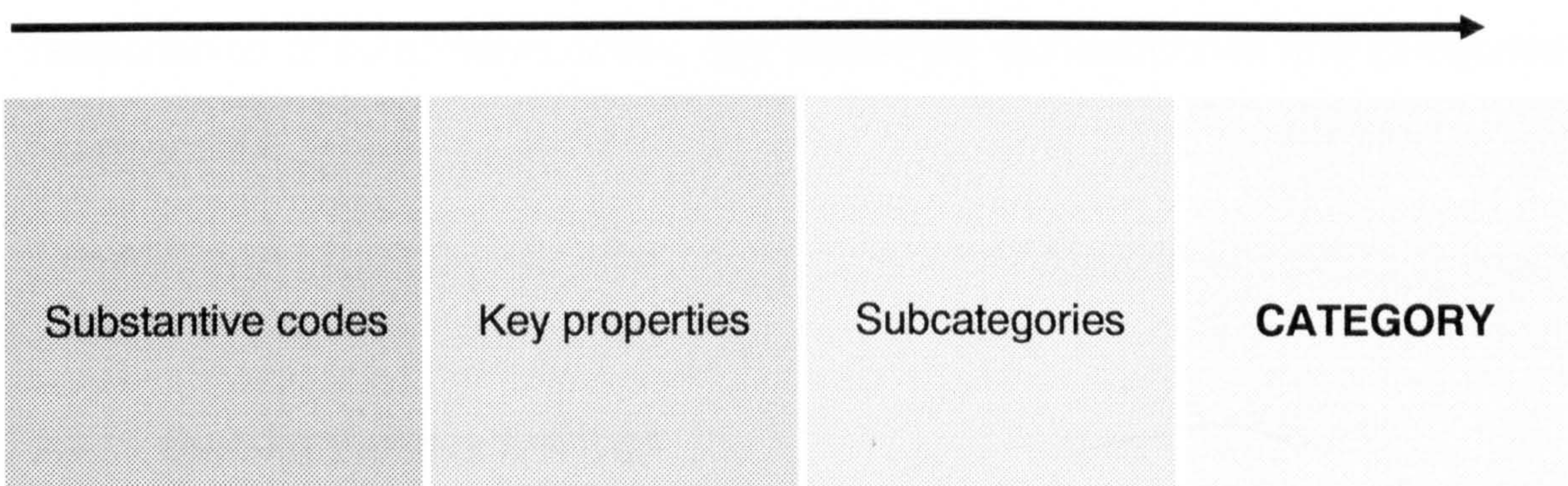
1. *Substantive codes* represent the conceptual meanings and their patterns found in my data, generated by processes of constant comparative analysis.
2. *Key properties* represent the interrelated conceptual characteristics of the substantive codes and essentially define my subcategories.
3. *Subcategories* are a distillation of the interrelated concepts expressed in the key properties and clarify the character of my categories.

4. *Categories* of Investment and Experience are defined by the conceptual characteristics of the key properties, which are distilled in the subcategories. The categories represent the creative conceptual constructs of my substantive theory.

The direction of progression of analysis from substantive coding to category construction is exemplified in figure 1.

Figure 1: direction of progression of analysis

Direction of progression of analysis



The categories of Investment and Experience are presented in circular diagrams, figures 2 and 3 which are included in 1.3 and reproduced at the beginning of chapters 6 and 7 respectively. In the circular diagrams, substantive codes are outlined in the outer circle and key properties that emerged from the data are outlined in the middle circle. Subcategories are presented in the inner circle. The category itself is at the centre.

The diagrams present the direction of progression of analysis leading to the construction of substantive theory in each category. The diagrams also show the direction of progression of analysis as 'darkness into light'. This is more than whimsy, in view of the role of emergence and discovery in conducting a grounded theory study (Glaser and Strauss 1967, Glaser 1992). The shading in the diagrams not only shows the 'darkness into light' of emergence, but also overcomes the hierarchy in theory construction created by QSR NUD*IST (version 4) discussed further in 5.2. The shading is seamless to portray the interaction of, and close relationship between, substantive codes, key properties and subcategories in the construction of my substantive theory. I show the inter-relationships of substantive codes, key properties, subcategories and categories in appendix E.

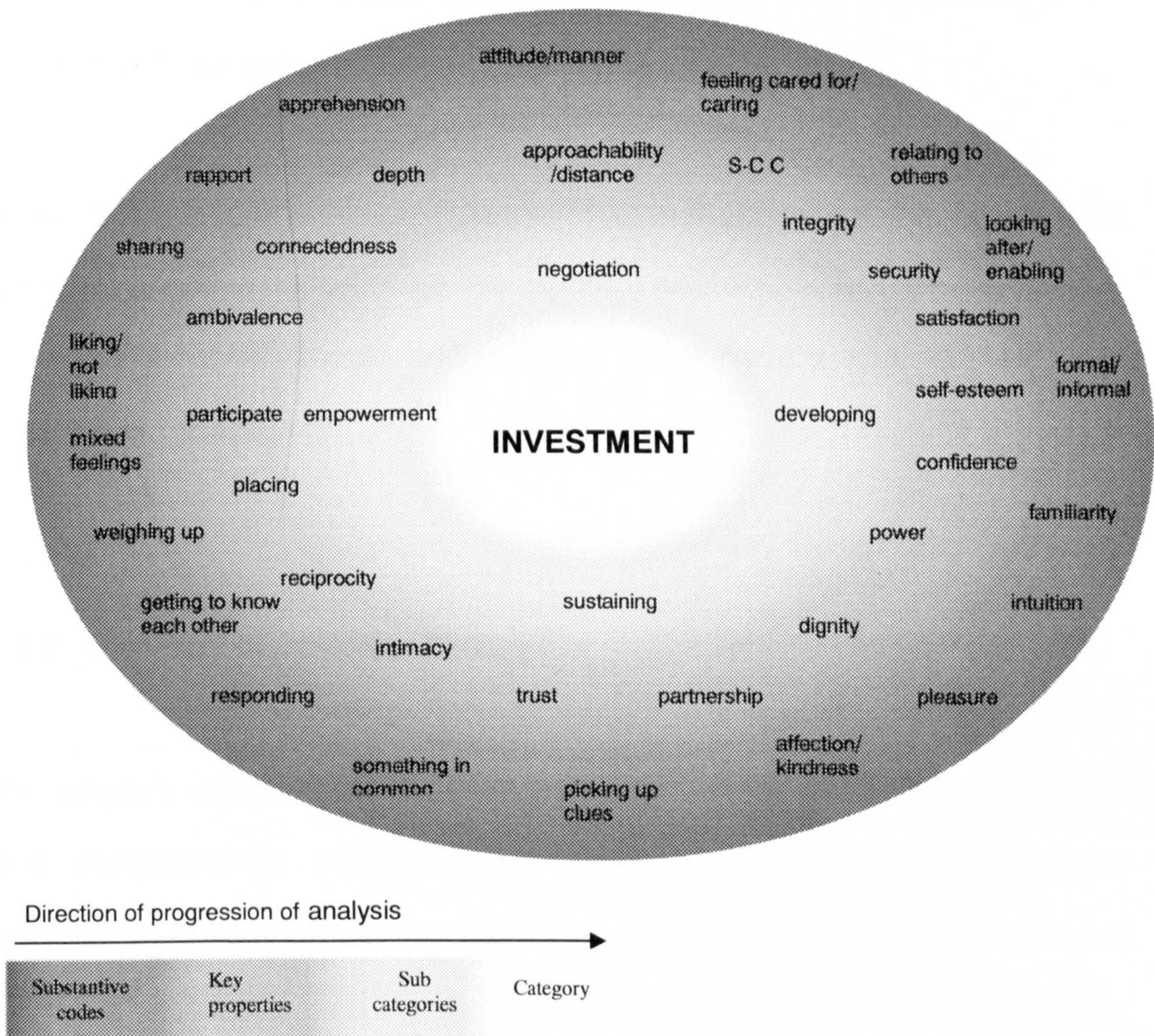
1.3 Summary of key findings

My data analysis resulted in two categories, Investment and Experience. I justify the use of those terms at the beginning of my findings chapters 6 and 7. At this point I provide a summary of the key findings of each category in terms of their subcategories. I also highlight what each category contributes to understanding about patient/nurse interaction.

1.3.1 Summary of category: Investment

The category of Investment (figure 2) relates to the extent to which patients and nurses may develop their relationship beyond the superficial, founded upon negotiation in their interaction. Subcategories of Investment are negotiation, developing and sustaining the patient/nurse relationship, and empowerment.

Figure 2: category of Investment



(S-C C = socio-cultural characteristics: age, gender, SES and ethnicity)

I show that patients and nurses qualify their commitment to investing in their relationship in a range of ways. These qualifications include the reason/s for their meeting/s, the duration of their relationship, the positive feelings they have regarding each other and reciprocity. Further qualifications to Investment include the generation of rapport and confidence, leading to a sense of partnership in patient/nurse interaction. I demonstrate that Investment is most likely to occur when the relationship between patients and nurses is sustained over several meetings or episodes of care. A sustained relationship in which Investment has occurred is one in which patient and nurse have agreed roles and responsibilities and is likely to be mutually rewarding and therapeutic.

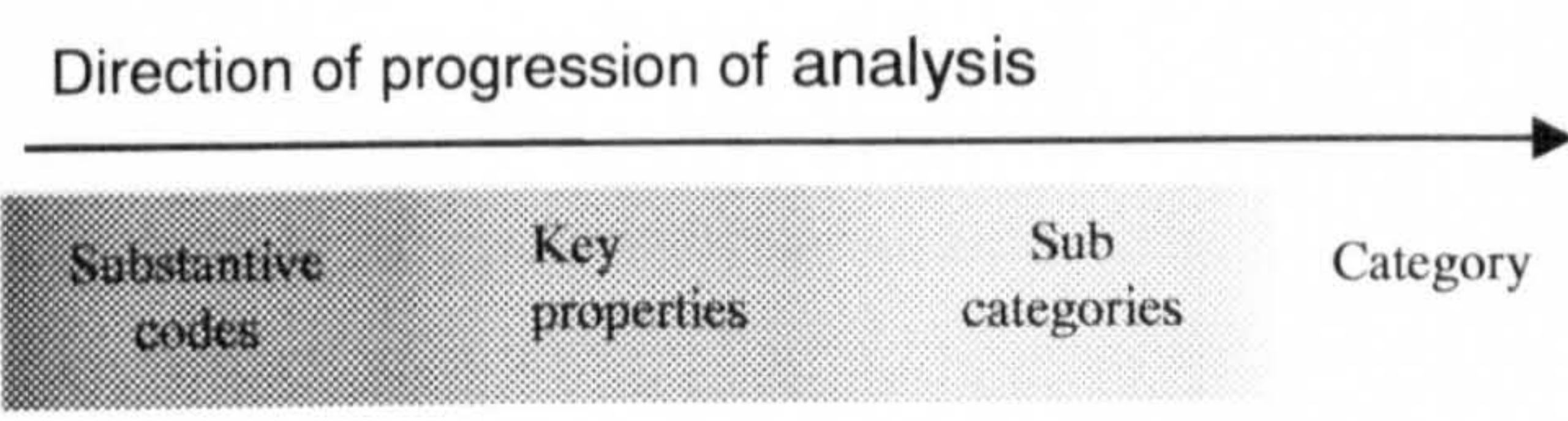
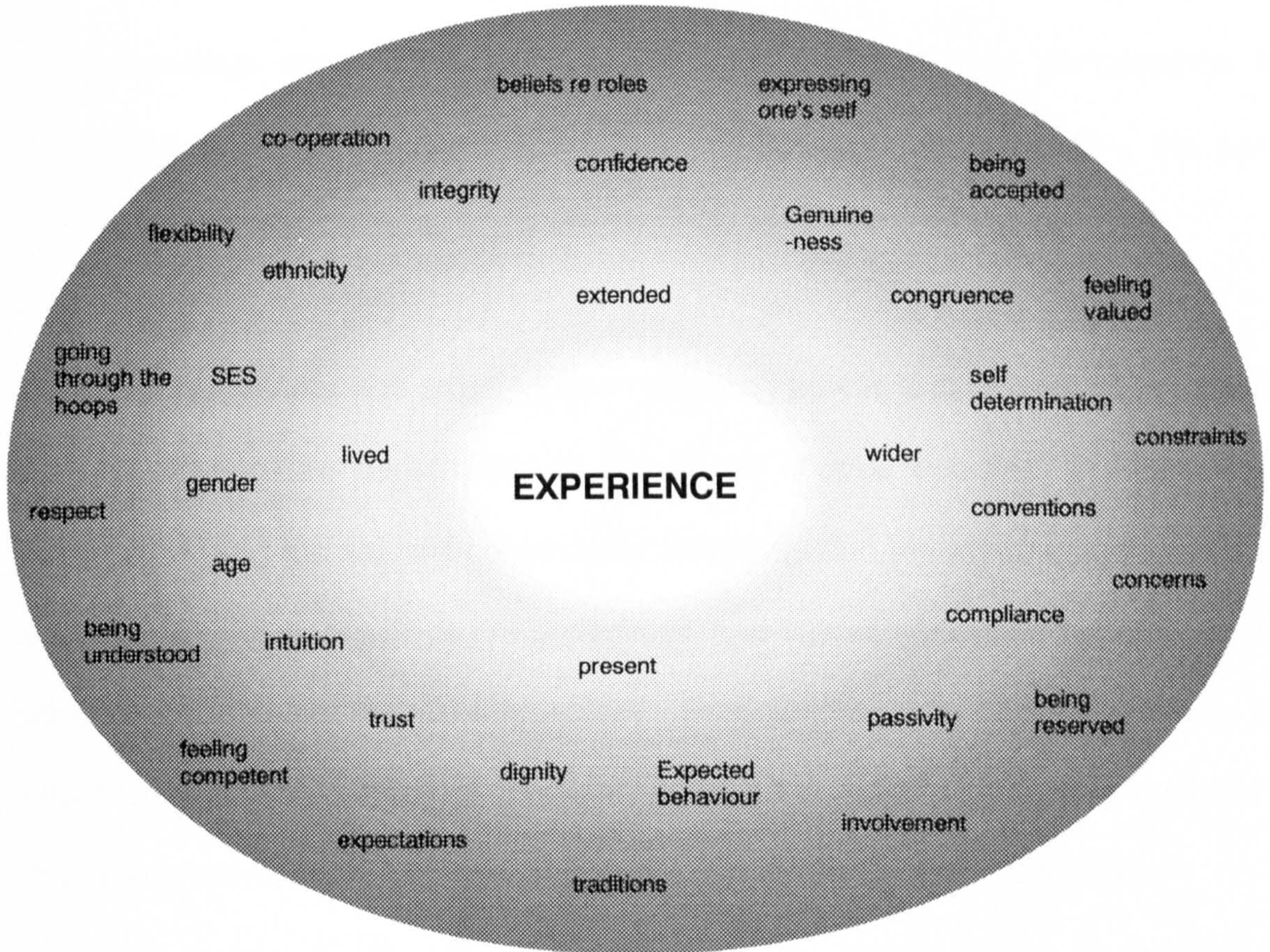
I show that empowerment is a central concept in Investment in the patient/nurse relationship, and in patient/nurse interaction. I also demonstrate that negotiation is a developmental process and is linked to involvement and participation in patient/nurse interaction.

1.3.2 Summary of category: Experience

The category of Experience (figure 3) relates to the historically crafted meanings and understandings that individuals have generated from diverse social experiences. I demonstrate that these meanings and understandings, and those related to socio-cultural characteristics, are influential in patient/nurse interaction.

Subcategories of Experience are extended, wider, present and lived experiences of health care and nursing.

Figure 3: category of Experience



The encounters of those engaged in patient/nurse interaction are imbued with historically crafted meanings and understandings generated from diverse experiences within and beyond the health care setting. Those diverse experiences are important influences in performance as, and in the social constructed reality of being, a patient or nurse. Historically crafted meanings and understandings serve as a pathway between the past, and performance in interaction in the present. I show that in patient/nurse interaction, the past articulates with the present.

I explain that beliefs and expectations regarding power and control in navigation and negotiation are constructed in individuals' *modus operandi* in interaction. Also I show that the socially constructed meanings and understandings related to socio-cultural characteristics are brought to, and interactive within, navigation and negotiation in patient/nurse interaction. Participants' extended experiences of health care and nursing over time and outwith the current context of need/care interaction are important to their performance in patient/nurse interaction.

1.4 Presentation of the thesis

The role of each chapter in my thesis is described in turn in this section. The major issues and arguments to be found within each chapter are also highlighted.

The use of literature in a grounded theory study and my approach to reviewing the literature in chapters 2 and 3 are examined in detail at the beginning of chapter 2. In that chapter, I examine critically the literature related to my research questions. The key concepts I discuss in chapter 2 are also related to my findings. I indicate throughout the chapter where I have been able to develop the concepts used in my analysis.

Chapter 3, a review of the literature about methodology, forms the basis of my critique of grounded theory. I clarify my traditional grounded theory approach in this chapter and argue that my work meets the criteria of 'fit, work and relevance' specified by Glaser and Strauss (1967:237). Whilst the review of literature in chapters 2 and 3 reflects the direction provided by my research questions and research methodology, other literature is integrated throughout the thesis where it contributes to discussion.

My research methods are detailed in chapters 4 and 5. In chapter 4, I specify and examine my methods of data collection which are observation, informal interviews and semi-structured interviews. Chapter 4 also includes description and discussion of ethical approval, the field of study and research participants. I critically review my data collection methods. In that review, I show how I obtained rich description of participants' meanings and understandings in relation to my research questions which fuels my analysis and substantive theorising.

In chapter 5, I discuss the processes involved in continual comparative analysis with specific reference to 'emergence versus forcing' (Glaser 1992). To show the interrelationships between the elements of my analysis, I include an illustrative pathway for each category, with reference to appendix E. The chapter also includes a critique of the utility of the software package, *Non-numerical unstructured data* indexing searching and theorizing*, (QSR NUD*IST version 4) in my study. I demonstrate that through the processes of constant comparison, my analysis is progressive and directed by my research questions. Discussion of my research process and my influence within it is integrated throughout chapters 4 and 5.

My findings are presented in detail in chapters 6 and 7 and relate directly to the two categories of Investment and Experience. In chapters 6 and 7 I make transparent the link between the literature, data collection and analysis. I show that my categories are robust in their construction and provide evidence of the 'fit, work and relevance' of my thesis. Whilst each category is discussed in turn, I show how they are related and together contribute to my substantive theory. In these terms, I make arguments throughout my findings chapters that articulate with the substantive theory I have generated from my analysis.

My substantive theory and the contributions it makes to sociologically informed understandings about patient/nurse interaction are discussed in the concluding discussion in chapter 8. I specify my substantive theory and identify the relationship to my research questions. I discuss how I have advanced grounded theory methodology, and conclude with the implications of my thesis for further work. I include a stakeholder analysis and refer to current practice and policy to make proposals for using my substantive theory to inform practice and suggest areas of further research.

Chapter 2 Literature review: substantive

The substantive literature related to my research questions is reviewed in this chapter. Relevant areas of substantive literature included are firstly literature on the development of the patient/nurse relationship with reference to key concepts of communication, trust, intuition and integrity. Secondly, literature concerning socio-cultural characteristics of age, gender, SES and ethnicity is included and refers to my research questions. Thirdly, literature regarding negotiation and empowerment in patient/nurse interaction is included as these key areas emerged from my analysis.

This chapter starts by introducing the methodological approach adopted in examining the literature (2.1) followed by an explanation of the organisation of the review (2.2). The literature that connects the research questions with my findings is examined in sections 2.3 – 2.6. For clarity of presentation, I draw attention to key sensitising concepts in each of those sections and relate them to my analysis.

2.1 Approach to reviewing the literature

Literature review in a grounded theory tradition places unique demands upon the researcher in terms of searching, evaluating and reviewing the literature. Other research methodologies demand that this be done at the commencement of research. This is not advocated in a grounded theory approach in which the identification of categories from the data is central to generating theory, rather than categories being proposed deductively from existing research or literature.

Glaser and Strauss (1967:37) recommend that:

An effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study, in order to assure that the emergence of categories will not be contaminated by concepts more suited to different areas. Similarities and convergences with the literature can be established after the analytic core of categories has emerged.

They alert the grounded theory researcher that familiarity with the literature beforehand may violate the principles of discovery within the research process. Glaser (1992:30) continues to support the basic premise of 'making no bows to the existing literature' to begin with and expresses this as:

concern not to contaminate, be constrained by, inhibit, stifle or otherwise impede the researcher's effort to generate categories.

Strauss and Corbin (1998:48) also acknowledge the constraints that may be imposed by reviewing the literature prior to embarking upon research whilst recognising that some familiarity can enhance sensitivity and suggest areas for theoretical sampling. However, it seems to me that it is more judicious to adopt the positive position that existing insights and knowledge are resources that can make a useful contribution to adopting a new direction in studying an area of interest.

Strauss and Corbin (1998:48) recognise that the researcher is not a 'blank sheet' and:

brings to the inquiry a considerable background in professional and disciplinary literature.

Glaser and Strauss (1967), Glaser (1992) and Strauss and Corbin (1998) agree that in the initial stages of research, insights provided by existing literature impede creativity and the freedom to discover. In essence, pre-existent conceptual frameworks are not accorded privilege in the process of emergence. Pre-existent conceptual frameworks do not drive the process before it has taken place, but to some extent may enhance emergence. The position presented by Glaser and Strauss (1967), Glaser (1992) and Strauss and Corbin (1998) however is somewhat idealistic in that it is unrealistic to suppose that one can 'empty' the mind of existing insights and knowledge.

I was not a 'blank sheet' when I embarked upon my study. I was aware of some of the literature as part of my professional and disciplinary background. Whilst I did not 'bow' to the literature, I was certainly acquainted with some of the substantive areas identified in this and the next chapter. That literature as a resource was part of my experience that supported and sustained my inquiry. The reading I did at the beginning of my research was mostly in the area of research methodology, grounded theory and interaction from a sociological perspective. In these terms, literature was accessed initially to inform my research approach. Introductory literature also informed my application to the Health Board Ethics of Research Committee as I discuss later in 4.1. As part of the interplay between data and analysis, Strauss and Corbin (1998:53) suggest that the researcher seek interaction with the literature to foster conceptualisation, and to enhance and drive theoretical sensitivity. As they recommend, I accessed literature in terms of its contribution and relevance to my findings, and to suggest and support areas of theoretical sensitivity and sampling and analysis.

As Glaser (1992:33) advocates, I sought out and interacted with relevant literature to nurture theoretical sensitivity as a drive towards maturing my analysis. My purpose was to look for similarities and convergences with findings and debates in the literature. Continual comparison of findings and debates in the literature invoked links that increased my theoretical sensitivity: an alert engagement with my data. This interaction served to sharpen my framework of ideas as Glaser (1992:33) predicts.

2.2 Organisation of the literature review

There is a substantial literature that examines the patient/nurse relationship and interaction. A great deal of that literature focuses on acute care and the relationship of patients and nurses in hospital settings. Additionally, much of it centres on biomedical concerns and ranges across medical and associated nursing specialisms at the (hospital) bedside, for example in oncology and palliative care. The demands of acute, hospital care differ from the community practice setting in that the environment and priorities of need/care are different. Consequently, the relationships of patients and nurses in acute hospital settings are different from those in the community. For example, a key difference in acute care settings is the large number of nurses the in-hospital patient may encounter within each 24 hour on-duty pattern. In the community setting, the number of practice nurses the patient may meet is much smaller and, by careful arrangements over time Monday to Friday, patients can see the same practice nurse on each visit. However, some of the literature that relates to the patient/nurse interaction in acute care and elsewhere is useful taking into account similarity of areas of interest examined, for example communication, and that the community perspective has been neglected somewhat.

Most of the literature I use has been drawn from the fields of sociology and nursing. Wherever possible, I include studies that adopted a grounded theory approach.

I also include studies that focus on nursing in the community practice setting. However, overall, there is a lack of literature that addresses patient/nurse interaction from a sociological perspective (Allen 2000a), despite the large quantity of it.

The organisation of my review draws upon the subcategories of Investment and Experience in the following way. The sections in my review are: negotiation in patient/nurse interaction (2.3), the development of the patient/nurse relationship (2.4), socio-cultural characteristics of age, gender, SES and ethnicity in patient/nurse interaction (2.5) and empowerment in patient/nurse interaction (2.6).

2.3 Negotiation in patient/nurse interaction

Strauss (1978:1) includes 'bargaining, wheeling and dealing, compromising, reaching agreements, making arrangements and tacit understandings' in creating his definition of negotiation in social interaction. Negotiation is used here to signify the process individuals embark upon in developing shared meanings, understandings and agreements in patient/nurse interaction. Review of the literature reveals that there is potential for development of substantive theory related to the process of negotiation in patient/nurse interaction.

Therefore, in this section I weigh the debates in the literature regarding consideration of negotiation as a process, rather than an act in specific contexts of patient/nurse interaction. I address the seminal work of Strauss (1978) on negotiation in some detail, which reflects the extent to which it informs my analysis.

There has been insufficient work done in relation to patients and nurses that includes negotiation from a sociological perspective. This omission reflects a lack of 'cross fertilisation' between nursing and social science. The work that has been done is mostly practice setting specific (Gwyn and Elwyn 1999, Masse and Legare 2001, Carr 2001, Gallant *et al.* 2002). Further work that includes conceptualisation of negotiation as process has been done in the area of empowerment and I discuss this valuable connection in 2.6. Other relevant literature includes negotiation as a dimension of the patient/nurse relationship and argues that it is a central concept in substantive theorising, (Roberts and Krouse 1990, Morse 1991), and I adopt that position in my analysis. Two grounded theory studies in particular support this argument by drawing attention to the lack of substantive theory (Wuest 2000, Durham 1999).

Wuest (2000) examines negotiating systems in women's caring and Durham (1999) explores negotiating activity restrictions in the home management of preterm labour.

Both authors include negotiation as a category that emerged from their work and submit that negotiation is an important consideration in all patient/nurse interactions regardless of context. It is in these terms that I draw upon their work. Wuest (2000) and Durham (1999) also identify the general lack of development of substantive theory related to interaction in differing situated contexts. Durham (1999:500) comments:

Although grand theory on negotiation exists (Strauss, 1978), what is needed to guide practitioners and researchers are substantive theories that provide insight into how people manage chronic and acute health problems.

Durham summarises the need to generate substantive theory to inform a range of areas of study, as a needed contribution to sociologically informed understandings: a central element of the aim of my study.

Strauss (1978) argues that the concept of negotiation has many possible meanings and usages. In the introduction to his negotiation paradigm, he cites industrial and diplomatic relations as an active process in which agreement is sought and coercion excluded. In relation to interaction, Strauss (1978:238) identifies key properties of any negotiation context, and I cite those which are particularly useful in examining meanings and understandings in patient/nurse interaction (his italics/emphasis):

- Whether the negotiations are *one-shot, repeated, sequential, serial, multiple or linked*

- The relative *balance of power* exhibited by the respective parties *in the negotiation itself*
- The nature of the respective *stakes* in the negotiation
- The *visibility* of the transaction to others; that is, their overt or covert characters
- The *clarity of legitimacy* boundaries of the issues negotiated

The properties he describes and the emphasis he makes are influential in generating understanding about negotiation as a process in my study. His further argument that attention must be paid to the developmental character of negotiation and to the analysis of the process itself rather than a 'description of narrative' is also influential in my analysis. 'Description of narrative' refers to chronicles of events in illness experience that omit analysis of the process of negotiation itself. Further literature that addresses negotiation of the patient/nurse relationship includes a great deal that can be described as 'description of narrative'. 'Descriptions of narrative' tend to lack depth of consideration of negotiation using a framework such as Strauss's (1978) to generate substantive theory (Bury 2001, Wenneberg and Ahlstrom 2000, Pooley *et al.* 2001).

As part of his negotiation paradigm, Strauss (1978:237) also identifies the structural context in which negotiations take place. He refers to the *modus operandi* of individuals in roles in specific settings.

My study refers to the *modus operandi* of patients and nurses, and the structural context is the community practice setting. Strauss (1978:252) includes the concept of constraint in his paradigm and stresses that:

not everything is either equally negotiable or - at any given time
or period of time - negotiable at all.

He draws attention to the prospect that negotiation should be a flexible process in which events beyond the negotiation context are influential and must not be ignored. As I discuss later in my findings chapters, *modus operandi* is important in exploring influential events beyond participants' situated interaction. In exploring *modus operandi*, it emerged that some of my participants find interaction in institutions other than health care not to be negotiable and brought the meanings and understandings they had developed from those contexts to patient/nurse interaction. I discuss in detail in chapter 7 how *modus operandi* is important in my category of Experience.

Strauss (1978:239) expands upon further uses of his paradigm especially for the researcher whose area of inquiry is not negotiation. He emphasises, in particular, sensitivity to possibilities in the data and inclusion of aspects of negotiation in analysis. Drawing on Strauss's key properties ((1978:238), these further uses have considerable utility in my analysis, especially in relation to 'balance of power', 'stakes' and 'experience' in the negotiation in patient/nurse interaction, and empowerment.

Strauss's (1978) framework highlights issues of responsibility and control, expertise and standards of care and in these terms supports my examination of the negotiation of participation and involvement in need/care interaction.

The key areas Allen (2000a) reports present a perspective that help to place Strauss's (1978) key properties in my study. These properties are related to the interaction of the complexity and diversity of negotiations in the social world, and include consideration of power in interaction and the influence of wider experience in generating meanings and understandings. Allen (2000a) explores the ways in which patients, nurses and informal carers negotiate care in an acute hospital setting. The key areas she identifies are negotiation of responsibility and control, expertise and standards of care. Allen (2000a) notes the constraints of the formal care setting including the pressures upon nurses to conserve and use their professional identity.

Allen acknowledges the difficulty in generalising her findings beyond the acute care environment and suggests comparison with the relatively uncharted waters of community settings. Whilst mine is not a comparative study, as demonstrated in my questions, Allen (2000a) highlights important issues that are identified by my participants in the community practice setting. Those issues are negotiation of responsibility, expertise, and power and control, and I explore them later in the thesis.

2.4 Development of the patient/nurse relationship

In focusing on literature regarding the patient/nurse relationship, I examine five key topics. Those topics are communication, trust, humour, intuition and integrity. I review the literature related to communication in 2.4.1, trust is addressed in 2.4.2. I evaluate the limited amount of literature regarding humour in 2.4.3 and weigh the evidence regarding intuition in 2.4.4. Finally, I critique the literature regarding integrity in 2.4.5.

2.4.1 Communication in the patient/nurse relationship

Literature on the patient/nurse relationship agrees that communication is paramount in patient/nurse interaction, but its scrutiny in the literature is restricted in scope in sociological terms in that it tends to focus on communication and counselling skills, particularly in hospital settings. In relation to interaction, the literature reveals that much work that has previously been done relates to nursing tasks, assessment and responsibilities usually related to illness, or practice context specific, for example asthma care. Importantly, the patient's contribution in communication and wider factors are addressed less often. Some wider research has been done on the patient/nurse relationship that does include the patient's perspective and wider factors (Morse 1991, Jarrett and Payne, 1995, Radwin 1996, Kralik, *et al.* 1997).

Commitment and involvement are primary factors in the process of developing the patient/nurse relationship and concerns are identified consistently in relation to the superficial nature of communication. Morse's (1991) frequently cited work is stimulating to my conceptualisation of patient/nurse interaction because her analysis is sociologically informed. Morse's (1991) grounded theory study of the negotiation of commitment and involvement in the (hospital based) nurse/patient relationship suggests that the experience and beliefs of the participants are influential in interaction.

Two analytical categories, connected relationships and over-involved nurse-patient relationships, emerged from her work that I am able to relate to my analysis. As I show later, Morse's (1991) categories present the possible dimensions to the depth of the patient/nurse relationship that depend upon context and the opportunity to develop it by patients and nurses.

The focus in examining communication in patient/nurse interaction is often on context specific and/or task focused communication skills (Jarrett and Payne 1995). Work which addresses the roles patients and nurses may have rarely includes consideration of their experiences or the beliefs that they have about relationship development and potential. Rather, it is the context and practicalities of need/care interaction that are the focus: practices are directed at the patient and delivered by the nurse.

Jarrett and Payne (1995:73) contribute broad issues about the role of experience and depth of communication. They identify that extensive work has been done that relates to the patient/nurse relationship. However, that work tends to focus on communication from the nurses' perspective. Jarrett and Payne (1995:73) summarise that:

Most nurse-patient conversation takes place during the provision of physical care, and consequently consists mainly of nurses instructing and explaining to patients.

Morse (1991) also found this to be true of care that concentrated on care related to physical procedures or interventions. She describes this process as 'clinical' with little or no involvement between the patient and nurse in brief interaction. Opportunities to develop a rapport or relationship are therefore limited and/or not pursued. Jarrett and Payne (1995) argue that communication is often viewed in isolation and its contribution to care/nursing as a whole is overlooked, the whole being the experience of patients and nurses. Their critique also notes that assumptions may be made by participants about intentions and motives in the relationship when communication is so limited.

Jarrett and Payne's (1995) critique of findings in the literature establishes that studies of communication relate mostly to hospital settings and they highlight that the patient's contribution in communication and the development of the patient/nurse relationship receives little attention. In particular, they emphasise the consistency of findings that much communication is superficial and brief.

They draw attention to the fact that it is often examined in terms of 'isolated excerpts of conversation'. This implicates the limitations of research methodology that fragments patient/nurse interaction by not considering it as a whole situated in the context of need/care interaction. Additionally, wider influential factors, including the wider experiences of patients and nurses, are rarely included in any inquiry.

Morse's (1991) and Jarrett and Payne's (1995) key observations are that the patient's contribution in communication and therefore in relationships with nurses, is neglected and understanding is therefore diminished. These authors observe that individualised care as a nursing concept is linked to positive therapeutic outcomes for the patient but that it remains, in essence, a conceptual aspiration of nursing, rather than a reality in practice. Von Essen and Sjoden (1991) also present this view and find that much communication between patients and nurses relates to the superficial, in particular details of physical procedures and social chat.

In contrast to concerns and research findings regarding the superficial nature of the patient/nurse relationship, others argue that an emerging concept in the practice of nursing is individualised care based on 'knowing the patient' (Tanner *et al.* 1993, Radwin 1996, Takman and Severinsson 1999, Luker *et al.* 2000, Attree 2001).

As I explain later, concepts of 'knowing the patient' are important in examining negotiation in patient/nurse interaction and led to my conceptualisation of patient and nurse knowing each other with reference to experiences beyond need/care interaction.

Findings regarding communication argue it to be fundamental to the patient/nurse relationship. Concerns are raised in the literature that communication often does not develop depth in nursing practice. Morse (1991), Jarrett and Payne (1995) and Kruijver *et al.* (2001) present strong arguments that, in relation to nurses, this suggests absence and/or neglect of skill development and, importantly, the lack of opportunity for communication to provide the foundation of a sustained relationship with patients.

Kruijver *et al.* (2001) examine the communication skills of nurses in interaction with simulated cancer patients and find that 60% of nurses' verbal communication with patients relates to tasks and procedures and those patients are rarely involved in conversation *per se*. Kruijver *et al.* (2001) find that patients had little opportunity to express their feelings or concerns. Kruijver *et al.* (2001:773) further identify that limitation of such opportunities jeopardises an environment of trust central to patient/nurse interaction. Limited opportunity is linked to lack of time necessary to develop the patient/nurse relationship.

Kralik *et al.* (1997:401) studied patients' experiences with nursing in depth, and therefore I deal in some detail with their work. The themes Kralik *et al.* (1997) identify can be placed at the heart of patient/nurse interaction, by discerning that nurses may be unaware of the importance and impact of engagement or detachment in interaction with patients. The work of Kralik *et al.* (1997) is important for highlighting the importance of patients' perceptions that related to the circumstances in which a relationship with the nurse can be developed. The two main themes they identify are 'engagement' and 'detachment'.

Kralik *et al.* (1997:401) list the following patient comments as exemplifying the 'engaged' nurse and I quote:

Nothing was too much trouble

Asked me/consulted me

Cheerful and uses humour

Compassionate and kind

Knows what I want without asking

Always available

Gentle touch, friendly and warm

The 'engaged' nurse is described by patients as a positive experience. Kralik *et al.* (1997:403) list the following patient comments as exemplifying the 'detached' nurse:

Depersonalised

Too efficient and busy

Made me feel lazy

You have to go along with what is happening

Sharp/cold in approach

Rough with physical care

Just a job

The 'detached' nurse is noted to avoid personal contact with patients and to promote feelings of vulnerability and insecurity in the patients. In interrogating concepts of 'detached' and 'engaged', Kralik *et al.* (1997:407) also note a relationship to quality of care:

From a patient's perspective, the engagement between a patient and a nurse is a significant determinant of the quality of care received.

Quality of care as identified by the patient can be couched in terms of the nature of their experience in patient/nurse interaction. Understanding of satisfaction can be further related to the accomplishment of the 'engaged' patient/nurse relationship: the positive experience identified by Kralik *et al.* (1997). As I explore later, satisfaction is identified as a key concern of my participants and linked to the concept of patient/nurse interaction as an accomplishment.

The key properties Kralik *et al.* identify emerge to some extent in my study and facilitate making conceptual links to the experience of participants. In particular, the relationship between meaningful communication and trust, as related to the development of the patient/nurse relationship, emerged as key meanings and understandings expressed by my participants.

2.4.2 Trust in the patient/nurse relationship

Trust is used here as encompassing confidence and expectations in patient/nurse interaction. I argue later that the conceptualisation of trust is closely connected to integrity and self-determination, and to the roles and responsibilities of being a patient or nurse.

Much of the nursing literature proposes that trust should be seen as a measurable outcome of care, especially in terms of the patient/nurse relationship. Whilst not seeking to measure anything in my study, trust is clearly perceived by participants as a central concept in the patient/nurse relationship and viewed as an individual social experience. The conceptualisation of trust requires more attention than it has received (Lotzkar and Bortorff 2001, Johns 1996).

Lotzkar and Bortorff (2001) identify the importance of trust as a central process in the development of the patient/nurse relationship. They argue trust to be the foundation of an effective relationship and note it to be a fundamental feature of negotiation. Trust as a process includes the assimilation of information, decision-making and developing a relationship. The consequences of trust are in terms of benefits, unanticipated positive results and stability. Johns (1996) represents trust as having an essential and pervasive role in patient/nurse interaction and therefore being fundamental to the caring relationship. Johns (1996:76) notes that the conceptualisation of trust in care settings is underdeveloped:

Much of the literature that discusses trust relies upon vague conceptualizations or borrows from other disciplines.

She goes on to argue that trust is both process and outcome in the patient/nurse relationship and that it is at the core of that negotiated and developing relationship. In John's view (1996:77), trust is represented as valued in the patient/nurse relationship, yet its conceptualisation in health care and nursing is elusive. Hupcey *et al.* (2001:290) articulate that nursing considers trust to be an element of endeavours in caring, whilst sociology considers it to be integral to individual social experiences that include, and go beyond, patient/nurse interaction.

Hupcey *et al.* (2001) address the development and utility of trust as a concept from an interdisciplinary perspective embracing nursing, medicine, psychology and sociology.

They did an extensive critique of the literature in these fields and, like Johns (1996), reflect that the conceptualisation of trust is ambiguous and elusive, and therefore confusing in practice. Hupcey *et al.* (2001) discuss the centrality of antecedents, attributes, boundaries and outcomes of trust and note key areas of critical inquiry for each discipline considered. From a sociological perspective, Hupcey *et al.* (2001) find trust to be focused on interaction, which is 'personal' or 'system'. The dichotomy they identify reveals how focus on the dimensions of trust in terms of wider experiences in health care and nursing may be fragmented. The sociological perspective which Hupcey *et al.* (2001) used is particularly sensitising in the development of key properties of Experience, in particular questioning if lack of trust emergent from processes in one institution will influence performance and *modus operandi* in another.

Mechanic and Meyer's (2000) findings relate to concepts of trust in an illness framework and the patient's experience is located at the core of their analysis. Mechanic and Meyer's (2000) caution regarding individual and unique circumstances enhanced my theoretical sensitivity in that they move from the general nature of the concept they are concerned about, to the more specific 'personal' experience of patients.

In their study of trust among patients with serious illness, Mechanic and Meyer (2000:667) emphasise that:

Most discussions of trust treat it as a general concept but the salience of trust and its various dimensions depends very much on the patients' circumstances, the extent they feel at risk, the particular characteristics of their illness and needs, and their level of sophistication and access to information.

Mechanic and Meyer (2000) draw attention to the importance of placing the patients' concerns as they identify them at the heart of interaction. Carr (2001:41) agrees and considers trust to provide 'the bedrock' of the patient/nurse relationship. He also emphasises the dynamic nature of trust through a process of continual re-negotiation between patient and nurse. Focusing on the patient's concerns may form the basis of meaningful negotiation in patient/nurse interaction.

There is little dissent in the literature about the importance of trust, which is asserted to be meaningful and important to individuals. However, wider considerations are overlooked in the examination of interaction, as Mechanic and Meyer (2000) and Hupcey *et al.* agree (2001). The limited consideration of wider issues neglects conceptualisation of risk or lack of trust. The positive benefits or potential of trust in interaction are addressed, but the opposite position of harms, hazards and mistrust are largely ignored.

I show later that the concerns of Hupcey *et al.* (2001:290) about what fosters or inhibits trust and its role in patient/nurse interaction, and Carr's (2001) emphasis upon trust as dynamic in nature in negotiation, were sensitising concepts in my analysis. Trust is identified by my participants as foundational to their relationship. Trust is also identified as a central concern in the patient/nurse relationship and associated with the responsiveness of the nurse to the patient.

Other concepts are associated with trust and I sought them out in response to the emergence in my analysis of 'weighing up' and developing rapport and confidence. I show that trust, intuition and integrity together are important to the development of, and self-determination in, the patient/nurse relationship.

2.4.3 Humour in the patient/nurse relationship

My analysis alerted me to the potential of the role of humour in the initiation, negotiation and development of the patient/nurse relationship. The lack of literature on the role of humour in the patient/nurse relationship may be related to the challenge it is perceived to present to investigators, or lack of appreciation of the potential of humour in the terms that I identify.

In their small, exploratory study of humour in health care interactions Olsson *et al.* (2002:21) suggest a range of effects and functions of humour. They conclude that humour has a positive role to play in health care, with empathy as a prerequisite. In these terms it has a role in the patient/nurse relationship. In the same vein, Struthers (1999) observes that appropriate humour is therapeutic and helpful to patients and nurses. Olsen *et al.* (2002) go on to comment that if humour is used inappropriately or misinterpreted, trust and personal integrity will be adversely affected. Inappropriate use of humour will be detrimental to the patient/nurse relationship and its potential forfeited.

Beck (1997) identifies humour used in a range of ways and proposes different effects in interaction. Bolton's (2001:95) study of the emotional work of nurses, refers to 'the humorous face' that nurses may use in interaction, and identifies different effects in interaction that are congruent with Beck's themes, for example, 'to let off steam' or 'pleasure in interaction' with patients and colleagues. The link made by Astedt-Kurki *et al.* (2001) between alleviating anxiety and creating rapport is important in considering the initiation of patient/nurse interaction in which I observed humour used spontaneously and intuitively. Beck (1997) identifies the positive value to nurses of including humour in practice, in particular the prospect of sharing and therapeutic effect.

She finds that humour has the overall effect or potential to facilitate the development of the patient/nurse relationship. Whilst she identifies humour as a resource for nurses for dealing with difficult situations and patients, she also acknowledges that further research is required from the patients' perspective.

The findings of Astedt-Kurki *et al.* (2001) are similar to those of Beck (1997). Their small qualitative study asked patients to write about their experiences of humour whilst in hospital followed by in-depth interviews. Spontaneity and intuition with humour emerges as integral to patient/nurse interaction and is valued by patients and nurses. They expand upon Beck's (1997) contributions in relation to the role of humour in coping with difficult situations related to illness and the outcomes of hospital admission: a different context from my study.

I observed, and my participants identified, humour as helpful in interaction as a positive resource in the initiation and negotiation of the patient/nurse relationship. The potential of humour as a resource in the patient/nurse relationship is, however, an unsung value in present theorising. This may be because humour is highly individual and paradoxical in nature, which makes it difficult and daunting to conceptualise and investigate. As I discuss in chapter 6, the realities in a community practice setting and the contribution humour makes are different from other practice settings.

2.4.4 Intuition in the patient/nurse relationship

Intuition is used here as encompassing the instinctive nature of knowledge, understanding and beliefs. Intuition in patient/nurse interaction is somewhat under-examined in health care research, although often referred to, as Beck (1997) does in discussing humour. There is also a lack of consensus as to the definition of intuition in health care and nursing (Easen and Wilcockson 1996, McMahon 1999). In attempting to address this deficit in conceptualisation in theory and practice, McCutcheon and Pincombe (2001) argue that nurses cite intuition as an implicit and core element of their practice. They find that the interaction of knowledge, expertise and personal attributes and experience are identified by nurses as a synergy that contributes to intuitive nursing practice. McCutcheon and Pincombe (2001) conclude that intuition plays a role in the patient/nurse relationship. Some of their participants identified it to be requisite to relationship development, whilst others felt the opposite. McCutcheon and Pincombe's (2001) proposal that the interaction of knowledge, expertise and personal attributes and experience serve as a synergistic process, in which intuition plays a part, is valuable in conceptualising negotiation and empowerment in patient/nurse interaction.

King and Appleton (1997:194) suggest that intuition occurs in response to knowledge and that it is an important component in decision-making by nurses. In their opinion, nurses are covert in their use of intuition because it does not 'fit' with 'measurable research-based evidence'. King and Appleton's (1997) view highlights issues about the lack of consensus as to the meaning and use of intuition in nursing practice. King and Clark (2002) urge that intuitive and analytic elements should be recognised in models of decision-making. However, whilst they emphasise the acknowledgement of the link between expertise and intuition, they fail to relate their recommendation directly to patient care. As Welsh and Lyons (2001) note, the conflict between the positivist nature of evidence-based practice and the tacit role that intuition plays, remains unresolved for nursing. If it is unresolved for nursing, then it continues to play an indeterminate role in patient/nurse interaction, especially from the patient's viewpoint.

Patients' intuition about knowledge, understanding and beliefs is absent from present conceptualisations of empowerment in particular. I show later that intuition played a role in participants' negotiation and development of their relationship.

2.4.5 Integrity in the patient/nurse relationship

I use the term integrity here as encompassing key concepts of dignity and vulnerability. These concepts were important to patient participants in particular and are evident in the substantive codes of each category in figures 2 and 3. Overall, there is agreement in the literature that personal integrity is a significant aspect in the experience of patients and nurses (Mairis 1994, Williams 2001, Walsh and Kowanko 2002). Concerns of trust and vulnerability are established clearly in the literature as important to the initiation and development of the patient/nurse relationship, and to empowerment (Williams 2001, Leino-Kilpie *et al.* 2001, Aranda and Street 1999). Williams (2001) highlights the potential of these concepts to be investigated and included in substantive theory about patient/nurse interaction. I explore that potential in my findings and make links to self-determination.

Irurita and Williams (2001) integrate two grounded theory studies that examined the phenomenon of high quality care in acute care hospital settings. They do this to extend their examination of how nurses and patients preserve the integrity of self and others. Irurita and Williams (2001:581) define integrity thus:

Integrity was interpreted as the state of being whole, entire, intact, or undiminished, and being in a sound, unimpaired, or optimal condition. It meant having control over one's life/situation, being able to protect oneself, maintaining dignity as a human being, being recognised as an individual.

Balancing and compromising in the patient/nurse relationship emerged as central in the 'preservation' process they describe. Threats to integrity of self are directly linked to this preservation process, as is vulnerability and the prospect of co-operating and contributing to care. Overall, Irurita and Williams (2001) argue that further insights had been gained into reciprocity in interaction by including the dimensions of personal and professional self. The concept of reciprocity in interaction contributes to my consideration of negotiation in the patient/nurse relationship.

The findings of Redfern and Norman (1999:420) resonate with those of Irurita and Williams (2001) in that they establish a link between establishing trust and addressing concerns of vulnerability. Nortvedt (2001) also considers concerns of vulnerability and trust as influential in the encounter between patient and nurse. Taking into account issues of vulnerability and trust, preservation and recognition of personal integrity is founded upon dignity.

Shotton and Seedhouse (1998:247) discuss the difficulties in defining or conceptualising dignity. However, they distinguish between different levels of dignity:

- a) Dignity maintained
- b) Dignity lost in a trivial way – dignity easily restored
- c) Serious loss of dignity – substantial effort required to restore it
- d) Devastating loss of dignity – impossible to regain dignity without help

The experience of loss of dignity is highly personalised and not recognised widely in the literature as a significant priority in individuals' experience in health care and nursing. As I explore later, several participants in my study referred to fear of loss of dignity, which is not included by Shotton and Seedhouse (1998:255) in their conceptualisation, however, they do concede that dignity is 'missing' in practice:

Unless and until dignity is recognized as a palpable concept, the preservation of dignity is not an obvious practical priority.

Widang and Fridlund's (2003) patient participants recognised self-respect, dignity, and confidence as critical to their personal integrity as did mine. Importantly, Widang and Fridlund are able to demonstrate links to concepts of empowerment and I review them in section 2.6.

2.5 Socio-cultural characteristics of age, gender, SES and ethnicity In patient/nurse Interaction

In this section I review the literature related to age, gender, SES and ethnicity. I show later that how these socio-cultural characteristics interact plays a primary role in how we experience, navigate and negotiate in the social world.

Bradley (1996:18) proposes that age, gender, SES and ethnicity interact and create the dynamics of lived experience, social realities and inequalities. She (1996:19) argues that age, gender, SES and ethnicity 'cannot be separated in their effects'. Bradley's (1996:26) central argument is that age, gender, SES and ethnicity should be seen as:

both a social construct (a way to categorize social relationships) and as a set of lived relationships. Together they can be seen as 'dynamics of inequality'.

Her position informs my analysis in two ways: firstly, in considering the social construction of the patient/nurse relationship and secondly, in exploring the lived relationships of age, gender, SES and ethnicity for patients and nurses. In light of my aim to investigate the influence of socio-cultural characteristics in patient/nurse interaction, Bradley's (1996) dynamic is instructive.

Further literature that is particularly sensitising regarding age, gender, SES and ethnicity is integrated in chapter 7 in particular to maintain in context the close connection between participants' accounts and related concepts. However, concepts related to specific dynamic socio-cultural characteristics in interaction that inform my study are reviewed here in turn, age in 2.5.2, gender in 2.5.3, SES in 2.5.4 and ethnicity in 2.5.5.

2.5.1 Interacting dynamic of age, gender, SES and ethnicity In patient/nurse interaction

A large volume of literature is available that interrogates social inequalities and health and its evaluation goes beyond the remit of my review. A substantial amount of that literature reports on epidemiology, mortality and morbidity and refers to age, gender, SES and ethnicity as variables in influencing the health of the nation (Wilkinson 1996, Acheson 1998, Graham 2000, Blamey *et al.* 2002). This focus has remained relatively unchanged since the publication of the Black Report in 1982, (Townsend and Davidson 1982), although that report gave scant attention to ethnicity. Forbes and Wainwright (2001:801) critique the methodological, conceptual and philosophical context of health inequalities research.

They draw attention to the limitations of survey derived data, and urge attention to the more complex social explanations of health inequalities by diverse methodological means. Attention to more complex social explanations encompasses the dynamic of age, gender, SES and ethnicity. Further to this, Forbes and Wainwright (2001) emphasise the inclusion of a lay perspective in seeking explanations. Forbes and Wainwright's (2001) conclusions connect with the aim of my study because they are notable in drawing attention to the importance of placing individuals' own socially constructed reality at the centre.

Socio-cultural characteristics as dynamic and individualised in social and health experience are a central issue in examining patient/nurse interaction. Individual experience goes beyond epidemiology, mortality and morbidity and relates to experience in health care, in patient/nurse interaction and more widely, as Popay *et al.* (2003) suggest. Socio-cultural characteristics are embedded in the identity of individuals and are resources that contribute to the construction of social identity and self-esteem (Turner 1999, Hockey and James 2003).

Forbes and Wainwright (2001:813) arrive at two conclusions that are valuable.

Firstly they suggest:

we must start seeing the questions about health inequalities in the context of the lives of the people most impacted by them.

Secondly, they consider that the importance of 'connecting to communities':

may also help us to resist labelling or assuming things about them

in isolation of *their* cultural and social reality.

Forbes and Wainwright (2001) urge that communities deserve attention in understanding the complexities of located health experience, rather than large surveys of population which, in their generalisation, overlook the concerns of specific communities and individuals. As Forbes and Wainwright (2001) suggest, socio-cultural characteristics should be examined in a range of combinations that take account of cultural and social realities.

Embodiment is part of social identity and realities and therefore important in the meanings and understandings brought to patient/nurse interaction. Turner (1996) represents embodiment as 'having' a body and 'being' a body. He calls for context, biography and the body to be central discourses in social identity. Concepts of embodiment have become part of the debate about social identity and are located in debates about health experience (Shilling 1991, Csordas 1994, Bradley 1996, Nettleton and Watson 1998). Turner's (1996) central discourses inform my conceptualisation of individuals' extended and wider experience in their cultural context.

In the literature, constructions of explanations of inequality and experience of health and health care are linked to social experience and reality in a range of ways, including 'place'/community and embodiment. Concepts related to individual experience are located, in particular, in the literature about lay understandings of social advantage or disadvantage (Popay *et al.* 2003, Lawton 2003). Blane *et al.* (1998:93) recognise the dynamic described by Bradley (1996) and consider inequality to be socially structured and related to health disadvantage. Baggott (2000) and Watterson (2002) include socio-cultural characteristics in debates about public health and discuss a range of explanations in detail, beyond, and including, the interacting dynamic of age, gender, SES and ethnicity. Popay *et al.* (2003:1) offer a further useful perspective. They argue that exploring lay understandings of inequalities in public health makes an important contribution in terms of addressing how individuals construct their experiences, particularly in relation to 'place' or community. Importantly, they found that the explanations of those living in disadvantaged areas included and went beyond 'place' by including concepts of construction of social identity. In addition to 'area effects', for example housing and pollution, Popay *et al.* (2003:20) find that:

An individual may be exposed to considerable social, material and psychological risks to their health but the way the individual responds to these will determine whether health is damaged.

Other personal resources are embedded in the construction of social identity that are influential in how one responds to the social circumstances that impact upon living. In relation to the study of inequalities, Bradley (1996:203) concludes 'local narratives must replace grand narratives'. The arguments of Popay *et al.* (2003) and Bradley (1996) highlight for me that the experiences brought to patient/nurse interaction as 'local narratives', should also refer to wider social frameworks of place and community.

2.5.2 Dynamic interaction and age

Conceptual links in relation to meanings and understandings of age are consistent in the literature. Older age is seen as central in the transformation of social identity across the life course (Woodward 1991, Fairhurst 1998). Changes in social roles and power are important within that transformation process. Assumptions, expectations and stereotypes in social and health experience are addressed at length in the literature (Avlund *et al.* 2003, Grundy and Sloggett 2003, Courtney *et al.*, 2000, Larsson 1999, Caris-Verhallen *et al.* 1999). The literature links generalisations about growing older with assumptions, expectations and stereotypes in health care and nursing.

The emphasis upon a biomedical view of health in older age is increasingly challenged in the literature in favour of a social, life course approach (Arber and Ginn 1995, Bradley 1996, Gillearn and Higgs 1998). Arguments prevail that aspects of successful ageing should confront the generalisations and stereotypes of ageing in health care and nursing. Larsson (1999) identifies that generalisations are made in relation to older age, particularly in relation to perceptions of increased care needs. Chater (1999:132) states these generalisations as:

the way in which ageing is portrayed is culturally constructed and historically located

Hockey and James (2003:21) recognise the centrality of transformation of identity as people age, and are concerned that the social construction of older age 'problematizes' it. The preservation of self-identity within that transformation emerges as a central issue (Hubbard *et al.* 2002).

In summarising generalisations about growing older as problematic, Chater (1999:132) presents a bleak view of the implications or consequences of growing older thus:

Instead of strength there is frailty; instead of growth there is decline; creativity becomes nonproductivity; competence becomes incompetence and independence becomes dependency.

Chater identifies generalisations about older age as opposite to the positive construction of youth, and includes the stereotypes of ageing identified clearly in the literature (Greipp 1996, Larsson 1999, Courtney *et al.* 2000).

Bryant *et al.* (2001:928) urge a focus on healthy ageing rather than on poor health outcomes. Bryant *et al.* (2001:940) argue that the concept of healthy ageing should be reframed in older peoples' own terms. Whilst the shift in emphasis from a biomedical view of older age, in favour of a social, life course approach, is identified clearly in the literature, the perceptions of nurses that older age is problematic is reinforced by the fact that much of their work is with older people (Larsson 1999). In these terms, a gap emerges between conceptualisations about ageing in the literature, and strategies to address the impact of generalisations by nurses upon the experiences of patients in health care.

2.5.3 Dynamic Interaction and gender

In relation to gender in patient/nurse interaction, some gaps are evident in the literature. However, two consistent findings are evident and they are important in my analysis. Firstly, the gendered construction of nursing and caring as female is identified clearly in the literature.

Secondly, the preference of patients and nurses for the same gender has been extensively researched (Smith 1992, Poole and Isaacs 1997, Staden 1998, Crowe 2000). Patients frequently prefer a nurse of the same gender, and this is related to the purpose of need/care interaction. Additionally, Kerssens *et al.* (1997) find that prior experience and communication style are influential in same gender preferences of patients. Kerssens *et al.* (1997) also suggest that gender preferences are related to traditional female/male stereotypes of gender roles and status. Over and above these issues, aspects of need/care interaction itself are identified as gendered, for example, womens' or mens' health (Coyle *et al.* 1993, Greipp 1996, Brooks and Phillips 1996).

The findings of Arber and Ginn (1995) and Charles and Walters (1998) are valuable in their emphasis upon the issues surrounding the relationship between an individual's gender and experiences of health care and nursing. Additionally, and as a further connection, Callaghan (1998) links the interaction of gender, SES and place in lived experience. Callaghan proposes that place and SES are not only intimately related, but also a between group process. The experience of gender is not universal but linked to other social diversities such as SES and community, in particular. Arber and Ginn (1995) highlight the relationship between gender and ageing. They argue that age and gender are related in the experience of life and should be examined as such.

Charles and Walters (1998) suggest that there are generational differences in social and health experience for older women. They link this to changes in social role, in particular social status and power. Similarly, Callaghan (1998:14) suggests:

The gender divide, which is evident in all groups, is contextualised in class relations in a particular place, so that while all women spoke of the gender divide their experience of it differed.

The experience of gender is not universal and interacts with SES and place in particular.

2.5.4 Dynamic interaction and socio-economic status

I found SES difficult to examine, as I discuss later in my findings chapters. The processes of evaluation in relation to SES in interaction are worthy of examination and are identified as 'weighing up' in my findings. The attention Sayer (2002) draws to perceptions of SES is valuable, in particular he raises issues about how people place themselves hierarchically in the social world by comparison to others.

SES is examined in a range of ways in the literature, over and above the substantial number of investigations into inequalities in health (Field and Briggs 2001, Blamey *et al.* 2002, Singh-Manoux *et al.* 2003, Bolam *et al.* 2003).

Bradley (1996:45) also notes the difficulty sociologists have with 'class' as a 'contested subject'. Definitions and conceptualisations of SES remain a subject of sociological debate. Sayer (2002) acknowledges the difficulties in asking about SES in sociological research and asks 'why is class an embarrassing subject?' If SES is an 'embarrassing subject' that we avoid raising, but consider important, then it emerges that valuations of worth, and evaluations as judgements of social status, are made in indirect ways within interaction, as I demonstrate later.

Sayer (2002:1) considers that there is ambivalence and embarrassment about SES as it raises issues:

of the relative worth of individuals, and about differences between how people are valued economically and how they are valued ethically.

Bradley (1996: 46) offers a useful perspective in relation to examining the nature of our construction of social hierarchies referring to: 'a label applied to a nexus of unequal lived relationships'. Bradley rightly argues that interrogating 'class' (SES) remains necessary to understanding the interactive dynamics of inequality and is related to social identity and the social construction of reality. Placing in a social hierarchy is an important process for my participants and central to negotiation in patient/nurse interaction.

2.5.5 Dynamic Interaction and ethnicity

I identified in my opening chapter that three participants are minority ethnic as defined in their own terms, and I justified there the inclusion of ethnicity in discussion of my aims. To address and overcome narrow definitions of ethnicity, I include participants' meanings and understandings of culture in my investigation. In my limited examination of ethnicity, nurse participants' adherence to a focus upon difference emerges as constraints in their meanings and understandings of cultural diversity. As I demonstrate in 7.4.4, constraints in patients and nurses sharing meanings and understandings in interaction emerge as important in my analysis. The constraints in shared meanings and understandings related to personal background, traditions and ways of life. I explore these areas in this section by highlighting some of the key issues in the literature.

Ethnocentrism provides a boundary that detracts from and distorts nurses' understanding of minority ethnic people. Ahmad (1996:190) observes:

Stripped of its dynamic social, economic, gender and historical context, culture becomes a rigid and constraining concept, which is seen somehow to mechanistically determine peoples' behaviours and actions.

His view is that a conceptualisation of culture or ethnicity by nurses/health care workers prevails in which different traditions from those held by the majority, or staff themselves, create boundaries. Previous studies focus upon reflecting the interests of the health service and health care professionals (Ahmed 1993). Latterly, the interests and priorities of minority ethnic communities have been increasingly considered (Bowes and Domokos 1998, Gerrish 2000, Bowes and Dar 2000). Ahmad (1996) presents a challenge to broad definitions of culture identified in the literature which emphasises the notion of sharing aspects that constitute a way of life.

Bradley (1996) identifies that acknowledgement of shared aspects of culture by nurses is important to appreciating and including diversity in patient/nurse interaction. However, appreciating and including diversity remains problematic for nurses. Lack of awareness of, and attention to, the boundaries and constraints experienced by patients and nurses, remains a source of difficulty in their interaction. Those boundaries and constraints are interactive in the construction of social identity as difference (Culley *et al.* 1999, Blakemore 2000, Atkin *et al.* 2002, Clegg 2003). In addressing the construction of identities by Caribbean nurses, Culley *et al.* (1999:158) argue:

Ethnic identities are socially constructed by social processes of boundary formation.

Minority ethnic nurses construct a 'racialized identity' as part of their boundary formation in opposition to ethnocentrism and/or racism. Review of the literature reveals a focus on the 'problems' of minority ethnic people, for example thalassaemia, at the expense of fundamental issues such as the impact of racism which Culley *et al.* (1999) interrogate. This focus is underpinned by the narrowness of definitions of 'ethnicity' in terms of race rather than culture. In addition to issues of narrow definitions of ethnicity, inequalities such as poverty and the social exclusion of minority ethnic people may be overlooked (Blakemore 2000, Smart *et al.* 2003, Houston and Cowley 2003). Constraints in the experience of health care by minority ethnic individuals relate to dissonance between the expectations of minority ethnic patients and the ethnocentrism of health services and nurses.

Cortis's (2000b) findings are important in highlighting the meanings and understandings which minority ethnic patients may bring to interaction. Cortis (2000b) studied the perceptions and experience of Pakistani (Urdu speaking) people of receiving nursing care. Cortis (2000b: 111) finds:

a lack of congruence between the group's expectations and their experiences. Nurses were perceived to have a poor understanding of ethnic needs, portraying ethnocentric attitudes and behaviours.

Gerrish (2000:97) argues that such a lack of congruence raises questions about: the appropriateness of the current interpretation of and practice of individualized care in a multi-ethnic society if the health disadvantage experienced by minority ethnic communities is to be overcome.

Gerrish (2000:97) agrees with Cortis (2000b) and argues that care, which fails to take account of different cultural perspectives, is probably ethnocentric. Ethnocentrism is the antithesis of individualised care. Clegg (2003:283) finds that culturally sensitive and appropriate care is a priority for minority ethnic patients and their carers. She argues that ethnocentrism in health care can be 'opposed', as Culley *et al.* (1999) propose, by understanding the expectations and priorities of minority ethnic people, and by health service staff challenging their own assumptions about culture. Further specific concerns are identified in the literature in relation to communication difficulties.

Communication difficulties between minority ethnic individuals and nurses are consistently identified in the literature as barriers in patient/nurse interaction. The communication difficulties relate to understanding of spoken and written English. These difficulties are identified throughout the literature as a disadvantage, which emerges as an inequality in care. Language barriers exclude minority ethnic people from participation in health care services and patient/nurse interaction.

Gerrish (2001:566) finds that:

The limited use of professional interpreters and the concomitant heavy reliance on family members to translate highlighted how ethnic minority patients and carers who were not fluent in English were disadvantaged.

Lack of provision and access to professional interpretation and translation services underpins concerns found in the literature about inequality in care. As a further link to the dynamic of social inequality, Gerrish (2001:572) finds that women and older minority ethnic people are most likely to be disadvantaged by communication constraints in health service and delivery.

2.6 Empowerment in patient/nurse interaction

The nursing literature concentrates upon exploring empowerment as act or process. Negotiation of empowerment by patients and nurses in their interaction is mostly overlooked in the literature. Conceptualisation of empowerment in health care and nursing is required that goes beyond situated contexts of care, and pays attention to whose meaning and understandings prevail in definitions of empowerment in patient/nurse interaction. Empowerment receives considerable attention in the literature, with a range of definitions. The conceptualisation I will use draws on concepts of independence and involvement, and includes processes of enabling individuals to maintain or achieve self-determination.

A substantial body of literature considers power in nursing in relation to the patient as passive recipient. In terms of understanding, Hewison (1995) describes how nurses exert considerable power by the language they use. He emphasises that the development of empowerment is constrained by this pervasive and pre-existing power relationship. Overall he conceptualises power as dynamic in patient/nurse interaction. Lindow and Morris (1995) also recognise that the debate about empowerment uses the language, and the terms of those in control as expert, or those who control resources.

Skelton (1994:415) notes that the term is often 'employed uncritically and in inappropriate contexts'. The wider literature about empowerment includes, in particular, the involvement of 'users' in decisions about service provision, for example, Tanner (1998), and Edwards and Staniszewska (2000). There is an increasing interest and volume of work that seeks the service users' perspective, using their terms or language, in the development and provision of services (Gallant *et al.* 2002, Pooley *et al.* 2001, Muir-Cochrane 2000). The concept of empowerment is central to the negotiation of the patient/nurse relationship and patient/nurse interaction. However, the reality of empowerment is problematic for patients and nurses. I explore later how I found that in reality, reconciliation of the expertise of patients and nurses is pivotal in strategies of receiving and providing care.

Empowerment in patient/nurse interaction proves difficult and complex to conceptualise. Kuokkanen and Leino-Kilpie (2000) observe that definitions of empowerment in nursing are very wide and this undermines the utility of the concept as a process in practice to patients and nurses. Rose (2003:59) finds that service users today are mostly unaware of the way in which the coordination of their care is underpinned by principles of empowerment, and are even less involved in it. Rose's point is that despite the emphasis on empowerment in policies that drive practice, greater awareness of, or involvement in, care have not evolved. Rose's (2003) view highlights a central issue to be explored about empowerment in patient/nurse interaction.

Previous findings agree with those of Kuokkanen and Leino-Kilpie (2000) that problems of definition impact on the 'how' of empowerment as a process (Malin and Teesdale 1991, Fulton, 1997). Tensions revolving around the 'how' are evident and driven by medically dominated political agendas and definitions, which are imposed in a range of ways. Traynor (2003:129) is more optimistic and argues that great prominence is now being accorded to how concepts of empowerment counterbalance 'paternalistic or authoritarian models and practices'. The work of Turner (1995) Mead and Bower (2000) and Dixon-Woods (2001) summarises the convergence of literature related to the medical political agenda, and patients as participants in care.

I demonstrate later how the important issues raised by these authors and the counter positions of Roberts and Krouse (1990) and Waterworth and Luker (1990) contribute to my examination of concepts of negotiation and empowerment.

The recognition in the work of Mead and Bower (2000) that most research on patient centredness has taken place in the community is particularly helpful in contextualising the views expressed by participants in my study about relationships with general practitioners (GPs) and, as important to my study, roles in interaction in the health care setting. Related literature (Turner 1995, Mead and Bower 2000, Drew *et al.* 2001) examines the patient's relationship with doctors (medical care) or with health care providers (institutions). This literature concentrates upon the development of a patient centred approach in the consultation process and medical management, including concepts of patient satisfaction, empowerment and health and illness experience.

Dixon-Woods' (2001) conclusions are relevant in that she urges circumspection in terms of looking at patient satisfaction, empowerment and health and illness experience within the parameters of 'medical hegemonies'. These medical hegemonies are influential in the health care setting and therefore influential in nursing. Dixon-Woods establishes a useful distinction between studying the views of the 'user' of any health service and studying the empowerment of patients.

The former implies gaining and taking into account the views of individuals as customer or consumer, whilst the latter encompasses the notion of individuals as partners in care. This distinction is central in my examination of empowerment in patient/nurse interaction, including the interrogation of what it is understood to be in policy and practice.

Dixon-Woods' (2001) grounded theory study looks at printed material as social practice and illuminates the trends in examining a patient centred approach in medical care. She observes that two main discourses can be identified in published material, firstly, bio-medical approaches and secondly, a discourse of patient empowerment that draws on a political agenda concerning the interaction of the 'user' with service providers. In relation to patient empowerment and the privilege accorded to medical knowledge and practice, she argues that the dominance of medical hegemonies must be questioned. Dixon-Woods (2001:1428) describes medical hegemonies as a distortion of meaning in her conclusion and reflects that:

A theoretical approach that emphasises the patients' role in creating meaning would perhaps see this plurality of views as less of a threat to medical orthodoxies than might currently be assumed by the 'patient empowerment' discourse.

In other words, this distortion of meaning suggests that research which is driven by a medical political agenda and does not include wider perspectives, in particular the sociological, is limited in its examination of interaction.

She concedes that the discourses she identifies are dominated by a bio-medical approach linked to patient empowerment. However, an evolving orientation towards the patient's perspective and interests is identified in her study. I address the orientation Dixon-Woods (2001) identifies in my findings chapters.

Waterworth and Luker (1990) argue that decisions about patient care are entrenched in the role of the doctor, in hospital, or in the community. Further to this, Waterworth and Luker (1990) hold that some patients prefer the 'co-operation-guidance' model, described a decade later by Mead and Bower (2000) as a reflection of their experience and expectations. Mead and Bower (2000:1089) summarise the change in the doctor/patient relationship thus:

a shift in doctor-patient relations from the 'co-operation-guidance' model (analogous to a parent-child relationship) to 'mutual participation' (analogous to a relationship between adults), where power and responsibility are shared with the patient.

The change in the role of patient and doctor is expressed in the emergence of the concept of 'therapeutic alliance' in the literature. In the therapeutic alliance there is a common understanding and agreement of the aims and requirements of any consultation between patients and doctors. The negotiation of roles and expertise in the therapeutic alliance is particularly sensitising in my consideration of empowerment.

The findings of Clarke (2001) and Wiles (1997) are useful in considering the development of the patient/nurse relationship with empowerment as a process within interaction. Clarke (2001) deliberates upon how to empower carers in the community and identifies that there is confusion about the concept and application of empowerment in patient/nurse interaction. In relation to this confusion, Clarke (2001:79) notes that:

A major limitation has been the tendency to treat empowerment as synonymous with participation in decision-making.

Participation in decision-making is limiting when considering the dimensions of empowerment. Clarke (2001) illuminates that the confusion may arise from the context in which empowerment is applied and advocates the adoption of a wider 'ecological' model in which individuals' self-determination is enhanced. Clarke (2001) invokes caution about definitions of empowerment and about who makes those definitions and why.

Mitcheson and Cowley (2003) present a key issue related to Clarke's (2001) concern by also asking, 'empowerment or control?' They argue that the demands of practice, for example structured patient assessment, leads to health visitors controlling interaction, yet the empowerment approach is key to the philosophy of health visiting. However, predetermined policies and practices are covert in nature and disempower patients (Houston and Cowley 2002, Mitcheson and Cowley 2003).

Paterson (2001) also identifies the subtle ways in which nurses contradict their philosophy of empowering patients by imposing their own framework of reference in patient/nurse interaction and so neglect the expertise of patients, thereby disenfranchising them of their contribution.

Empowerment of patients presents a challenge to the historic relationships of power and control in patient/nurse interaction. Pivotal to this is the reconciliation of the expertise of the patient and the nurse. Wilkinson (1999) asks if power as a resource can be withheld or transferred. Thorne *et al.* (2000) consider that traditional assumptions are made regarding power in the patient/nurse relationship. The assumptions are that the nurse, not the patient, is expert, the nurse is a legitimate gate-keeper to health care services and the patients' role is one of compliance and self-reliance. Parson's (1951, 1975) legitimisation of the 'sick role' is evident in these historic assumptions.

Foucault (1976, 1979) argues that power is created by, and permeates every situated interaction and that imbalance cannot simply be explained by reference to institutional power. Porter (1996:61) disputes Foucault's conceptualisations by arguing:

as a function of their social structural position, some groups possess more power than others. Maintaining this more traditional concept of power means that it is possible to compare the amount of power enjoyed (or suffered) by different groups within society.

Nurses 'enjoy' power in terms of deploying their professional expertise in the institutions of nursing and health care. The power of patients lacks recognition within health care and nursing structures and remains ambivalent despite the rise of 'user involvement' cited by Rose (2003). These different perspectives highlight important issues surrounding empowerment in that it is subject to wide, competing, claims in health care and nursing, power as liberating or power as controlling.

The notion of change in terms of balance of power and the role of patients and nurses in contributing to patient/nurse interaction and self-determination provide important conceptual links to my study. Throughout the literature attempts are made to link the positive effects of partnership and participation in the enhancement of the experience of health care and caring. Empowerment is mostly critiqued in terms of difficulties and barriers (Martin 1998, Pill *et al.* 1999, Lewis and Urmston 2000). Many of the difficulties can be related to the problematic of viewing empowerment as act or process.

Wiles (1997) sought to explore the views of patients about the role, status, knowledge and expertise of practice as it interfaced with their care needs by using a grounded theory approach. The patient participants in her study identified the key features of care to be that the nurse should be easily accessible in a comfortable environment, feel confident in her/his skill and knowledge and also possess the social and emotional skills to support them.

In this way, patients recognised the contribution nurses could make to their care. Participants in Wiles' (1997) study emphasised the centrality of supportive skills.

In relation to nurses furnishing or contributing to care, Nordgren and Fridlund (2001) infer that there exists a period of transition in which patients may move from 'passive recipient' of care to a position of empowerment. Nurses are part of this transition process. Nordgren and Fridlund (2001) investigated patients' perceptions of self-determination in the context of care. Their findings are that, in relation to self-determination, patients' perceptions are often feelings of being powerless. Nordgren and Fridlund (2001:123) report that:

The patients' perceptions of their care environment included that: they were not respected, their views of their conditions were not listened to, they were not well informed, and that the staff were pressed for time.

Overall the patients identified the wish to be respected, to have more information and to participate in decisions about their own care. Feelings about power, trust and acceptance relate to the freedom of individuals to make, or be involved in, decisions about their own well being. Nordgren and Fridlund's (2001) findings can be compared with those of Wiles (1997) in terms of their emphasis upon the influence and control of the nurse in empowerment. The findings of Wiles (1997) and Nordgren and Fridlund (2001) together are valuable in highlighting the issues that are central in debates about empowerment from the patients' perspective.

In discussing principles of user empowerment linked to service provision, Barnes and Walker (1998) provide an overview of the key principles in relation to 'users' of health and social care that is very useful. They consider that empowerment has a number of contributions to make in relation to an individuals' influence over, and in, health services. Barnes and Walker (1998:199) emphasise that:

Empowerment should aim to increase people's abilities to take control over their lives as a whole, not just increase their influence over the service.

In relation to service users they identify that a partnership model in patient/nurse interaction has considerable merit. As a precondition to this, Barnes and Walker (1998:201) observe:

The concept of empowerment implies shifting the balance in existing relationships already characterized by imbalances of power and influence. Such imbalances derive from structural as well as personal aspects of the relationship.

Barnes and Walker (1998) note that this should be an empowering process for all concerned if the tension between empowering 'users' and disempowering workers can be resolved. This reflects the competing claims regarding power as liberating or power as controlling mentioned earlier. Barnes and Walker (1998) advocate the negotiation of a reciprocal relationship in which the notion of professional expertise is challenged. I consider their view of particular value in examining definitions of expertise in patient/nurse interaction, specifically I query later who is expert and who defines the 'problem'?

Much nursing literature presents the nurse, rather than the patient, as expert in defining, and therefore controlling, the 'problem'. In these terms dilemmas of, and tensions in, definition may arise. For example, the nurse may identify lack of nutrition as the problem whilst the patient may identify lack of resources to buy food. The difference in definition would clearly affect the patient/nurse interaction in relation to decision-making, as different priorities would be operating. This raises issues of ownership and responsibility, linked to perceptions of role as patient or as nurse. These issues emerged from my data in the context of participants discussing decisions about progress with, for example, a leg ulcer dressing. This led me to consideration of who identifies the problem and the priorities associated with it. As I explain later on in the thesis, I established that the beliefs, expectations and experiences related to role as patient or nurse are influential in the negotiation of their relationship. These are important considerations in a patient/nurse relationship that embraces empowerment.

Allen (2000b) investigated lay participation in health care and agrees that it is often understood to be a matter of involvement in decision-making, whilst overlooking the notion of a shift in the balance of power in the patient/nurse relationship. She also identifies that there is lack of substantive theory to support the assertion that empowerment is a working concept in practice.

Allen (2000b: 189) suggests:

Of course many other factors are likely to affect the form 'lay participation' takes in a given context, such as the individual preferences of patients, the stage of their illness/recovery trajectory, age, education, gender, ethnicity and socio-economic status.

Allen (2000b: 189) contributes further to theoretical sensitivity by her perspective regarding the roles patients may or may not wish to assume:

Furthermore, there may be certain circumstances in which traditional professional-client role relationships are entirely appropriate. The vital thing is that this should be negotiable.

Allen's perspective contributes to my examination of the balance of power in the participants' relationship, in particular the different perspectives they presented and why they did so. Allen's (2000b) findings are also very relevant to my study in terms of her acknowledgement of the importance of wider factors beyond the patient/nurse setting. I also link the argument of Pill *et al.* (1999) that nurses may find it difficult to relinquish their power and control in order to involve patients as partners in their own care to my exploration of who defines the 'problem' and whose accomplishment is patient/nurse interaction in the community practice setting.

2.7 Conclusion

In my substantive review I have examined literature that connects my research questions with my analysis. The key concepts to be used in my analysis and the generation of my categories of Investment and Experience are as follows.

I identified the conceptualisations of Strauss (1978), in particular, *modus operandi* as important in examining interaction from a sociological perspective. I use *modus operandi* in my examination of patient/nurse interaction by linking it to 'the social construction of reality' and participants' experiences in 'everyday lives'.

In relation to negotiation in patient/nurse interaction, I found that further research is needed to generate substantive theories to guide practitioners as Durham (1999) and Wuest (2000) advocate, and to examine negotiation in situated interaction that, importantly, includes all participants as partners in using or providing services. This prompted me to explore with participants the relationships they made between the balance of power and the role of experience in negotiation in interaction.

In my analysis of the development of the patient/nurse relationship, communication, trust, intuition and integrity are important in examining what happens when patient and nurse meet and interact.

Meanings and understandings of negotiation and empowerment in patient/nurse interaction are central areas in my analysis of patient/nurse interaction. The influence of socio-cultural characteristics of age, gender, SES and ethnicity is a fundamental area in analysing navigation and negotiation. As I show later, concepts of commitment and involvement (Morse 1991), and engagement and detachment (Kralik *et al.* 1997), provide important sensitising links in my examination of interaction. Those sensitising links are in particular the impact of superficiality and task-focused communication upon patient/nurse interaction. Conceptualisations of commitment and involvement and engagement and detachment are of considerable value in exploring the complexities of the development of the patient/nurse relationship.

I identified that conceptualisation of knowing the patient in nursing theory attempts to place the patient's interests and concerns at the centre of individualised care. As I demonstrate later, I draw upon the concept of knowing the patient as a person to explore the social dimension of patient/nurse interaction. I develop this concept further in my analysis to generate links between negotiation and empowerment in patient/nurse interaction. Furthermore, concepts of knowing the patient as a person contribute to exploring the meanings and understandings related to navigation and *modus operandi* in patient/nurse interaction.

In my analysis, I link concepts of trust, intuition and integrity in examining reciprocity in the patient/nurse relationship which is an under investigated area in negotiation of the patient/nurse relationship. Relating issues of reciprocity and the generation of rapport to those of navigation and negotiation addresses a gap in present theorising about patient/nurse interaction. Those concepts are particularly valuable in exploring the initiation and development of the patient/nurse relationship, and in considering influential issues in negotiation.

In the literature, integrity is linked to 'preservation of self' and therefore important to sense of personal control and involvement in patient/nurse interaction. Dignity is found 'missing' with regard to definitions or conceptualisations in practice, although links are established to trust and vulnerability. Under-conceptualisation and connection of trust, intuition and integrity are reflected in the gaps in conceptualisations of self-determination in health care and nursing. In recognising this, I explain later how I explored with my participants the links they made to, and between, these concepts in their beliefs about their performance in patient/nurse interaction.

The influence of socio-cultural characteristics in interaction in health care and nursing was explored in my review, and as stated previously further relevant literature is integrated in my findings chapters. The literature examined here identifies the role socio-cultural characteristics play in experiencing, navigating and negotiating in the social world.

I discuss later the impact that age, gender, SES and ethnicity have upon advantage or disadvantage in health care experience and performance. In relation to ethnicity, ethnocentrism and communication are identified in the literature as creating boundaries and constraints in health care and nursing. These key concerns emerged in particular as viewing the needs of minority ethnic individuals as problematic. The literature makes clear that to address the constraints and boundaries in patient/nurse interaction, meanings and understandings of culture need to be shared and negotiated. I explain later how this insight led me to explore these issues with those participants who raised them as a substantial part of their meanings and understandings of lived experiences. Age, gender, SES and ethnicity emerge clearly in the literature as social constructs and as a set of lived relationships. Informed by this literature, I connect the 'dynamics of inequality' identified by Bradley (1996), with concepts of embodiment and self-esteem and the construction of social identity in my analysis.

I investigated the meanings and understandings participants had of empowerment in interaction. As I identified earlier, there is a tendency to take a narrow view of empowerment in the nursing literature. Conceptualisations that are made in that literature focus on empowerment as a nursing act or strategy, rather than as an active process in negotiation of patient/nurse interaction.

In other words, debates in the literature centre on concepts of nurses empowering or patients empowered, especially in relation to situated decision-making or involvement in care. From that body of literature, I gather that clarifying and expanding definitions of empowerment by drawing on sociologically informed understandings would be of value and it is in these terms that I explored it with my participants. I pursue the links between the prospect of participation and involvement in patient/nurse interaction as related to power and self-determination later in the thesis. The literature suggests strongly that examining empowerment from the perspective of participation should include reference to the expertise of patients and nurses. However, existing research does not address the issue of negotiation of the expertise between the patient and nurse in their interaction. Central to this conceptual challenge is the question of who defines patient/nurse interaction: an issue I pursue in my analysis. Importantly in my analysis, I pursue the conceptualisation that empowerment must be considered, not just as a strategy in health care and nursing, but rather as a concept patients and nurses may value and aspire to, which is contingent upon their meanings and understandings generated from wider and extended experiences, and brought to patient/nurse interaction.

I continue my review of the literature in chapter 3 by appraising the evidence about grounded theory methodology. A brief review of the literature about social interaction is also included. Chapter 3 clarifies my approach in using grounded theory and the use of theories of interaction in my thesis.

Chapter 3 Literature review: research methodology

In this brief chapter I detail the research methodology I use to best answer my research questions. I review the literature regarding grounded theory and offer a critique of it as a theoretical approach. Addressing grounded theory methodology with an integrated literature review in this way clarifies why and how I use grounded theory to address my research questions.

My study is a naturalistic inquiry using grounded theory methodology. A naturalistic inquiry involves the study of events in their natural setting with a view to generating understanding of phenomena in terms of the meanings individuals bring to them. This chapter provides an account of the role of grounded theory throughout my research processes and in the generation of theory.

The enterprise of my grounded theory study is to embed the generation of substantive theory in data that is situated in the participants' world and to nurture and sustain links between their accounts and wider conceptual connections. The arguments and evidence I discuss in my findings chapters are related directly to the experiences of patients and nurses, including the links they make to situated patient/nurse interaction and the wider social world.

Grounded theory is the identification of concepts and construction of theory from data by means of constant comparative analysis. Glaser and Strauss's (1967:6) original description states:

Generating a theory from data means that most hypotheses and concepts not only come from the data but are systematically worked out in relation to the data during the course of the research.

Generating grounded theory is achieved through the interplay between data and constant comparative analysis and the asking of conceptually orientated questions, which lead to theory development. Strauss and Corbin (1998:15) define theory as:

A set of well-developed concepts related through statements of relationships, which together constitute an integrated framework that can be used to explain or predict phenomena.

A theory therefore involves a credible relationship between concepts with explanatory and predictive power. The development of theory demands identifying concepts and formulating them into a logically constructed, systematic framework. This conceptual framework must serve to explain the phenomena studied and contribute to the development of a field of knowledge. Silverman (2001:71) cautions that grounded theory:

can degenerate into a fairly empty building of categories

His caution reinforces the emphasis I place upon a systematic approach that includes constant comparative analysis.

In the opening section 3.1, I draw on the literature to identify my position in using grounded theory in the tradition of Glaser and Strauss (1967) and Glaser (1978, 1992). The conceptualisations of social interaction that informed my approach are discussed in 3.2.

3.1 Grounded theory methodology

Glaser and Strauss (1967) presented the 'discovery of grounded theory' over thirty five years ago. Grounded theory is used extensively in social science, nursing and other academic domains as shown in its considerable presence in the literature (Williams 1998, Durham 1999, Cortis 2000a, McCann and Baker 2001, Ellefsen 2002, Borup 2002, Clegg 2003, Glacken *et al.* 2003). Glaser and Strauss (1967) argue that grounded theory has the capability to generate theory grounded in data from the field. The capability they identified is considered a major development in qualitative research. Glaser and Strauss (1967) advocate that theories should be generated directly from the field, particularly in relation to social interactions and social processes.

My systematic approach in using grounded theory is consistent with the original work of Glaser and Strauss and the subsequent work of Glaser (1978, 1992).

As an expression of this consistency, I detail in chapter 5 my approach in constructing theory as advocated by Glaser (1992). I refer to the work of Strauss and Corbin (1997, 1998) where it makes a specific contribution. The key features of grounded theory Glaser and Strauss (1967) identify prevail today, despite diverse evolution of the methodology in practice. These key features are inductive thinking, constant comparative analysis and the generation of theory. An examination of the integration of these key features in my study follows.

Grounded theory demands that theory be developed directly from data in close relationship with the phenomena being examined. Data collection and analysis are conducted simultaneously and inform each other in theory development and the building of categories. In other words, they stand in reciprocal relationship to each other in the research process. Conceptual assumptions and frameworks are not developed or applied *a priori*. The process of theory generation should be dominated by induction to discover, rather than test theory by deduction. In practice induction and deduction are not mutually exclusive concepts, rather they are related (Glaser 1992, Dey 1999, Silverman 2001, Hall and Callery 2001). I found the interplay between induction and deduction natural and useful in examining participants' meanings and understandings of the nature of reality.

Glaser (1992) advocates induction as the dominant conscious process in using grounded theory. Strauss and Corbin (1998:137) agree and acknowledge the role of the interplay between induction and deduction in constant comparative analysis. In relation to advancing my analysis, I found concepts identified by induction led to deduction, which in turn fostered further induction. The dominant conscious process of induction played a central role in constant comparative analysis which Glaser and Strauss (1967:21) describe as the strategic method to generate 'theoretical ideas'. Constant comparative analysis is the continual comparing of incident with incident in the data to recognise similarities and differences. These similarities and differences are classified by coding and subsequently grouped into properties and subcategories.

Glaser and Strauss (1967:105) and Silverman (2001:71) informed my approach in using constant comparative analysis in the following ways. Responsiveness to meanings in the data and constantly comparing those meanings was part of my creative process in developing key properties and categories. Identification of multiple related conceptual meanings led to the saturation of categories, or 'delimitation' (Glaser and Strauss 1967:105). Finally, the maturing of key properties and categories led to the development of substantive theory. Constant comparative analysis must be purposeful in generating theory, from the drawing board of identifying and coding conceptual meanings, to the delivery of analytic frameworks which are presented as key properties and sub categories in my study.

Glaser and Strauss (1967), Glaser (1992) and Strauss and Corbin (1998) all consider that constant comparative analysis can be used to generate two types of theory: substantive and formal.

Glaser and Strauss (1967:33) recommend that the researcher should focus on either substantive or formal theory. My focus is on generating substantive theory. Substantive theory is related to a specific area and context of study or 'everyday life', for example patient/nurse interaction in a community practice setting. Formal theory is generated and sustained by linking substantive theories and developed for conceptual or wider areas of sociological inquiry, for example stigma (Glaser and Strauss 1967:32). The key distinguishing characteristic of substantive and formal theory is their degree of generality. Glaser and Strauss provide the example of substantive theory about dying and 'status passage'. Comparison with other substantive theories, for example about becoming a student or embarking upon marriage, served to generate formal theory about 'status passage' which transcended the specific area of dying.

Charmaz's (1994) grounded theory study is exemplary in illuminating the strength of a systematic approach to generating theory by constant comparative analysis and the development of categories. Her systematic approach enables the development of substantive theory in relation to the experience and response of men to chronic illness, and formal theory in relation to traditional assumptions regarding male identity.

She identifies critical understandings in relation to her own work and is able to extrapolate them to further avenues of research. These avenues include comparative research in relation to age, gender and SES. She also identifies the prospect of enhancing sociological interpretations of the accounts of those with chronic illnesses. Strauss and Corbin (1997) note with approval that Charmaz applies a grounded theory approach systematically, which serves to achieve clarity of analysis and theory generation. However, the methodological integrity of Charmaz's study appears to be the exception rather than the rule. Critiques of grounded theory note a lack of methodological consistency or integrity, or 'slurring' as Cutliffe (2000:1476) describes it.

Wilson and Hutchinson (1996) are robust in their critique of studies that are presented as a grounded theory but are in fact descriptive studies. In their critique, Wilson and Hutchinson (1996:80) list six types of methodological mistakes in grounded theory, which are:

'Muddling qualitative methods

Generational erosion (straying from the key features of grounded theory)

Premature closure of analysis

Overly generic analysis (that is not context specific)

Importing concepts (with failure to provide an original and grounded interpretation)

Methodological transgression (violations of grounded theory methodology)

Dey (1999:14) agrees with Wilson and Hutchinson (1996) and identifies a further range of issues. The issues he identifies are principally the imposition of preconceived conceptual frameworks, inflexible focus on methodological rules in the tradition of Strauss and Corbin (1998), and failure to analyse and conceptualise the data fully. Perhaps the most notable potential flaw Dey (1999) and Wilson and Hutchinson (1996) identify is in relation to grounded theory being referred to as an analytic method or technique rather than a methodology. The avoidance of methodological 'slurring' or 'mistakes' is an integral part of my research process. I identify a methodological mistake I made in 5.2.

Silverman (2001: 71) comments:

At best, grounded theory offers an approximation of the creative activity of theory building found in good observational work, compared to the dire, abstracted empiricism present in the most wooden statistical studies.

Like Silverman (2001), Bryman and Burgess (1994:221) argue that the generation of theory is rarely evident, rather most grounded theory studies present a description of the phenomena studied. Indeed Wilson and Hutchinson (1996:124) consider this is particularly true of grounded theory studies conducted by nurses who concentrate on specific need/care issues or contexts. Layder (1993) identifies the creative potential of grounded theory.

However, as Silverman does, he notes the pitfall of building categories that merely provide a descriptive framework rather than actual analysis. Importantly, commentators observe that excluding wider and existing conceptual frameworks limits the usefulness of grounded theory. These commentators advocate the integration of these frameworks whenever appropriate in order to strengthen grounded theory. It seems that the link between data and theory generation which Glaser and Strauss (1967), Glaser (1978, 1992) and Strauss and Corbin (1998) advocate is a strength in terms of theory related to a specific research field. However, that link is also a weakness in terms of limiting the range of focus and connections to wider contexts (Silverman 2001, Layder 1993, Bryman and Burgess 1994). Layder (1993:70) strongly advocates using grounded theory flexibly, including openness to other conceptual frameworks that may inform and so enhance research in progress:

The definition of grounded theory must include theories which are guided by, rather than simply limited by empirical data.

I include wider theories wherever they contribute to analysis and the generation of theory, for example theories of empowerment.

Since the early 1990s, Glaser and Strauss differ on the development of grounded theory from a philosophical perspective and the ongoing work of Strauss (with Corbin) is more evident in the British academic domain (Bryman and Burgess 1994).

Their key differences are in relation to Strauss and Corbin's (1998) coding and analytic procedures and shift of focus from the analysis of social process to the production of substantive generalisations. Glaser (1992) retains his view that the creative researcher should 'trust the data' and theory will emerge, which he summarises as 'emergence versus forcing'. Glaser (1992) believes that any attempt to 'force' analysis and subsequent theory from the data will result in regression of analytic thought and activity. Glaser (1992) is adamant that the relevance of data must be discovered by identifying credible relationships between concepts and sets of concepts. The relevance of data should not be forced by the premature introduction of 'theoretical ideas'. He advocates that the researcher should be patient and invest in the process of theoretical sensitivity, painstaking coding and development of categories.

Strauss with Corbin (1998) diverge from Glaser and have developed more structured criteria and protocols in relation to coding procedures, and category and theory development. I am most persuaded by Glaser's (1978, 1992) arguments regarding theoretical sensitivity and 'emergence versus forcing'. He argues that preconceived ideas should not be forced on the data and made to fit, although one might refer to existing theory to make wider connections in the later stages of the research process.

The researcher's theoretical sensitivity in emergence has to be relied upon in the process of constant comparative analysis to develop categories. These fundamental concerns regarding a systematic approach in using grounded theory are discussed in detail in chapter 5 where I demonstrate how the principles of emergence relate to meeting the aim of my study.

3.2 Social Interaction

I define and clarify the use of theories of interaction in this section. In order to generate insights from a sociological perspective into my research questions, I draw upon the work of interaction theorists to inform my work as follows.

Berger and Luckmann (1967) conceptualised 'the social construction of reality' as the processes by which individuals creatively shape reality through social interaction. Social interaction involves the negotiation of reality as we make sense of our everyday lives. Interaction includes processes by which people act and react in relation to each other. Our interaction with each other draws on social guidelines for behaviour which include social roles and status.

In Garfinkel's (1967) seminal terms, taken-for-granted rules are central to the achievement of everyday life in which social meanings and order are created and sustained by the ongoing 'performance of social actors'.

How individuals navigate their way through the problems of everyday life requires them to apply methodologies of knowledge, definitions and rules. The skilful application of these methodologies is done routinely and usually unthinkingly. Achieving meaning is an everyday accomplishment that emerges in and of interaction, as is the use of rules (Scott 1995, Layder 1994). In my thesis, issues related to negotiation and empowerment emerge as important to performance in patient/nurse interaction. As I discussed in my substantive literature review, individuals draw upon a wide range of resources to create and sustain their 'performance', including the influence of socio-cultural characteristics.

Each individual has subjective meanings and understandings to bring to interaction, which is a rule-governed and evolving social process. Social meanings are created and defined by the social situation in which they take place. All interactions occur in contexts in which social relationships and identities, for example as patient or nurse, are established. Situated interaction is socially constructed, in this instance patient/nurse interaction in a community practice setting (Berger and Luckmann 1967, Campbell 1996).

Considerable debate regarding interaction lies at the heart of sociological analysis (Scott 1995, Seidman 1998, Denzin and Lincoln 1998a). A summary of the key concepts follows.

Turner (1988:3) defines action as conduct which has social meanings and he argues that:

The basic unit of sociological analysis is not action but interaction; and the assumption that one can begin with elementary conceptualizations of action and then progressively move up to the analysis of *interaction* and structure is highly questionable.

Turner argues that it is appropriate to consider how interaction rather than action is accomplished. Turner's argument proposes a concentration on the development and contribution of theories of interaction from a sociological perspective. Turner's (1988:41) argument is based on the belief that to focus on action is to risk 'regression' into a psychological or behaviourist approach. Campbell (1996:16) argues that the study of interaction describes conduct or situated behaviour, rather than examining the subjective meanings brought to action in social contexts. Campbell's (1996:43) concern is that the 'meaning' or 'the meaningful' in situated interaction is divorced from the wider social context of action. He argues that sociology requires theories of interaction and action if it is to understand human behaviour.

In the tradition of discovery, grounded theory is most often used in a situated context. However, it does not discriminate in the construction of theory between how and where the 'meaning' or 'the meaningful' are achieved in individuals' 'performance'.

In reviewing grounded theory methodology Layder (1993:68) argues that:

current conceptions of grounded theory need to be extended and amended to incorporate aspects of social reality that are normally thought to fall outside of its legitimate parameters.

He refers to the 'macro – micro' debate in approaches to social analysis. Macro relates to the wider world of, for example, institutions and power, and micro relates to, for example, situated (patient/nurse) interaction. Initially, my research appeared to fall into the domain of the micro world, the situated interaction of patients and nurses. However, Layder's (1993:70) proposal that 'ligatures' bind micro and macro phenomena of social reality together is relevant in my exploration of participants' meanings and understandings. The influence of 'ligatures' as described by Layder (1993) are important conceptual connections in my analysis, in particular to the experiences of participants in settings beyond health care and nursing. Arguments that in everyday lives different levels of social realities exist, which are distinct but interdependent are useful in my analysis. In relation to the social construction of reality by patients and nurses, it proved to be possible not only to examine situated 'meaning' or the 'meaningful', as Campbell (1996:430) describes it, but also to explore the wider social world beyond the community practice setting. My study is founded in the context of situated interaction. However, issues related to the experience of patients and nurses in wider social contexts emerged from their accounts as influential and significant aspects of their understanding.

The emergence of issues related to the wider social context in participants' accounts contributes to my analysis in that it became clear that grounded theory had the potential to include and link the 'macro and micro'. The relevance of wider social contexts is particularly evident in the subcategories of extended and wider experience in the category of Experience.

3.3 Conclusion

In this chapter I have examined grounded theory to identify and support the methodological approach in my thesis. I have also examined critically the nature and development of grounded theory. My terms of engagement with grounded theory are consistent with the traditional features of Glaser and Strauss's (1967) original work and the subsequent work of Glaser (1978, 1992). I have clarified that my systematic approach in using grounded theory, especially the interconnectedness of data collection and constant comparative analysis, contributed to the achievement of the aim of my study. I have argued that Glaser's (1992) contentions about 'emergence versus forcing' are critical to appreciating fully the role of theoretical sensitivity. The interplay between theoretical sensitivity and emergence is central in my research process and animated the creative potential of grounded theory. Fulfilling the exacting demands of the traditional approach is enlightening in terms of appreciating fully what grounded theory is and the potential it has.

Bhaskar (1979) relates the nature of social inquiry directly to the research participant and stresses that it is their perspective in relation to the complexity of social realities that is important. My inquiry does not create a separation between situated interaction and the 'meaning' and 'meaningful' generated from the wider social context. In relation to the issues raised in participants' accounts, it would have been artificial and methodologically inconsistent in terms of discovering 'phenomena', to separate situated interaction and wider social context. Meanings and understandings of participants emerged as situated in, and interconnected with, wider social contexts, and included their 'social construction of reality' (Berger and Luckmann 1967).

I have drawn upon the theorising of Berger and Luckmann (1967) and Garfinkel (1967) to clarify my conceptualisation of social interaction. I have argued that Garfinkel's (1967) view of interaction as an accomplishment in everyday life, and the processes Berger and Luckmann (1967) identify as central to as 'the social construction of reality', provide insights with which to explore how patients and nurses accomplish meanings and understandings in interaction.

In the next two chapters regarding data collection and analysis, I detail how I have addressed my research questions using grounded theory and how the work of Strauss (1978), Berger and Luckmann (1967) and Garfinkel (1967) is embedded in the generation of my substantive theory.

Chapter 4 Research methods: data collection

My research methods are detailed and examined in this chapter and related to my grounded theory approach. The process of gaining Health Board Ethics of Research Committee approval (HBERC) is presented and ethical practice discussed. Ethical considerations permeated my research process and guided the conduct of my study, in particular, gaining informed consent. I describe gaining access to fieldwork areas and participants as a cascade from HBERC approval to identifying participants.

Building on the arguments in chapter 3 regarding generating theory directly from the field and constant comparative analysis, my specific methods of data collection, and the utility of those methods are described in detail. Those methods are observations and two types of interviews: informal and semi-structured. Data collection, coding and constant comparative analysis informed my activity in the field and directed the progression of analysis. Transcription of data is part of that process. The participants are representative of those attending as a patient or working as a Registered Nurse in community practice settings, specifically, health centres.

Thirty eight observations (appendix C) contributed to the development of substantive codes and informed the direction of informal interviews (appendix D). Informal interviews with twelve patients and twelve nurses developed the substantive codes further and led to the identification of key properties. Informal interviews also contributed to the development of subcategories. Semi-structured interviews with six patients and six nurses provided my theoretical sample. These interviews fortified and consolidated my subcategories and ultimately led to the development of two analytic categories: Investment and Experience. My discussion of research methods includes reflection upon the data collection process.

4.1 Ethical approval

Successful application for 'Ethical Approval of Research Protocol' was made to the HBERC. My application was informed by the guidelines of the British Sociological Association (BSA 2002) with regard to ethical research practice. Taking into account that I had no sponsors/funders and was not conducting covert research, the key areas the BSA identify to guide ethical research practices relevant to my research are: professional integrity and relations with, and responsibilities towards, research participants. The BSA guidelines are underpinned by principles of justice, beneficence, nonmaleficence and autonomy.

The HBERC application requirements emphasise quantitative methodology, especially in relation to protocols related to drug or medical treatment trials. Despite this, it was possible to relate and integrate the BSA guidelines to the HBERC application requirements. Fulfilling the criteria for HBERC ethical approval was exacting. It required me to address issues related to rationale, aim, methodology and research design and methods. I believe this stimulated care and attention, not only to ethical considerations from the outset, but also provided a clear beginning to launch the research process. Gaining informed consent is the primary ethical consideration in research (BSA 2002). Informed consent to participate must be given freely by an individual who understands information and explanations given related to what the research is about, why it is being done and how it will be conducted.

My criteria for inclusion/exclusion in the study related to competence and vulnerability. I indicated those patients I identified as potential participants to the practice nurse and excluded those whom it would be inappropriate to approach in terms of their ability to understand, and past or present experience, for example terminal illness. Participants had the opportunity to ask questions and withdraw their consent at any time if they wished. In addition to this, I made participants aware of my background and purpose in conducting my study. If a patient participant raised a health issue with me I advised them to speak to the practice nurse.

Principles of confidentiality and anonymity are included in the consent instrument (appendix A) which integrated the requirements of the Data Protection Act (1998).

At every stage of the research process there are ethical considerations. Kylma *et al.* (1999:226) note:

Ethical issues are combined with methodological issues in each phase of a study.

Kylma *et al.* link choices in research methodology and design to evaluating ethical robustness. Whilst ethical considerations are discussed wherever they arise throughout the research process in acknowledgement of their fundamental role, they are addressed in this chapter in the sections that follow.

4.2 The field of study

My research was conducted in four health centres in the community practice setting. The health centres are located in the central area of Scotland. The four health centres as my field of study are representative of health status of communities in Scotland in relation to social factors, such as employment, and health indicators, for example incidence of cardio-vascular disease, as exemplified in Scottish constituency health reports (Office for Public Health in Scotland, 2001) and interrogated by Blamey *et al* (2002).

Age, gender, SES and ethnicity are included in analyses of health status of communities. The minority ethnic population in Scotland is small at 2.25% of the population. In the Health Board area where I conducted my study, it is smaller, at 1.9% of the population (Registrar General, 2001 Census of Population).

The health centres in which I conducted my research are located in areas with geographic and social differences. The patient and nurse participants are distributed across these health centres, which have approximately the same number of patients registered with them, and offer the same practice nursing services to their patients. Geographically, the health centres are located in three different local authority areas, and within a thirty-mile radius of each other. Each serves predominantly urban communities. Two of the health centres are in large towns, W and X, the other two are in smaller towns, Y and Z. All of these towns serve as social and administrative centres for the population in the surrounding areas. Rather than include statistical material to demonstrate social differences, I draw upon constituency health reports to provide summaries of each area the health centres serve (Office for Public Health in Scotland, 2001). A summary of the field of study is presented in table 1 after the description which now follows.

Large town W has an average population structure, a higher level of educational attainment amongst school leavers, a higher average household income, and a lower unemployment rate compared to the national average. Almost all the health indicators are better than the national average.

The health centre is under ten years old and of modern design, particularly in terms of accessibility features. It accommodates GPs, practice based and community nursing staff (general, mental health and learning disability), midwives and visiting allied health professionals.

Large town X has a population structure that is younger than for the nation as a whole and average household income. Educational attainment for school leavers is lower than average. It has a higher unemployment rate than the national average. All the health indicators are close to, or better, than the national average. The health centre was built just outside the centre of town in the early seventies, has a dated, cramped feel and has been extended several times to accommodate the service needs of a growing population. It houses GPs, practice based and community nursing staff, and midwives. Mental health and learning disability community nurses visit regularly but have no permanent base there.

Small town Y has a slightly lower than average proportion of older people in the population. Educational attainment among school leavers is lower than average, as is household income. The unemployment rate is higher than the national average and most of the health indicators are either close to, or lower than, the national average.

The rate of low birth weight babies is higher than the national average. The health centre was built in the mid eighties. It accommodates GPs, practice based and community nursing staff (general, mental health and learning disability), midwives and visiting allied health professionals. It also has non-acute outpatient services related to general medicine and surgery. This historical arrangement reflects attention to enhancing accessibility to services by public transport which are otherwise available in the general hospital on the outlying boundary of the nearest large town.

Small town Z has a population structure similar to Scotland as a whole, with below average educational attainment for school leavers. Economic status, as measured by average household income and proportion of adults claiming income support, is fairly close to the national average. Unemployment is slightly above the national average. The health indicators are close to, or slightly below, the national average. The death rate for stroke is well above the Scottish average. The health centre accommodates GPs, practice based and community nursing staff and midwives. Community mental health and learning disability nurses visit. Whilst chiropody is available, other allied health professional services are only available in the general hospital in the nearest large town.

Table 1: summary of the field of study

| Town | W | X | Y | Z |
|-------------------------|---|----------------|--------------|---|
| Population structure | ⋮ | ↓ (younger) | ↑ (older) | ⋮ |
| Educational achievement | ↑ | ↓ | ↓ | ↓ |
| Household income | ↑ | ⋮ | ↓ | ⋮ |
| Unemployment rate | ↓ | ↑ | ↑ | ↓ |
| Health indicators | ↑ | ↑ | ↓ | ↓ |

- ⋮ = of national average (Scotland)
- ↓ = lower than national average (Scotland)
- ↑ = above national average (Scotland)

The health centres are similar in layout and organisation of space. The entrances lead to reception areas which include consultation waiting areas. These consultation areas serve all the services offered in the health centres. In three of the health centres the consultation rooms are in short corridors that lead off from the waiting areas. In the other, the consultation rooms open directly onto the large waiting area.

The consultation rooms used by the practice nurses differed a little in layout, but contain the same type of institutional hard and soft furnishings. The rooms have cupboards for supplies such as bandages and medications, an examination table with adjacent light, desk and soft chairs. My observations, informal and semi-structured interviews took place in these consultation rooms in the health centres, which by prior inquiry and arrangement were not required for other use at the time I was there. None of the health centres has interview rooms that did not contain furniture related to medical/nursing health examination matters. However, on each interview occasion I arranged the furniture to minimise the medical nature of the environment and create a focus upon a conversational context. I achieved this by arranging the seats to face each other and away from the examination table and desk, and tidying away equipment on work surfaces.

On each occasion before the interview commenced, I asked the participant if some further re-arrangement of the chairs would improve their comfort.

Giving participants some control over the environment in this way allowed them the opportunity to make adjustments that took into account the space and angle they preferred to be from the interviewer. Ten patient participants and six practice nurse participants made small changes to the positions of their chairs in relation to mine. Rather than site the tape recorder in front of us where it would have been a focus of attention and possible distraction, I was able in each instance to place it to the rear of the seating arrangement.

Kvale (1996) and Arksey and Knight (1999) argue that the interviewer is in a position of power, for example, the research process was instigated and driven by me and reflected my values. The parameters of informed consent and the involvement of participants in control of their interview environment perhaps lessened my power as interviewer. Whilst it would have been appropriate to interview in a room without equipment, I had no alternative but to make use of the resources available in the health centres. I was able to ensure that participants were as comfortable as possible in an environment which was at least familiar and reduced inconvenience to them as they had already arranged to visit the health centre. Time was the inconvenience that they agreed to when approached to consent to participate. Each interview lasted on average 40 minutes. The shortest was 30 minutes and the longest was 65 minutes.

4.3 The participants

The participants are adult patients and practice based Registered nurses. Participation was sought from patients and nurses encountered within the health centres. Informed consent was sought and given by all participants. I did not seek out a representative sample in relation to socio-cultural characteristics, rather I considered the participants to be typical of those attending or working in a health centre. The rationale for this is that the research is located in the natural setting, the health centre, and the participants are 'performing' in that environment. In terms of examining patient/nurse interaction therefore, every individual had meanings and understandings to contribute in relation to my research questions.

Following thirty eight observations of patient/nurse interaction, I conducted informal interviews with twelve patients and twelve nurses. I then conducted semi-structured interviews with six patients and six nurse participants. Informal interviews and semi-structured interviews were conducted with patients and nurses I had observed. The twelve participants selected for semi-structured interviews were chosen on the basis of their potential to contribute to emergent theory. Theoretical sampling was done in a grounded theory tradition in response to theoretical sensitivity to extend and develop theory as it emerged.

The approach to identifying participants at each stage of the research process produced rich data and assisted subsequent analysis as discussed in chapters 6 and 7. All of the nurse participants are female, white British and aged between early twenties and late fifties. Patient participants had a range of socio-cultural characteristics in relation to age, gender and SES. As previously identified, consistent with the profile of the population of Scotland, three patient participants are minority ethnic. However, participants had a range of backgrounds with different ways of life, customs and traditions.

Patients' SES proved to be difficult to establish. I overcame these difficulties by gaining a reasonable indication of SES in interviews in relation to questions around family background and local connections. In this context, all participants mentioned occupation and some mentioned economic means, for example, living on basic state pension only. I translated their responses using the definitions of the Office of National Statistics (1999), which are based on form of remuneration, training and responsibility. I present the definitions I used in table 2.

Table 2: non inclusive extract from the classification of socio-economic status, The Office of National Statistics (1999).

| SES category | Definition |
|---------------------|--|
| 1.1 | Employers, and managers in larger organisations <i>For example, company directors and senior civil servants</i> |
| 1.2 | Higher professionals <i>For example, solicitors and university academics</i> |
| 2 | Lower managerial and professional occupations <i>For example, musicians and police officers</i> |
| 3 | Intermediate occupations <i>For example, clerks and computer operators</i> |
| 4 | Small employers and own account workers <i>For example, publicans and decorators</i> |
| 5 | Lower supervisory, craft and related professions <i>For example, plumbers and TV engineers</i> |
| 6 | Semi-routine occupations <i>For example, shop assistants and traffic wardens</i> |
| 7 | Routine occupations <i>For example, labourers and refuse collectors</i> |
| 8 | No employment <i>For example, never worked and long term unemployed</i> |

A summary of the range of the socio-cultural characteristics of participants as representative of those attending or working in a health centre, combined with detail of their contribution to my study, is presented in appendix B. Further description to serve as introduction to the participants is provided in sections 4.3.1 and 4.3.2.

In the brief descriptive notes about participants that now follow, I use their terms and emphasis. I draw upon the areas of inquiry identified in the informal interview instrument (appendix D) to present this information.

4.3.1 Patient participants

F = female. M = male. W/UK = white British. ME = minority ethnic.

(Estimated) SES = socio-economic status (Office of National Statistics, 1999)

* = semi-structured interview (theoretical sample)

| | |
|----------------|--|
| P1* | She and her family have lived locally 'always', doesn't ever want to |
| F, W/UK | live anywhere else. Worked locally as do most of her family now. |
| 66 – 80 | Enjoys ongoing relationship with nurse and is comfortable in the |
| SES 6 | health centre with which she is very familiar. Feels in tune with the |
| | nurse who she perceives as responsive to her feelings and |
| | supportive. Referred to influential experiences in other institutions. |

- P2** Resident in the small town for ten years with her partner and one child. Commutes to city to work forty miles away where she previously lived and was brought up. Reserved and self-conscious on meeting the nurse, feels shy on first meeting people. Paying a one off visit for a cervical smear and described feeling scanned and appraised by the nurse's scrutiny.
- F, W/UK**
18 – 40
SES 1.2
- P3** Has lived locally for many years and worked in nearby large town, now retired. Describes himself as a formal man and raised issues of conventions of how to behave in the health centre to which he is an infrequent visitor. Appreciated straightforward, pleasant approach of the nurse as conducive to the purpose of his visit.
- M, W/UK**
66 - 80
SES 2
- P4*** Lives and worked in the area all her days. A regular attendee for some months for dressings to leg ulcer. Identifies a sense of partnership in her relationship with nurse with whom she always felt a sense of rapport. Identifies the nurse as 'knowing best' and believes the nurse to be an expert and as such in control of meeting her needs.
- F, W/UK**
80 +
SES 5
- P5** Has lived in the area since she married, and was born and brought up in central Scotland. Very familiar with the health centre and staff, confident in the services they offer to her and large and extended family. Feels that being known, and similarities established in social and cultural terms, was linked to generating rapport and being accepted.
- F, ME**
18 – 40
SES 4

- P6** Returned to live in this area where he was brought up when he retired to be closer to his family and grandchildren. Whilst working he had lived in a range of places in Scotland and latterly, Yorkshire. He has considerable experience of health centres which he has attended for monitoring and management of diabetes mellitus. Described taking a while to get to know and trust people. Appreciates the nurse's concern with his care and following a period of 'weighing up' feels confidence in her ability to meet his needs. Raised issues of control and negotiation of management of care.
- M, W/UK**
66 – 80
SES 3
-
- P7*** Has always lived within a ten mile radius. Regular attendee for dressings who raised issues of ownership of meeting needs. Feels at ease in the health centre. Identified sense of partnership and intimacy in relationship with the nurse, who 'knew best'. Referred to influential experiences in other institutions.
- F, W/UK**
80 +
SES 5
-
- P8*** Has lived in the area for many years with some extended periods elsewhere, including Pakistan. Well known in the health centre which she and her family have attended since it opened. Feels that being overweight puts her at a disadvantage in terms of how she is perceived in health terms. Also feels that the nurse knows best by having professional knowledge and skill. Referred to influential experiences in other institutions.
- F, ME**
41 – 65
SES 4
-
- P9** Local resident for many years. Has been attending the practice nurse for over a year for dressings to an intractable leg ulcer. Identifies that she likes meeting people and expects to develop a rapport with most. Believes the nurse to be expert and in control. Defers all decision making to the nurse and takes an interest only in the progress of wound healing.
- F, W/UK**
80 +
SES 4

- P10** Moved to the area with his family from England for work purposes. Identified responsiveness of the nurse as approachability with resultant sense of rapport. Values sense of purpose of the nurse. Feels that the nurse should lead patient/nurse interaction and knows best by drawing on knowledge and skill.
- M, W/UK**
41 - 65
SES 2
- P11*** Has always lived in central Scotland and very familiar with the local area. 1st visit and unsure of what to expect and apprehensive. Ambivalent about connecting to the nurse who had a formal, business like approach, prefers an informal approach to put him at ease. Felt he had to follow the lead of the nurse and couldn't initiate any contribution. Referred to influential experiences in other institutions.
- M, W/UK**
41 - 65
SES 3
- P12** French visitor, paying a single visit with minor injury. Appears abrupt in manner and appeared very reluctant to engage in pleasantries. Seemed to be very controlling in interaction to the nurse, who considers attributing this to cultural difference. Issues of understanding did not arise for the nurse based on the clear and concise description of her needs the patient presented.
- F, ME**
66 - 80
SES 1.2
- P13** Moved to back to the area from the north of Scotland with her three children under a year ago (lone parent). 1st visit, unsure of what to expect and apprehensive. Feels summed up and scrutinised by the nurse with resultant difficulties in identifying a sense of rapport. Referred to influential experiences in other institutions.
- F, W/UK**
41 - 65
SES 2

- P14 M, W/UK 80 + SES 1.2 Has always lived and worked within a fifteen mile radius. Describes a wide range of ex-work and leisure related activities. Single visit and apprehensive. Feels his usual confidence in social interaction is lessened. Self-conscious about physical presentation, specifically in health care setting where he felt inspected.
- P15 F, W/UK 66 – 80 SES 7 Has lived in the same street nearby for almost all of her life. At ease in the health centre and with the practice nurses. Reflects upon changes in health care and nursing practice, in particular the power of the doctor. Referred to influential experiences in other institutions.
- P16* M, W/UK 41 – 65 SES 3 Moved with his wife to the large town from the surrounding rural area several years ago. Regular attendee in past few months for blood pressure checks, anxious about progress. He describes himself as 'cautious' with people and so took a while to develop rapport with the nurse. Feels the nurse shares his concerns and having developed confidence, trusts her to address them.
- P17 F, W/UK 41 – 65 SES 5 Lives locally and works in large town. 1st visit, feels loss of confidence and control as she did not know what to expect or what would be asked of her. Ambivalent about connection to the nurse who had a more formal, business like approach. Believes she is more receptive to informality in interaction. Also believes the nurse to be expert and in control. Referred to influential experiences in other institutions.

P18 Moved to the town to be near his family when his wife died several years ago. Attended for single consultation for travel immunisation and hadn't attended the health centre otherwise for a considerable period of time. Surprised by changes in services offered and unaware of the role of the practice nurse and who in the health centre is 'expert' in what.

M, W/UK
66 – 80
SES 3

4.3.2 Practice nurse participants

F = female. M = male. W/UK = white British. ME = minority ethnic.

(Estimated) SES = socio-economic status (Office of National Statistics, 1999)

* = semi-structured interview (theoretical sample)

N1* Has been employed in the health centre for just over a year and lives in the area with her parents. Has an informal approach and values listening to 'the story' and the contributions of patients, made links to empowerment of patients.

F, W/UK
20- 35
SES 3

N2 Employed in the health centre on a part time basis for over five years. Lives outwith the area on a small holding and travels for over an hour to work. Has an informal approach and values involving patient in their own care and developing a therapeutic relationship. Reflective of changes in health care and nursing and related to present practices.

F, W/UK
51 – 60
SES 3

- N3** Appointed to the health centre several years ago when she moved to the area from Edinburgh with her young family to be nearer her parents and extended family. More formal in approach and takes a while to get to know patients. Values the contributions patients could make to their own care (ideas and experience).
- F, W/UK**
20 – 35
SES 2
- N4** Part time in the health centre for several months. Her first post since returning to nursing following a career break. Informal in approach, likes to work at developing rapport with patients. Identifies that a therapeutic patient/nurse relationship is related to participation and involvement.
- F, W/UK**
36 – 50
SES 3
- N5** Has worked in the health centre for several years and lives locally. Has an informal, confident approach. Feels a sense of partnership with patients about their shared need/care concerns. Values giving full information to patients. Emphasises recognising similarities in culture, rather than differences.
- F, W/UK**
20 – 35
SES 3
- N6** Has considerable community nursing experience in three different areas of Scotland and has been in the health centre for several years. Lives in the nearby large town. Has a more formal approach. Feels that informing patients involves them in their care and that nursing expertise is central to the patient/nurse relationship and satisfactory outcomes.
- F, W/UK**
36 – 50
SES 3
- N7** Has been a practice nurse for several years and has always lived in the locality. Has a more formal approach. Values generating confidence between patient and nurse as a two way process. Identifies surveying the patient by gaze as a part of weighing up health status.
- F, W/UK**
36 – 50
SES 3

- N8*** Practice nurse for three years and lives in the surrounding rural area. Has an informal approach and values involving patients in their own care. Reflective of changes in health care and nursing which she related to present practices in health care and nursing, in particular participation and involvement.
- F, W/UK**
20 -35
SES 2
- N9** Employed in the health centre recently and lives outwith the immediate locality. Cited the centrality of the patient/nurse relationship to her practice, had an informal approach. Looks for similarities and differences in socio-cultural characteristics as part of knowing the patient and developing a relationship with them. Identifies and values sense of partnership and intimacy with regular patients.
- F, W/UK**
20 – 35
SES 3
- N10** Part time in the health centre for several years and lives locally. Has an informal approach. Feels a sense of partnership with patient requiring regular dressings. Identifies older patients who are independent as 'special' and makes links to increased surveillance of needs in those who are older.
- F, W/UK**
36 – 50
3
- N11*** Very experienced practice nurse who has worked in several health centres in the area. She lives alone in the nearby large town, her family has grown up and moved away. Has an informal approach. Enjoys developing relationships with regular patients in particular and made links to job satisfaction. Links complexity of language and use of the vernacular with SES. Reflective of changes in health care and nursing and relates to present practices.
- F, W/UK**
51 – 60
SES 2

- N12** Has worked in the area as a practice nurse for some years. Lives in the nearby small town. Has an informal approach. Values patients' involvement in their care beyond decision making and makes links to empowerment.
- F, W/UK**
36 – 50
SES 2
- N13** Recent appointment to the health centre and inexperienced in practice nursing. Takes a while to get to know and feel comfortable with new patients. Uncertain about including patients in decision making as part of their participation in their care.
- F, W/UK**
20 -35
SES 3
- N14*** Experienced part time practice nurse who has lived in the locality for twenty years. Informal and values being approachable. Appreciates responsiveness of patients and believes it leads to participation. Values listening to 'the story' and the contributions of patients. Identifies difficulties of achieving empowerment in practice.
- F, W/UK**
36 – 50
SES 3
- N15** Part time practice nurse who has always lived in the immediate area. Has an informal approach, feels she 'knows everybody round and about'. Identifies older patients who are independent as 'special', linked to increased surveillance of need in those who are older.
- F, W/UK**
51 – 60
SES 3
- N16*** Recently employed on a part time basis when she gave up full time employment elsewhere. By preference, has always lived outwith the immediate area. More formal in approach and takes time to develop rapport with patients. Tussles with translating patients' ideas and experience into her practice.
- F, W/UK**
51 – 60
SES 3
- N17** Recent appointment as practice nurse upon her return to this part of Scotland from the Highlands to live. Informal and confident in approach. Recognises trust as foundational in the development of patient/nurse relationship.
- F, W/UK**
20 – 35
SES 3

N18* Experienced part time practice nurse, has always lived within a ten
F, W/UK mile radius of the locality. Informal in approach. Identifies and values
36 – 50 confidence in the patient/nurse relationship as a two way process.
SES 3 Reflective of changes in health care and nursing and relates to
present practices.

4.3.3 Researcher participation

In this section, I identify my characteristics and discuss my influence in the research process as researcher. I note here the role of subjectivity and reflection in critical and creative thinking in my grounded theory research process. I expand further on these issues in chapter 5, research methods: analysis.

In summarising the characteristics of a grounded theorist, Strauss and Corbin (1998:7) emphasise the centrality of 'absorbed' involvement in the research process, in particular to abstract thinking and generating ideas. Strauss and Corbin (1998:8) also consider that the researcher should be creative and innovative. Glaser (1978, 1998) agrees and makes special reference to sensitivity to the words and actions of participants. Sensitivity extends to self-awareness regarding the researcher/participant relationship. In the same way that I have, wherever possible, described participants' socio-cultural characteristics, they did the same assessment of me.

I am female, early middle aged, SES 1.2 and British. Participants were also aware of my nursing background and I surmise that in their eyes this added to the health centre being a natural setting for me to conduct research.

In laying claim to the integrity of research, researchers must find ways to analyse how subjectivity influences their research. Finlay (2002:531) argues that:

Through the use of reflexivity, subjectivity in research can be transformed from a problem to an opportunity.

I have not considered subjectivity to be a 'problem' throughout the conduct of my study, rather I have consciously used it, reflection has been a driving force in learning and doing. My existing reflective skills were imported into the research field and adapted. Reflection need not be self-indulgent, as it is sometimes presented, if used purposefully in the research process, which was my aim (Labaree 2002, Silverman 2001). Hunter *et al.* (2002) consider the process of reflection to be linked not only to creativity or intuition in the research process, but also to integrative power in analysis. Hall and Callery (2001:257) identify that the role of reflection has been overlooked in grounded theory and recommend that:

the effects of the researcher-participant interactions on the constructions of data and power and trust relationships between researchers and participants, should be incorporated into grounded theory.

Hall and Callery's (2001) view presents a considerable task and links to Strauss and Corbin's (1998:7) emphasis upon sensitivity to the words and actions of participants. The task requires openness and consistency in approach and explanations to participants with a view to engendering confidence and approachability. It requires care in the approach to observing and interviewing. Reflective questioning should follow the lead of the participant in presenting the realities of their social world as the research demands, rather than interrogating them around the aim of the study. Reflection demands inclusion of the demeanour and responsiveness of the participants in field notes, so that their voice is represented contextually in the data. Translating subjectivity and reflection as terms of engagement in the research relationship is expressed explicitly throughout my research process.

Sword (1999:270) identifies that:

Qualitative investigators often do not acknowledge how, among other things, their own background, gender, social class, ethnicity, values and beliefs affect the emergent construction of reality.

Sword suggests that the researcher positions clearly their background in the research process to make the context of research explicit and self aware. Therefore, before I address my research methods in detail, I now discuss the influence of my presence as 'constructing a reality' in observations and interviews. I have also included here the import of my identity and socio-cultural characteristics in the research process.

I presented myself and was identified by all of the participants as a nurse researcher. In these terms and as stated previously, they conveyed that the health centre was a natural setting for me to be conducting field work in. In the process of gaining consent, patient participants recognised that I am a nurse by background, working in an academic domain, who was in the health centre for a specific purpose. The nurse participants are all familiar with the research process I invited them to participate in. The participants found the aim of my research, as explained in the consent to participate process, an understandable area of inquiry. In constructing my identity as researcher I accept that I became part of the research process and my socio-cultural characteristics influential within it.

Appreciating my position within and throughout the research process helped me to maintain focus on the research questions, to give attention to consistency in my approach in observing and interviewing and to concentrate on the meanings and understandings of participants. By the fact and nature of my presence as researcher, I was part of the interactive process in observations and interview process and therefore contributed to their social construction.

In 4.5 I detail my strategy in interviewing techniques to address concerns about the effect of participation and researcher presence.

In my non-leading (reflective) interviewing technique, I emphasised to participants that there were no right or wrong answers, or pre-existent assumptions or theories, rather I was interested in their meanings and understandings. The richness of the data I obtained suggests that participants did feel comfortable to disclose and expand in their own terms. This is congruent with a grounded theory approach. The combined meanings and understandings participants chose to share are central in the achievement of the aim of my study.

Descriptive and reflective notes helped to me to consider and document other factors that may have affected observations and the interview process. For example, I noted from observations if participants included me in their glance and in interviews if they expanded their answers and followed their own train of thought.

None of the participants made any direct comment upon my age, gender, SES or ethnicity. However, my socio-cultural characteristics and how I was perceived by the participants in my interaction with them will have affected observations and interviews as part of their *modus operandi*. The evidence to support this view lies in my own data which is discussed in chapter 6. In particular, processes of weighing up in relation to similarities and differences in socio-cultural characteristics and placing in the social world emerged as central in initiation of, and negotiation in, interaction.

Participants weighed me up in relation to socio-cultural characteristics as they did each other in need/care interaction. They found similarities and differences and having 'placed' me in the social world expanded in their own way in response to my areas of inquiry in informal and semi-structured interviews. I felt a sense of rapport with participants and they with me in that having placed each other in the social world, no explicit constraints emerged in our interaction. However, I did note that participants mostly avoided using the vernacular in their interviews, the evidence for which can be observed in the *verbatim* extracts from interviews I include in chapters 6 and 7. As I comment upon in my findings chapters, this is consistent with beliefs regarding performance as patient or nurse in the health care setting.

In informal interviews (appendix D) and semi-structured interviews I openly inquired into age, gender, SES and ethnicity. In these terms socio-cultural characteristics were an explicit part of my agenda and participants responded to that agenda and in their own terms. Assumptions regarding the sharing of views or values related to age and female gender in particular did emerge in participants' accounts of their own experiences. Participants' expectations and beliefs regarding age and gender are addressed in my findings chapters.

In light of the fact that I have not worked directly in (acute) clinical practice for some years, I believe the nurse participants identified me as knowledgeable in health care and nursing, but outside the realm of community practice insider.

In terms of my age and gender in particular, I fitted with the patient participants view of what a nurse would be, counter posed with the fact that I had explained that I was in the health centre for a different purpose.

Over and above the issues of the influence of researcher identity, the interaction in interviews I conducted was different from need/care interaction in relation to balance. The difference was achieved by positioning the participant as the focal point of the interaction. Whilst I initiated and contextualised the interviews, I also generated the scope for participants to contribute in their own way and time.

The interviews were guided and facilitated by me in relation to my research questions and subsequently transformed in analysis. In these terms, I was a participant in the interviews and instrumental in the construction of participants' accounts. The role and influence of the researcher in the interview process in this way is well-documented (Kvale 1996, Arksey and Knight 1999, Wengraf 2001). Rapley (2001:317) views the interview as interaction. He emphasises that the interviewer is a central and active participant in the interview, analysis and presentation of analysis. Kvale (1996) considers the researcher to be a research instrument most evidently in the collection of data. He argues that the researcher is an influential presence in the research process, which their identity and interpretive framework permeates.

In conducting fieldwork, Silverman (2001:113) directs the researcher to consider purpose of method counterbalanced with methodological (and analytic) position. The interviews in my study generated participants' situated accounts of multiple realities. Jarvinen (2000:386) observes:

When interviewees report on experience, they do so from different social positions and in greater or lesser agreement with recognizable cultural scripts.

Participants' accounts are uniquely constructed by them as emergent from, and located within their social world, elements of which are recognisable by us all to a greater or lesser extent. My interviewees reported on their individual experience and included reference to 'social position' and socio-cultural characteristics. I was instrumental in constructing their accounts in the development of my categories. As discussed in the previous chapter, my approach in using grounded theory in a traditional style is informed by recognising the challenges that grounded theory presents to the researcher as research instrument. Glaser and Strauss (1967:8) recognise that grounded theory may 'take many forms' and Glaser (1992) advises the researcher to be 'flexible and creative'. Taking these key recommendations into account, my grounded theory study is a custom built version like all others and includes the key features of interplay between inductive and deductive thinking, and constant comparative analysis.

The evidence of the creative potential of grounded theory lies in the theory I have constructed about the 'unknown' of patient/nurse interaction from a sociological perspective, as exemplified in figures 2 and 3. As I discuss in my findings chapters, my account of phenomena emerges directly from the field of study and the participants portrayed in 4.2, 4.3.1 and 4.3.2.

It was very valuable to explore research methodology thoroughly throughout the research process. To do so it is important to be transparent about, and faithful to, the fundamental principles of grounded theory. Taking into account my professional and academic background, the issue of being an insider arose. In light of my knowledge and experience, being an insider adds a dimension to my study to some extent. However, as a novice researcher, grounded theory provided me with the opportunity to open up in a new way an area of inquiry that had some familiarity. Adopting a robust approach in using grounded theory discovery methodology permitted me to take a step to the side and avoid as far as possible any assumptions and beliefs that I may have had.

In sections 4.4 and 4.5 that follow, I pursue the issues raised in this section and those identified by Rapley (2001), Kvale (1996), Silverman (2001) and Jarvinen (2001) in particular. I include further reflective comment upon my influence in the research process in those sections and in chapter 5, I drawn attention to my influence in constructing my analysis.

4.4 Observations

Observations of patient/nurse interaction were conducted to initiate my research process and inform informal interviews and subsequent semi-structured interviews. Burgess (1984:103) cites and emphasises Zweig's (1948) recommendation that it is important to observe participants before a detailed conversation as interview can occur. This preparatory process is very appropriate in discovery methodology such as grounded theory.

An observation instrument (appendix C) provided the means to record systematically what I had observed. Descriptive and reflective notes as field notes helped me to capture the context and essence of what I had observed. Theoretical memos were generated from these notes. I wrote field notes throughout data collection and the research process. The creation of field notes was self-conscious in that they are both descriptive and reflective. Wolfinger (2002:889) observes that often the different or deviant is noted rather than a full description. However, this would have been methodologically inconsistent with grounded theory and I generated inclusive notes of all aspects of observations and interviews. My notes were not extensive, but contributed nevertheless. Throughout data collection, field notes and memos were stimulating to my theoretical sensitivity.

Observational bias has been well documented as a major issue for field researchers using observational methods (Burgess 1984, Strauss and Corbin 1998). In my study, these issues can be summarised as selective attention, premature interpretation and selective memory. Layder (1993:116) notes the contribution that observations may make in the research process that includes both observation and interviews. He observes that as such research progresses, focus will shift from:

an account of the texture of interaction in observed events that took place in the immediate past, and more on a specific person's recollections, perceptions and feelings about their social experience over extended periods of time.

Layder's view mirrors my experience of observation in the research process exactly. Observation was appropriate to gain insights into the context of interaction and propose areas of further, detailed inquiry in interview.

Only two practice nurses I approached declined to participate in my study for 'personal reasons'. Identifying patient participants to observe at the beginning of my fieldwork was relatively straightforward. Participating practice nurses had lists of those attending scheduled sessions. Prior to each session, I asked the practice nurse to identify any patient whom they deemed it would be inappropriate to approach. Seven patients were so identified (for clinical reasons).

I found the practice of observing every second or third patient on a list worked best. This allowed time in between to write key field notes and to approach subsequent patients for consent if I had not already had the opportunity to do so. All patients apart from five agreed to participate. This organisational approach was time consuming as I observed approximately one third of patients at each session; however, it was effective. I interviewed practice nurse participants at their convenience at the end of each list. In total, thirty eight observations of patient/nurse interaction were conducted.

Considerable thought was required about how and what I observed. For example, a meeting between a patient and a nurse is purposeful. That purposefulness is evident in key elements of the meeting. I observed a wide range of purpose to meetings, for instance, immunisation, wound dressings, blood pressure measurement, depot injections and general health screening. I experienced a range of different ways of engaging with what I observed. Initially I tended to focus on the actual clinical procedure and embarked upon skill analysis, and ruminated about evidence-based practice and clinical effectiveness. In other words, the purpose of the meeting and my professional curiosity intruded upon the aspirations of my observations as located in my research questions. In addition to this, I 'tuned into' or was drawn into the content of patient/nurse discussion as a participant, for example in anecdotes and neighbourhood information, rather than observing the nature of interaction itself including the content.

The content of patient/nurse conversation is an important domain of interaction. The roots of my assuming the role of researcher and all that entails required considerable reflection upon this process. In relation to this, my interaction was inherent in every observation in terms of the effect my presence had on the interaction and the detail and range of choices that I was presented with. As Kvale (1996) identifies, these choices were moderated by my values, for example, the formation of my initial impressions on meeting patients or nurses.

I observed displays of social and conversational conventions and norms overlain with specific, individual strategies by patients and nurses in context. Adopting the role of patient was related to the reason for their presentation to the nurse, specifically their needs and goals. The reasons for presentation ranged from ongoing care, for example, wound dressings, to specific and singular presentations, such as travel immunisations. Nurse participants were observed to apply specific strategies during each interaction with patients. These strategies related to knowledge, information and clues supplied by or related to the patient. Knowledge was related to knowing what to do and how to do it. Information related to patient notes, referral forms or the patient as informant. Clues about meanings and understandings were embedded in behaviour and difficult to interpret without explanation or expansion from the participants to enhance my understanding, a weakness of observations as method.

Grounded theory demands a dynamic and process orientated approach. It demands close collaboration between the researcher and the participants. That collaboration requires communication, or in other words, interaction that is dynamic and sensitive. The essence of grounded theory research lies in the relationship between the researcher and participants as Glaser and Strauss (1967) describe.

Deliberate efforts to be increasingly self-conscious and consistent in approach led to the development of areas of interest to inform the subsequent interviews, for example weighing up and confidence in patient/nurse interaction. Those areas of interest were also related to my research questions. Continual interrogation about what I saw, or what happened, is embedded in the research process. Describing and contextualising what I observed with a view to generating analysis is a complex but necessary task as Strauss and Corbin (1998) advise. That task became part of generating a rich descriptive account fundamental to my research process, including informing an ongoing process of analysis, and the conduct of future informal interviews.

Conducting observations and informal interviews overlapped after I had conducted 20 observations. This overlap was to capture the accounts of participants involved in specific and singular need/care interaction for my analysis.

4.5 Interviews

In this section, I describe how informal and semi-structured interviews contributed progressively to analysis. Interviews are recognised as a historic, valuable and evolving method in research and everyday life (Denzin 2001). Glaser and Strauss (1967) consider interviews to be a core method in grounded theory studies, without interrogating how they should be valued. Holstein and Gubrium (1995) identify that interviews are reality-constructing and meaning-making occasions. They argue that interviews involve collaboration between participant and interviewer in the construction of accounts. The interview process is therefore an active one, as it promotes the negotiation of horizons of meaning. Horizons of meaning are the meanings and understandings of the participant. The role of the interviewer is to promote the visibility of those horizons of meaning. Both have interpretive frameworks in play. Those frameworks are a reflection of the nature of their background and experience. It was my responsibility to preserve participants' meanings within the process of constant comparative analysis. I did so by retaining their accounts in context by completing field notes. At the end of every interview, I summarised the key points I had gleaned to the participant and made any amendments they suggested.

Recorded interviews were transcribed by me usually within twenty-four hours of taking place, at first in full. After ten informal interviews had been conducted, I omitted extraneous material, such as preliminary comments about the weather, from my transcriptions in order to capture the substance of the interviews only. Following transcription, data was coded and imported into QSR NUD*IST (version 4). This approach to transcribing was a deliberate strategy to enhance my recall and sustain the momentum of data collection and comparative analysis. Kvale (1996:166) describes transcribing as a 'transformative process' in that interpretative constructions are achieved or mediated via the subjective choices the researcher makes. Kvale (1996:1668) presents a conceptual and methodological issue. The central issue is that of trustworthiness in relation to the participant's voice. The interview itself is a social construction leading to a constructed text. The participant's voice is decontextualised in this process. Lapadat and Lindsay (1999:82) describe this construction process as interpretive positioning and conclude:

Acknowledging transcription as representational avoids the mistake of taking the written record as the event and opens the transcription process for examination of its trustworthiness as an interpretive act.

Lapadat and Lindsay reflect my own concerns regarding constructing, deconstructing and reconstructing of participants' accounts in the process of analysis. I describe this process and using QSR NUD*IST (version 4) in detail in chapter 5.

The hazard of data coding procedures of grounded theory is over-fragmentation, especially in using QSR NUD*IST (NUD*IST). I show how I made efforts to overcome this fragmentation in 5.2.

My research methods of informal and semi-structured interviews are now discussed in detail and related to the progression of direction of analysis which is pursued in chapter 5.

4.5.1 Informal interviews

Twenty four informal interviews (twelve patients and twelve nurses) were conducted following observations. Issues arising from observations were noted on the informal interview instrument (appendix D) prior to each interview. In this way, I could follow lines of inquiry proposed by observing participants. For example, the ease or not of participants in an unfamiliar situation led to inquiries about their concerns and confidence in patient/nurse interaction. As a further example, participants were varied in their style of approach with regard to informality/formality in patient/nurse interaction, which led to inquiries about what contributes to the generation of rapport or not between patients and nurses, and its role in patient/nurse interaction.

The issues arising from observations provided the cornerstone of substantive code development. As shown in figures 2 and 3, concerns, confidence, informality/formality and rapport became substantive codes in the construction of my theory.

The informal interview instrument (appendix D) was constructed in relation to my research questions. Three main areas of inquiry identified were personal background, health centre experience and interaction. Possible topics to cover in each area of inquiry were also identified. The areas of inquiry and topics served as ice breakers and conduits of inquiry in each interview. The topics were used flexibly with an open questioning technique initially that led to participants expanding on areas they wished to. Also, in practice, participants made links between the areas of inquiry that reflected the nature of their personal experience. The topics in 'personal background', which included age, gender and occupational background, contributed to establishing the socio-cultural characteristics, backgrounds and circumstances of participants. Topics of inquiry into 'experience as patient or nurse' in the health centre contributed to participants expanding on the nature of their experience in health care and nursing in the present and in the past. The topics in 'interaction' contributed to discovering the meanings and understandings participants brought to patient/nurse interaction as patient or nurse, particularly in relation to negotiation and concepts of empowerment.

Once each interview was established and the participant appeared to be at ease, reflective questions were used to invite the participant to expand on the meanings and understandings they presented, for example, on their role as patient or nurse. In this exploratory way I established similarities and differences in meanings and understandings as presented in chapters 6 and 7. Striving to develop imagination and integrative power in relation to the data was prolonged and somewhat perplexing for a period of time. This was partly due to my premature expectations of the research process and under developed appreciation of theoretical sensitivity (Glaser 1978). I had to engage with the continually enriching data and seek a conversation with it. Different questions had to be asked rather than seeking answers to meet the demands of my provisional coding. For example rather than seeking data to 'fit' provisional codes such as 'expectations', I had to continue to interrogate my data and to expand and develop connections between substantive codes and key properties in particular. Developing integrative power and imagination were key elements to developing theoretical sensitivity. In Glaser and Strauss (1967) and Glaser's (1992) terms this development is 'emergence'. Intensifying the relationship with the data was a major turning point in generating texture and depth in my analysis.

The quality of informal interviews improved as fieldwork progressed in terms of the conduct and ethos of the interviews. The conduct of interviews related to confidence as well as competence and confidence in terms of developing a sense of ease to fully explore participants' views.

Whilst I continued to use reflective questioning throughout interviews, it also became more comfortable, and appropriate, to be more searching in questions to clarify accounts, and to explore emergent and interesting concepts. Patton (1990) argues that probing or searching questioning improves the potential for effective interaction between the researcher and participants, helping rapport and presentation of understandings. In Patton's (1990) terms, breaking down barriers by moving from open questions to reflective or searching questions related to the participants' responses appeared to be productive, in that it created an ethos of exchange and increasing rapport. Overall, I found my approaches to questioning appropriate and productive in facilitating participants to articulate and expand their thoughts. Competence in interviewing relates to balancing flexibility and consistency whilst avoiding, as far as possible, influencing or shaping participants' responses.

In each interview, the sequencing of questions became decreasingly dependant on the informal interview schedule and more dependant on following the participants' responses and train of thought. This flexibility enhanced the flow of the interviews and the expression and development of the participants' accounts.

Denzin (1989) notes that reliability in interviewing in qualitative research depends upon equivalence of meaning rather than use of the same questions inflexibly. Each interview was therefore individualised. Further to this, my competence also developed in relation to being alert to and exploring subtleties. This alertness was particularly true in the later stages of fieldwork when reflection and theoretical sensitivity had increased. Increased theoretical sensitivity was achieved by shifting emphasis on the questions I asked based on the areas of inquiry. The possible topics to be covered included those in the interview instrument, but in practice this was adapted depending upon 'leads' emerging from the data and what participants said.' For example, I expanded questioning relating to rapport with those participants who identified that there were certain ways to behave and I was able to link this to the nature of their health centre, nursing and wider experiences.

Expanding questioning was productive in gaining participants' views about conforming and led to consideration of issues such as the balance of power in the patient/nurse relationship, including reciprocity and intimacy, and trust and security within that relationship. The conduct of informal interviews was therefore a progressive process in which data collection and analysis were interdependent. Every interview informed and enriched the data obtained.

4.5.2 Semi-structured interviews

Semi-structured interviews were my final method of data collection. In informal interviews I sought the participant's unique accounts and attempted to balance this with pursuing the lines of inquiry proposed by theoretical sensitivity and the aim of my study. Concurrently I was able to respond to lines of inquiry proposed by the participants themselves. Having distilled similarities and differences in meanings and understandings into provisional substantive codes and key properties, which are discussed in chapter 5, semi-structured interviews were embarked upon.

Theoretical sampling occurred at the final stage of the data collection process and involved twelve participants whom I had observed: six patients and six nurses. These participants were chosen to contribute to emerging theory as reflected in the direction of progression of my analysis. Selection was based upon their ability to contribute to enhancing explanatory power and therefore to fortifying the subcategories. Theoretical sampling is guided by emerging theory and designed to examine how concepts might vary. Theoretical sampling enabled me to build in variation in the development of theory construction and increase explanatory power, which is linked to verification of grounded theory.

Due to time constraints, I was not able to interview all the participants possible at this stage. However those I did interview were able to contribute to emerging theory. It can be seen in the characteristics presented in appendix B that a range was achieved in terms of patient participants. As previously identified there was little range available in relation to nurses, apart from age. I did not develop a semi-structured interview instrument *per se* because each interview was highly individualised.

Rather than using the topics related to each area of inquiry as in the informal interview instrument (personal background, health centre experience and interaction), I drew directly upon my emergent key properties to guide routes of inquiry with each participant. I found that participants made their own natural links between the key properties. Some of the key properties had greater resonance with some participants than with others: a reflection of the individuality of their accounts. Each research method contributed to the direction of progression of analysis. Examples of the difference in the topics in areas of inquiry between informal and semi-structured interviews are presented in table 3.

Table 3: examples of topics in areas of inquiry

Direction of progression of analysis



| Areas of inquiry | Informal interview topics | Semi-structured interview: emerging key properties |
|--------------------------|--|---|
| Personal background | Connections Interests | Conventions Gender Age |
| Health centre experience | Nature of experience | Partnership Satisfaction |
| Interaction | Forming reactions Weighing up Developing rapport | Expected behaviour Confidence Power and control |

Semi-structured interviews and theoretical sampling enabled me to interrogate the key properties and substantiate the subcategories. Encouragingly, all twelve participants in the semi-structured interviews used at least three of the subcategory terms, in particular negotiation, empowerment and experience.

4.6 Conclusion

This chapter has traced my research methods from ethical approval to completion of fieldwork with semi-structured interviews and theoretical sampling. The process of obtaining ethical approval of HBERC was demanding but productive in generating a research proposal, clarifying research methods and providing an *entrée* to fieldwork areas. Gaining ethical approval also engendered a consciousness of ethical issues and fostered a reflective approach throughout my study. I have identified the role of self-awareness and skills as researcher as a critical involvement in the research process. Reflection is purposeful as an integral and interactive part of my methods and methodological approach.

Access to fieldwork areas was represented as a cascade with negotiations at each stage. Fieldwork was conducted in health centres located in areas with geographical and social differences. This was a useful strategy for accessing participants whom I have described by referring to a range of socio-cultural characteristics, backgrounds and experiences.

I also described and recognised my position within field work as influential in 'constructing a reality', including the generation of my research questions. The participants are representative of those attending these health centres as a patient or working as a Registered Nurse in a health centre, and their accounts of their meanings and understandings of patient/nurse interaction are diverse and extensive.

The study uses observations, informal interviews and semi-structured interviews which are recognised as core 'discovery' methods in a grounded theory approach. Observations, informal interviews and semi-structured interviews serve to advance the direction of data collection. Observations initiated insights into patient/nurse interaction. Those insights were developed into the areas of inquiry I pursued in informal interviews. I have argued that observations contributed primarily to the development of substantive codes. I have identified that in examining data from informal interviews, links between the participants' accounts and theoretical sensitivity were made, and an interactive process of data collection, coding and comparative analysis progressed. Field notes summarising observations were integrated in this developmental process which led to theoretical memos. Theoretical memos played an important role in stimulating theoretical sensitivity.

Data from informal interviews contributed to the development of substantive codes, key properties and the emergence of subcategories. Analysis emerging from observations and informal interviews informed semi-structured interviews. Analysis of semi-structured interview data enhanced the explanatory power of my overall analysis. I discuss the contribution of explanatory power later in the thesis. Here, I have described how semi-structured interview data contributed to the final stage of analysis, and to the construction of two categories: Investment and Experience. My research methods were dynamic in the research process by driving analysis from the unknown to the known or 'discovery' in grounded theory terms. I have argued that the strength of informal and semi-structured interviews is that flexibility with each participant allowed full exploration of their meanings and understandings. The construction of my substantive theory is directly attributable to the richness of data that I obtained by these research methods.

In chapter 5 that follows, I specify my approach to analysis. I describe how theoretical sensitivity informed the process of data collection and constant comparative analysis. I also demonstrate the relationship between theoretical sensitivity and emergence that led to theoretical saturation by describing in detail the direction of progression of my analysis.

Chapter 5 Research methods: analysis

In this chapter, I explain my approach to analysis by building on the detail I provided about research methodology and methods of data collection in chapters 3 and 4. Having provided an overview of my approach to analysis, I discuss the central role of, and the relationship between, theoretical sensitivity, emergence and theoretical saturation. I therefore demonstrate here how I constructed my categories of Investment and Experience. In appendix E, I show diagrammatically the interrelationships and pathways between the elements of my analysis from which the categories of Investment and Experience were generated.

I describe how my analysis was guided by my research questions and focused upon continually interrogating the data obtained from observations, informal interviews and semi-structured interviews. Building on the research methods I have detailed, I explain here the process of how I constructed my substantive theory from the data as I gathered it, starting with observations and concluding with theoretical sampling. The data was organised as I obtained it and I used my research questions to examine it. In this way, analysis was progressive. My approach to analysis involved interactive, continual processes of data collection, coding of data and comparative analysis.

In grounded theory, comparative analysis means constantly going back and forth in the data in detail to identify emerging similarities and differences, organise them and use them in the generation of categories.

In order to make my analytical approach transparent, I examine the divergence of analytical approaches in grounded theory. Following a summary of my analytic approach in 5.1, the construction of my substantive theory in substantive codes, key properties, and subcategories, is detailed in 5.2. I also incorporate a critique of QSR NUD*IST's (version 4) utility in organising and managing data in 5.2, and expose its strengths and weakness in my analytical approach.

The discussion in 5.2 represents stage 1 of my analysis in that I describe the process of 'forcing' that Glaser (1992) warns of. The turning point in my analysis is identified in section 5.2 and discussed in detail as stage 2 of analysis: 'emergence', in sections 5.3 and 5.4.

In 5.3 the nature and role of theoretical sensitivity are shown to be central to the progression of my analysis. I refer to appendices E2 – E8 to clarify how I visualise the relationships between substantive codes, key properties and subcategories of each category. Emergence of substantive theory and theoretical saturation as related to my research questions and findings are examined critically in 5.4. I also provide an example of an illustrative pathway for each category.

5.1 Overview of analytic approach

In chapter 3 I introduced the methodological differences between Glaser (1992) and Strauss and Corbin (1998). Their dispute over fundamental principles is evident in the diverse evolution and use of grounded theory in practice today. In relation to the development of grounded theory, Dey (1999) and Wilson and Hutchinson (1996) present the key methodological issues about grounded theory in practice. Dey (1999:2) focuses upon the widespread use of grounded theory and notes that there are:

probably as many versions of grounded theory as there were
'grounded theorists'.

Wilson and Hutchinson's (1996:123) critique focuses on the adoption of highly specific 'rules' of procedure at the cost of:

the spirit of creativity inherent in the original grounded theory
method.

Dey (1999) endorses Wilson and Hutchinson's critique and warns of the dangers of 'an overly mechanistic approach'. Dey (1999:273) emphasises:

the stress in grounded theory on creativity, conceptualization, and
theoretical endeavour.

Dey's concern is that interpreting grounded theory largely in terms of complex coding in using the procedures recommended by Strauss and Corbin (1998) diverts the researcher from using their intuition and creativity and ultimately compromises conceptualisation.

Taking these critiques of the two major approaches to analysis in grounded theory into account, I have sought to achieve clarity and transparency in my approach to constructing substantive theory.

At first I found it difficult to understand the key tensions in approach between Glaser on one hand and Strauss and Corbin on the other hand and I attempted to incorporate both in my study. Strauss and Corbin (1998) argue that structured, rigorous processes and procedures support a systematic approach to research. Only when my fieldwork was under way did it become apparent that the complex processes and procedures they prescribed were exacting and rather seductive to an inexperienced researcher. They were seductive in that I tried to carry out their processes and procedures at the partial cost of fostering my imagination and intuition, both of which are essential to generating analytical power. Upon reflection, Strauss and Corbin's (1998) processes and procedures seemed to provide a safe haven: a refuge from the uncertainty experienced on embarking upon my study. I draw upon Strauss and Corbin's approach to advise, rather than inform, my analytic process. Their approach helped me to understand the elements of analysis in grounded theory. This is implicit in that, whilst I rejected the specifics of their detailed approach, I did draw on their wider theorising, for example regarding theoretical sensitivity, to contribute to conceptualisation and development of my analytical approach.

Glaser (1992) notes the risks of creating a description rather than an analysis. He also recommends to the novice that they should develop 'procedures' that are clear, transparent and achievable. A discussion of how I have taken his advice in constructing my substantive theory follows. Glaser's (1978, 1992) emphasis is upon being simple and uncomplicated without losing rigour. In Glaser's (1992:38) terms, conceptual power is initiated by seeking concepts in the data which he defines as:

The underlying, meaning, uniformity and/or pattern within a set of descriptive incidents.

Glaser also urges constant comparison of incident with incident, and incident with concept, to support the emergence of properties and categories.

Glaser (1992) places full conceptualisation of data and developing conceptual relationships at the heart of developing explanatory power. Following Glaser, my data analysis is simple and uncomplicated. My substantive theory is constructed in the following way:

1. *Substantive codes* represent the conceptual meanings and their patterns found in my data, generated by processes of constant comparative analysis.
2. *Key properties* represent the interrelated conceptual characteristics of the substantive codes and essentially define my subcategories.
3. *Subcategories* are a distillation of the interrelated concepts expressed in the key properties and clarify the character of my categories.

4. *Categories* of Investment and Experience are defined by the conceptual characteristics of the key properties, which are distilled in the subcategories. The categories represent the creative conceptual constructs of my substantive theory.

I also used *theoretical memos* to help conceptualise theoretical ideas and constructs. In her grounded theory study, Orna (1990) describes theoretical memos as useful for capturing thoughts that occur speculatively in relation to analysis, or 'out of the blue' ideas. She used memos as a means to 'unblock' her thoughts and stimulate her sociological imagination, and to document the beginnings of conceptualisation.

I adopted Orna's (1990) approach and used theoretical memos throughout my analysis in the terms she describes. They were important for unblocking thoughts and generating sensitivity in relation to my research questions. They included brief notes of leads to follow in analysis, and helped to generate awareness of conceptual relationships. Glaser (1978:116) describes the usefulness of memos in this way as 'conceptual sorting'. Theoretical memos were particularly useful in making links between my key properties and subcategories whilst connecting both to my research questions. For example, memos related to participants' experiences in the social construction of reality can be traced throughout my analysis.

In addition to the exhortations of Glaser and Strauss (1967), Strauss and Corbin (1998) and Glaser (1978, 1992), other commentators of the grounded theory approach acknowledge the usefulness of theoretical memos (Dey 1999, Miller and Fredericks 1999). I used theoretical memos throughout data collection and analysis and they were important in conceptualisation in the construction of substantive theory.

Stage 1 of analysis: 'forcing'

5.2 Coding of data and QSR NUD*IST (version 4)

Bryman and Burgess (1994) describe grounded theory as a major influence in the evolution of qualitative research which includes the development of QSR NUD*IST (version 4): a software system for the development, support and management of qualitative data analysis. The use of grounded theory supported by QSR NUD*IST is evident in the large number of such studies to be found in the literature (Buston 1997, Webb 1999, Mechanic and Meyer 2000, Kelly *et al.* 2002). In light of the link between grounded theory and QSR NUD*IST, and assertions regarding their compatibility (Richards and Richards 1994), I used it to support my research process. I provide a personal account of the strengths and weaknesses of QSR NUD*IST for the inexperienced user.

The difficulties encountered are integrated in my discussion of grounded theory analysis. The resolution of those difficulties lay in stimulating theoretical sensitivity, as I describe in section 5.3.

My approach to analysis and use of QSR NUD*IST was advised by Glaser's (1992:45) rhetorical question apparently directed to the novice in particular:

is it simple and simply best to go directly for categories, their properties and the theoretical codes that direct them.

My coding of data was driven by seeking responses in the data to my research questions. As Glaser advises, I aimed to generate an account that was clear, transparent and related directly to my research questions.

A range of claims is made about the application of QSR NUD*IST, principally in relation to its role in analysis. It is frequently, mistakenly, described as actually performing analysis, for example:

qualitative analysis using the software package NUD*IST...

(Maskarinec *et al.* 2001:12)

subjected to qualitative analysis using NUD*IST ...


(Kelly *et al.* 2002:339)

QSR NUD*IST does not analyse *per se* and the authors and developers do not make such claim for it. Rather it can substantially support the organisation and management of data which contributes to analysis, and this was the case in my study (Richards 1998:10). I used QSR NUD*IST to import and organise data that in the raw were notes of observations and transcripts of conversational style interviews. The transcripts were unstructured, rich and complex text.

Meaningful segments of text were identified and manually assigned to codes or 'nodes' in QSR NUD*IST terminology (auto coding was not used). Identifying meaningful segments emerged from examining phrases and sentences and identifying those which related to a similar pattern. Meaningful segments of text from participants' accounts were allocated to codes that I devised based on the conceptual meanings I identified from observations and participants' accounts. Examples of my substantive coding process in action are presented in table 4. The table illustrates the relationship between segments of text and coding.

Table 4: examples of the relationship between segments of text and coding

Direction of progression of analysis



| Segments of text | Code assignment |
|---|---|
| <p>Looked welcoming and ready to see me</p> <p>Pleasant looking ... approachable</p> <p>Responsive when I introduced myself</p> | <p>Weighing up</p> <p>(in category of Investment)</p> |
| <p>Different now from years ago</p> <p>It's a health centre now ... no' just into the doctor</p> <p>We're interested in the patient as a person now</p> | <p>Tradition</p> <p>(in category of Experience)</p> |

The names of my substantive codes (and QSR NUD*IST nodes), such as 'weighing up' and 'tradition', were derived from the terms used by the participants. The use of participants' terms in this way contributes to maintaining the context of their meanings and understandings and relationships to my research questions. The QSR NUD*IST nodes were imported and constructed into index tree structures.

These index trees were built through constant comparative analysis and provided the basis from which the categories of Investment and Experience were developed. I found that the coding of data and subsequent processes resulted in data being decontextualised and recontextualised into units of analysis. Constructing QSR NUD*IST nodes and index trees is part of the analytic process. However, it is dependent upon the adequacy of the coding process.

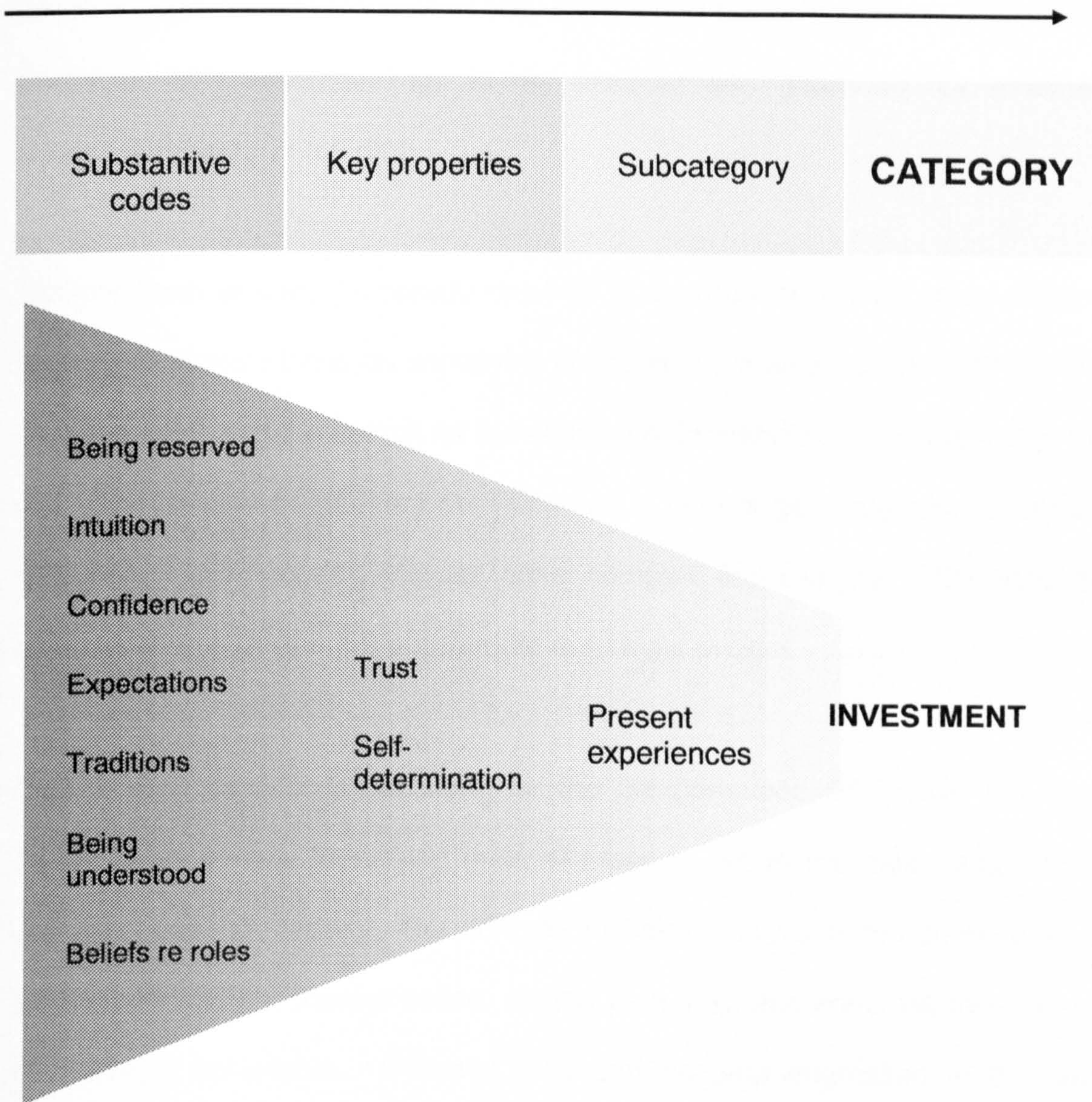
In practice, grounded theory (constant comparative) analysis demands that you go back and forth to substantive coding, in which participants' meanings and understandings are located, in order to build up key properties systematically. Analysis has a progressive direction, as the aim of grounded theory is to achieve theoretical saturation. The development of key properties leads to the construction of subcategories. In this way, substantive codes, key properties and subcategories become conceptually interrelated. I have illustrated this close interrelationship by the seamless shading in figures 2 and 3. Using the same means of illustration, I show the interrelationships between the elements of analysis in appendix E.

The development of the categories, Investment and Experience, was founded in the interrelated conceptualisation inherent in the key properties. The subcategories are the pathways that lead to the category. Emergence is linked with the direction of progression of analysis as now shown in figure 4.

Figure 4: emergence and progression of analysis

(Non inclusive extract from figure 2)

Direction of progression of analysis



I endeavoured to sustain consistency in approach in analysis by continually reflecting upon the relationship between the meanings I was generating and conceptualising, and those of my participants. Emergent ideas and concepts were reviewed in relation to both the data and the research questions.

For example, the ideas that I generated related to the key property of 'confidence' were reviewed by revisiting segments of text assigned to substantive codes such as 'sharing' and 'getting to know each other'. Reviewing participants' actual terms of expression in the context they were made sustained the integrity of their meanings and understandings in my analysis and grounded my emergent substantive theory in the data.

The continual analytic processes required in a grounded theory study demand that attention must focus on underlying conceptual patterns. QSR NUD*IST was useful in beginning the search for overlapping or intersecting concepts and in this way it contributed to category development. I did not generate reports, display matrices or build models, or use other complex facilities that QSR NUD*IST offers as they appear more appropriate to a larger project.

Coding involves difficult decisions for the inexperienced QSR NUD*IST user. Open coding means identifying units of meaning within the data related to an emerging area of interest. The difficulty for me lay in clustering open codes of similar type into substantive codes. As my data grew and enriched, this became increasingly achievable. However, one can become engrossed in the time-consuming activity of coding data and so diminish sensitivity to deriving meaning from the data one is engaged with. I encountered several difficulties in generating meaning from coded text/data.

Firstly, the identification of the relationships between codes was difficult to establish. Secondly, constant comparison was hampered by the difficulties I encountered in identifying relationships between codes. Thirdly, it seemed that the conspicuously hierarchical structure of codes in the QSR NUD*IST index trees limited my capacity to identify related concepts necessary to develop substantive theory. On the one hand data was organised and provisional categories were identified and related to, for example, the 'patient/nurse relationship'. On the other hand however, I felt that QSR NUD*IST fragmented and de-contextualised data.

Fragmentation and decontextualisation of data engendered a sense that QSR NUD*IST was, in essence, hiding prospective meanings. This sense of deprivation was consolidated by the need to expand theoretical sampling and enhance theoretical sensitivity so that I could identify robust categories, rather than the superficial 'patient/nurse relationship' or 'situated interaction' I started with. In Wilson and Hutchinson's (1996:80) terms which I referred to in chapter 3, this was a methodological mistake. I had fallen into the trap of 'forcing' that Glaser (1992) warns of. Further to this, issues arose about the way I was visualising each category.

The turning point in analysis

In my original construction, each category seemed to be a pyramid. The four subcategories of each category occupied a side of that pyramid, founded upon their substantive codes and key properties. The turning point in my analysis was realising that each category should be multidimensional and viewed in the round. This realisation occurred in the early stages of semi-structured interviewing.

The turning point in analysis was when I achieved an image of what my analysis should look like that enabled me explain the meanings in my data and represent them as multidimensional. Viewing analysis in the round helped me to overcome the sense of hidden meanings and compromised theoretical sensitivity. To generate categories and construct substantive theory that was consistent with the tenets of grounded theory, it was evident that my data needed to be revisited and reflected upon in a different way. It also became evident that it was necessary to develop a different relationship with the data so that I might generate categories with texture and depth, rather than the one dimensional perspective I started with. These insights led me to visualise and present my categories in circular diagrams which illustrate the full perspective of my analysis in each category. Figures 2 and 3 and appendices E2 – E8 represent the 2nd stage of my analysis: emergence.

Stage 2 of analysis: emergence

5.3 Theoretical sensitivity and emergence

Theoretical sensitivity leading to the emergence of substantive theory is discussed in this section. A discussion of theoretical saturation as a natural conclusion to my analytic approach follows in 5.4.

In his discussion of analysis embedded in data, Layder (1998:107) emphasises:

three things are required: intuition, perception and sensitivity or readiness. Taken together, these three represent a predisposition to 'lock-on' to suggestive ideas and concepts.

Theoretical sensitivity in the creative analytic process is, indeed, essentially a realisation of 'locking on'. Layder (1998:107) goes on to stress that:

The combined effects of intuition and perception result in general sensitivity or readiness to 'see' concepts and thereby identify or discover them.

Conceptual connections are made following a sensitive examination. Theoretical sensitivity arises from an alert engagement with the data to seek meanings. Engaging with the data means closely examining statements by participants such as 'that's what you do' to attempt to discover participants' own meanings and understandings of what 'that' may be.

Strauss and Corbin (1998:35) define sensitivity as:

The ability to respond to the subtle nuances of, and clues to, meanings in the data.

Sensitivity must be understood to be intuitive, perceptive and responsive. There is wide agreement in the literature, including Glaser (1992) and Strauss and Corbin (1998), about the nature of theoretical sensitivity. Cautions that are issued relate to paying due attention to the individuality of the researcher and I addressed those issues mainly in chapter 4.

Clearly the difficulties I experienced with QSR NUD*IST had to be overcome to build on the useful work that had been achieved. For example, in the initial stages, participants' comments related to 'rapport' were linked to 'patient/nurse relationship', and perhaps to 'gender' or 'age'. As my data became richer, the core category of Investment was developed from many of the codes that had previously been imported into the simple 'patient/nurse relationship'. By the stage of achieving theoretical saturation during the semi-structured interviews, QSR NUD*IST had served its purpose in supporting my analysis. In order to address compromised theoretical sensitivity and the concerns associated with 'forcing' discussed in 5.2, it seemed prudent to resort to a simpler approach, revisiting and reflecting upon the work done to date.

The next logical step was to revisit and reflect upon my data. In addition to re-reading all transcripts and theoretical memos, re-listening to the interview tapes was also productive. In other words, I resorted to a 'by hand', more intuitive, approach. Using all the information available, it was possible to draw the threads of lines of inquiry together and create a 'hard map' of emergent concepts. Increased perception and awareness of subtleties and connections permitted the participants' voices to re-emerge, and the creation of the diagrams, figures 2 and 3, that illustrate my analysis 'in the round'. Many of the subtleties that seemed to be lost or hidden were either noted afresh or picked up for the first time.

Glaser and Strauss (1967), Strauss and Corbin (1998) and Glaser (1978, 1992) all emphasise the benefits to be gained from continually reading and rereading the data in this way. Listening to the interview tapes again was helpful to identify material relevant to how participants constructed their identities, meanings and understandings. In relation to maintaining the centrality of participants' voices, Spradley (1979:17) notes narrative to be:

more than a means of communication about reality: it is a tool for constructing reality.

By actively re-listening I was, in effect, able to reconnect with participants' socially constructed realities.

For example, some participants, in particular patients, included remarks such as 'waiting in line' and 'dae whit you're telt', [do what you are told]. Initially such comments were provisionally coded in relation to a 'situated interaction' between patient and nurse. Subsequently it became apparent to me that the participants were not referring specifically to how to behave in a health care setting, but expressing meanings and understandings of *modus operandi* in more general terms. Participants' meanings and understandings of *modus operandi* were related to experiences in other institutional settings such as, and including, the Department of Social Security. It was evident that participants included description of, and reflected upon, other significant experiences outside health care and nursing.

The theoretical memos that emerged from participants' accounts of *modus operandi* in institutions other than health care and nursing contributed to the development of Experience as a category. The benefits of creating and referring to theoretical memos through data collection and analysis are that they provide a means to look at data afresh to generate wider and deeper lines of inquiry, essentially bring about turning points in analysis. In the case of the example just cited, the role of power, empowerment and participants' experience of them emerged as key analytic interests.

As an example of theoretical sensitivity, I noted from observations that on a continuum, participants adopted a more formal or informal approach in their interaction with each other. Having followed this up in interviews, I associated it with the emerging key property of 'approachability/distance'. This observation provided a theoretical memo to inform consideration of negotiation as a subcategory of Investment in subsequent interviews.

By integrating the subtleties and nuances that seemed to be lost in QSR NUD*IST, combined with theoretical memos, as the example just given shows, it was possible to make the most of theoretical sensitivity and begin to develop interrelated conceptual constructs. Generating theoretical sensitivity served as a breakthrough in generating an analysis with many perspectives. Those perspectives included for example, meanings and understandings of *modus operandi* brought to, and influential within, patient/nurse interaction. Achieving theoretical sensitivity in this way strengthened Glaser's (1992) argument that one cannot force analysis, rather it will emerge.

5.4 Theoretical saturation

Theoretical saturation means that the generation and extent of the explanatory and conceptual power of the analysis can be explained in relation to work, fit and relevance to the context of the study and beyond. 'Work, fit and relevance' are key issues in the verification of grounded theory, which relies upon theoretical saturation (Glaser and Strauss 1967:237).

Theoretical saturation is achieved by means of a process of constant comparison until no more variation occurs. Glaser and Strauss (1967:61) consider that:

saturation means that no additional data are being found whereby the sociologist can develop the properties of the category.

The thrust and purpose of grounded theory is to construct theory. The critical questions must be when to stop coding and identifying when no further properties are emerging from analysis of the data. Strauss and Corbin (1998:212) define theoretical saturation as follows:

- (a) No new or relevant data seem to emerge regarding a category
- (b) The category is well developed in terms of its properties and dimensions demonstrating variation
- (c) The relationships among categories are well established and validated.

There are robust relationships between substantive codes, key properties and subcategories in my categories. I have displayed the interrelationships between those elements of category generation diagrammatically in appendices E2 - 8. The presentation of those diagrams is in the same style of figures 2 and 3 representing 'darkness into light'. In the diagrams in appendix E, I show the interrelationships between the substantive codes and key properties and subcategories of each category. However, as illustrated in figures 2 and 3 and discussed later in chapter 8, every element makes a compound contribution to the whole process of category generation. To support the diagrams in appendix E, I include an illustrative pathway for each category with examples of the elements that contributed to the progression of analysis. The findings related to all pathways are discussed in the chapters that follow.

In Investment for example (appendix E2), the conceptual meanings of 'picking up clues', 'weighing up', 'something in common' and 'relating to others' as substantive codes relate to the key property of 'placing'. The interrelated conceptual characteristics of 'picking up clues', 'weighing up', 'something in common' and 'relating to others' were identified from data about what happens when patients and nurses first meet. These interrelated conceptual characteristics are represented in the key property of 'placing' and distilled in the subcategory of negotiation (appendix E2). 'Placing' means that patient and nurse seek understanding of each other in relation to social background, in particular 'seeing if someone is like you'.

The substantive code of 'weighing up' is also linked to key properties of 'approachability/distance', 'socio-cultural characteristics', 'confidence' and 'satisfaction'. The category of Investment is defined by the conceptual characteristics of the key properties (with associated substantive codes) that are distilled in the subcategories, which include negotiation. The relationship of the subcategory of negotiation in the category of Investment is shown in figure 2. I discuss the importance of 'placing' in chapter 6, in particular section 6.1. In my arguments about negotiation in my concluding chapter, I make a case that the emphasis patients and nurses place upon 'placing' in the social world and acting and reacting to each other is important to understanding patient/nurse interaction.

In Experience for example (appendix E8), the conceptual meanings of 'being valued', 'being understood' and 'expectations' as substantive codes relate to key properties of 'SES', 'conventions' and 'self-determination'. The interrelated conceptual characteristics of those substantive codes were identified from data about the meanings and understandings patients and nurses have of their experiences in health care and beyond. These interrelated conceptual characteristics are represented in the key properties of 'SES', 'conventions' and 'self-determination' and distilled in the subcategory of lived experiences (appendix E8).

The category of Experience is defined by the conceptual characteristics of the all the key properties, including 'SES', 'conventions' and 'self-determination', as distilled in the subcategories of which lived experiences is one. The relationship of the subcategory of lived experiences in the category of Experience is shown in figure 3. I discuss the importance of 'SES', 'conventions' and 'self-determination' in chapter 7, in particular section 7.4. In my arguments about lived experiences in my concluding chapter, I make a case that that social meanings and understandings are more influential in the experience of being a patient or nurse, and in their interaction, than previously recognised.

The basis of my argument regarding the robustness of my categories as just illustrated, links to questions of verification. Grounded theory must have 'fit, work and relevance' (Glaser and Strauss 1967:237). 'Fit' means that connections to the data are clearly established and those connections are confirmed by continuous comparison. 'Work' refers to the substantive theory's explanatory power in relation to the phenomena studied, and therefore to its relevance. In a relevant account, substantive theoretical connections can be made to the field of study (Glaser and Strauss 1967, Strauss and Corbin 1998, Glaser 1992, Silverman 2001, Dey 1999). These connections are plausible and their potential to explain contextually is discernible. The central connecting concepts in my analysis are identified and addressed in chapters 6 and 7, and discussed in chapter 8.

In relation to the 'verification' of grounded theory, Glaser and Strauss (1967:237) argue that substantive theory generated must emerge directly from the field of study, and be 'readily understandable'. Both of these criteria are met in my study. Methodological consistency in a fully specified research process provides further verification of my work. I have identified clearly the transformative role of theoretical sensitivity and emergence in constant comparative analysis. I have also included context and wider conceptual connections in my explanations of phenomena.

5.5 Conclusion

My approach to data analysis largely adheres to the original prominence given to discovery and generation of substantive theory from the data by Glaser and Strauss (1967). Glaser's (1978, 1992) work was identified as particularly influential in my analysis, especially his recommendation that one should concentrate upon 'emergence' rather than 'forcing'.

Instead of imposing a one dimensional, hierarchical structure upon the data, I have emphasised the emergence of multi-dimensional categories. I have also argued that my analytic processes were clear and achievable. The construction of substantive theory, using my conceptualisation of substantive codes, key properties and subcategories, was systematic.

Together, substantive codes, key properties and subcategories contributed to the generation of the conceptual and explanatory power of the categories.

My analytic approach confirmed the strengths and weaknesses of QSR NUD*IST (version 4) for the novice as found by others, in particular Bustin (1997) and Webb (1999). QSR NUD*IST contributed to the first stage of construction of my substantive codes, key properties and subcategories in analysis. Weaknesses of QSR NUD*IST emerged as a diminished sense of the whole landscape of my analysis. It is reassuring to note that others, especially the less experienced conducting small studies, have had the same experiences in relation to using QSR NUD*IST (Bustin 1997, Webb 1999). Whilst I did not find QSR NUD*IST simple or intuitive to use, it permitted me to organise and manage a large amount of data in an orderly manner and therefore it supported my research process, in particular to the turning point in analysis.

A further issue in using QSR NUD*IST was the tension between Strauss and Corbin's (1998) prescriptive procedures, and the analytical process of Glaser and Strauss (1967) and Glaser (1978, 1992). QSR NUD*IST appears to be designed primarily to fit Strauss and Corbin's complex procedures, and did not match well with the emergence process emphasised by Glaser.

The turning point in my analysis from pyramid to viewing in the round, was brought about by moving on from using QSR NUD*IST and re-listening to the interview tapes, and re-reading of all notes and transcripts. Revisiting and reflecting upon my data in this way invigorated theoretical sensitivity.

Developing theoretical sensitivity was critical in my analytic process and was engendered by moving from the superficial to the intuitive and perceptive. I have described theoretical sensitivity as emerging from an alert engagement with my data. In essence, one needs to develop a close relationship with the data, otherwise subtleties will be lost. Informed by research questions, leads in analysis originate in identification of subtleties and nuances. I have argued that nurturing theoretical sensitivity ultimately led to the generation of explanatory and conceptual power as expressed in my categories. I identified participants' meanings and understandings by continual engagement with the coded data. Constant comparison stimulated theoretical sensitivity leading to the building of categories whose characteristics I can describe and expand upon to address fully my research questions. In relation to the requirements of theoretical saturation, I have argued that my categories are robust in their construction. The evidence of the utility of my substantive theory is 'fit, work and relevance'. 'Fit, work and relevance' are integrated in my findings, and addressed in my final chapter 8 where my substantive theory and its utility are detailed.

The outcome of my data analysis is discussed in detail in my findings chapters. They provide an account of my two categories, Investment and Experience. I use the subcategories as major sections to organise those accounts. I draw upon, and refer to, the substantive codes and key properties of each category in the sections of my findings chapters to make transparent the link between my research methods of data collection and analysis, and my findings.

As further transparency and key link to the field of study, the patient (P) and practice nurse (N) participants are quoted from time to time in my findings. These quotations present the similarities and differences in their meanings and understandings. I also quote participants whose contributions were particularly influential in stimulating my theoretical sensitivity. These *verbatim* excerpts are therefore used to link participants' accounts with my arguments.

Whilst Investment and Experience are discussed in turn, they are very closely related in that they are founded upon the same research questions and together contribute to my substantive theory which is presented in my concluding discussion in chapter 8.

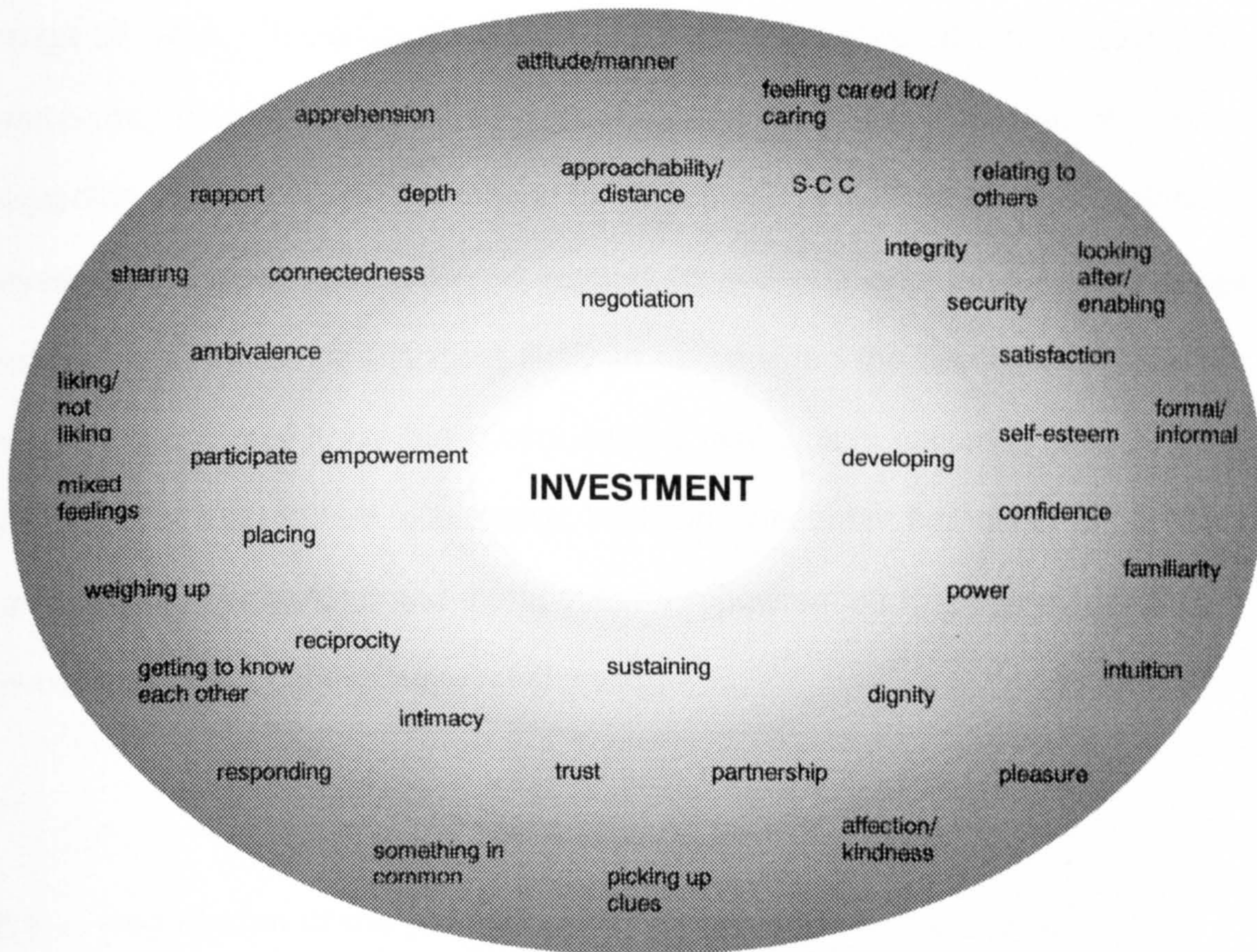
Chapter 6 Investment

Investment is a term associated with effort, time and profit. We anticipate a multiplicity of gains or rewards from our diverse investments in the social world. The category of Investment emerged from the participants in my study identifying the assets and resources they brought to patient/nurse interaction. Identification of these assets and resources emerged from my participants' accounts about negotiation, developing and sustaining a relationship, and empowerment.

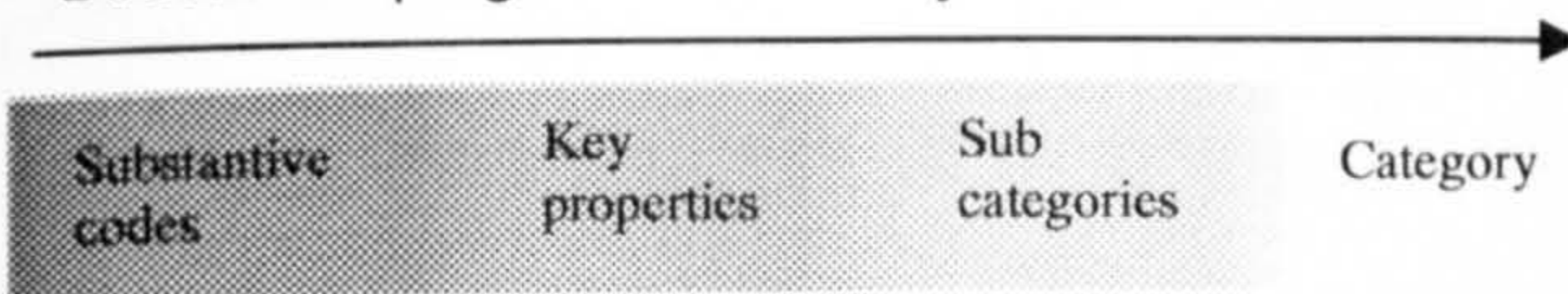
I use the subcategories of negotiation in the patient/nurse relationship (6.1), developing and sustaining the patient/nurse relationship (6.2), and empowerment in the patient/nurse relationship (6.3) as illustrated in figure 2 and appendices E2 – 4, as sections within the chapter. The key properties and the contribution of the substantive codes are integrated in my discussion. The construction of my substantive theory is also integrated throughout.

Rather than conserve discussion of issues and gaps in the substantive literature as related to Investment until the conclusion, I have integrated it throughout the chapter.

Figure 2: category of Investment



Direction of progression of analysis



(S-C C = socio-cultural characteristics: age, gender, SES and ethnicity)

I argue that Investment relates to the degree to which patients and nurses may develop their relationship beyond the superficial and involves a social dimension. The personal dimension in their relationship goes beyond the parameters of need/care interaction.

Patients and nurses qualify their commitment to investing in their relationship in a range of ways. These qualifications include the duration of their relationship, which may be brief or sustained over time, and the positive feelings they have regarding each other and the reason for their meeting/s. Further qualifications to Investment include generation of rapport, confidence and trust. My findings suggest that Investment is most likely to occur when the relationship between patients and nurses is sustained over several meetings or episodes of care. I will suggest that a sustained relationship, in which investment has occurred, is likely to be mutually rewarding and therapeutic. Empowerment is a central concept in Investment in the patient/nurse relationship.

6.1 Negotiation of the patient/nurse relationship

I found that seeking meaning in patient/nurse interaction happens from the beginning, as a process of weighing up, and throughout the situated interaction of patients and nurses. Strauss (1978) describes negotiation as an active process and emphasises the developmental nature of negotiation. I refer to the process of negotiation in the terms Strauss presents (1978:237), in particular the *modus operandi* of patient/nurse participants in patient/nurse interaction.

The demeanour of the patient/nurse, including degrees of formality or informality, the purpose of the meeting and the meanings attached to the meeting by the patient and the nurse, emerged as fundamental to the accomplishment of their interaction. In relation to the tacit or ritualistic elements of negotiation, Strauss (1978:239) refers to the 'visibility' of negotiation to others. 'Visibility' as awareness and control of elements of negotiation is integrated in examination of the *modus operandi* of participants in my study.

6.1.1 Approachability/distance in negotiation

The nature of the relationship between patient and nurse is central to their interaction, and this is evident in a range of ways, including at the initiation of their meeting, or at the point of introduction, where certain proprieties were observed. The form of address/greeting or response supported this, for example, addressing each other respectively as Mr/Mrs or Nurse/Sister, or by first name. Rituals observed by patient/nurse were integrated in the conduct of their meetings. These rituals included language, demeanour, gesture and the sequence of events in need/care interaction. Rituals also included mode of greetings, such as exchange of customary greetings. Two common examples (mostly observed in waiting areas) included:

N7: Good morning Mr...

P3: Good morning Sister [stands up]

N1: How are you today 'Agnes'?

P15: [stands up and starts to move] Fine thanks ... not too bad hen.

The first example illustrates a more formal approach, the second a more informal one. Obviously the characteristics of the individuals must be taken into account, for example, individuals may be inclined towards being reserved or gregarious in any context, and/or specifically in this one.

Individuals may have met many times and maintain formality, which was true of several participants. Seven participants identified that they felt that their temperament led them to be more formal in approach in what they described as a formal setting. Five of these participants mentioned that they were reserved 'by nature' and that apart from within family or other close relationships, always behaved in a similar manner:

P2: I have always been rather restrained and somewhat reserved...everywhere apart from at home I suppose... it's just my way

I noted degrees of formality or informality not only in verbal communication, but also in the demeanour of the patient/nurse, for instance, how they approached and responded to each other. Six patients who were regular/frequent attendees waited to be invited to sit down by word or gesture, or to be spoken to by the nurse, and did not initiate action or conversation.

Four nurses conveyed formality by their form of address and approach, for example, issuing instructions regardless of whether or not the patient 'knew the ropes', and patients participated in this and appeared to acquiesce.

These participants appeared to have a standardised, ritualistic way of approaching need/care interaction. Conversely, most patients and nurses had established a relationship that conveyed agreement based on mutual understanding. Body language and gesture played a part in this, in particular by signalling intentions by actions, for example by motioning with the head towards the door or a chair. In Strauss's (1978:238) terms, they had negotiated 'clarity of legitimacy of boundaries' of mutual understanding in their interaction.

Variations in approaches by nurses related to formality were contingent upon the type of patient case, in particular brief and uncomplicated cases such as suture removal, or 'one shot' interactions (Strauss 1978: 240). A further common example is the administration of intra-muscular or sub-cutaneous injection. Brief and uncomplicated cases had stated objectives and predictable outcomes. In relation to this the approach of six nurses came across as more structured than that of others. They greeted the patients, verbally invited them to 'follow' or enter a room and then embarked upon a sequence of events related to the task in hand, such as a series of questions prior to a simple clinical procedure. Morse (1991) describes interaction such as this as 'clinical' with little personal involvement by patients or nurses. Participants had little engagement with each other and what there was was contained within the brief interaction and did not extend beyond it.

I identified whether or not participants liked each other as a central issue in weighing up and connected to ambivalence and reciprocity in patient/nurse interaction. Discussion with participants around this area is distinctive in its agreement in the following terms: if you liked each other it was likely that you would respond warmly to each other and develop a relationship that was satisfactory. Kralik *et al.* (1997) relate this to the positive experience of engagement between patient/nurse. A satisfactory relationship did not necessarily include a personal dimension of great depth, but it did include the same feelings one might have for a friend, for example, being pleased to see each other, sharing of news and personal inquiries beyond the need/care setting. Weighing each other up is central to this responsive process. These examples present the two different impressions identified by participants:

P10: She looked nice ... welcoming ... I'm glad she was smiling. I felt she was ready for me and it made me feel like I had her attention ... much easier to get on with someone like that ... makes it all more pleasant if the nurse is approachable. It's OK if they look a bit stern ... it just seems more business like and you might be in and out with no time of day.

N14: It's no effort to smile and it is important to make patients feel that they've got your attention. To be honest it's always nice when patients respond to you ... if they don't it means you just get on with it and you don't get to know them so well and something is lost or missing.

These examples illustrate the importance patients and nurse place upon feeling responded to. P10 and N14 infer that satisfaction in need/care interaction is affected by feelings of unresponsiveness, it becomes 'business like' and 'something is lost or missing'.

Participants identified clearly that initial impressions were important to them. These impressions took into account how each other looked and presented themselves. Manner is important in terms of non-verbal clues, such as smiling, appearing to be comfortable in the setting, and looking approachable.

Manner is equally important to those patients and nurses who had a more formal approach. They found a formal approach more comfortable as a reflection of their demeanour and expectations. The courtesy of smiling on greeting was acceptable to all participants. The majority of nurses appeared to have more open, relaxed approaches, used a questioning approach and followed the patient's lead in terms of how they talked and what they talked about, or, on several occasions, did not talk about. As in my study, Kralik *et al.* (1997) find that similarities in approach in interaction by patients and nurses are a positive experience that augurs well for the development of their relationship.

Participants found it amenable to be able to share responsiveness to each other as a foundation for their relationship whether brief or of longer duration. Presentation included comments that can be described as 'suitability for purpose' and three participants made specific comment related to dress. Two patient participants commented approvingly that the nurses had clean uniforms and looked 'smart'. One nurse participant stated that it was 'inappropriate' for a male patient to attend in working clothes (overalls and safety boots).

In these instances, the participants had clear expectations of how individuals should look in the role of nurse or patient. Interestingly, Roberts and Snowball (1999:44) find that the absence of uniforms is a sign that barriers between patients and nurses had been broken down. The issue of uniforms as a barrier did not emerge in my study. In terms of expectations, participants only referred to suitability for purpose in role as patients 'appropriately' dressed or nurses wearing uniform.

Attitude and manner also contributed to the weighing up process. Nurse participants identified patients who had a positive attitude as being prepared and willing to participate in need/care interaction. In this way, nurses appeared to be extending their evaluations of 'suitability for purpose' to being prepared for role as a patient. Positive attitudes of patients identified by nurses were punctuality and having the appropriate information necessary to pursue the purpose of the meeting, for example a hospital discharge letter or a prescription. This preparedness was linked to the purpose of the meeting. Evaluations of 'fitness for purpose' exemplified the control exerted in the negotiation of interaction by nurses. Strauss (1978:238) notes the relativity of balance of power between participants as quintessential in interaction.

6.1.2 Ambivalence and reciprocity in negotiation

Importantly, participants began to predict the prospect of developing a satisfactory relationship in the initial stage of their meeting. Following brief encounters, four patients identified that they had very mixed feelings as to whether they liked the nurse or not on first meeting her. This ambivalence is also related to the reason for the visit:

P11: She seemed all right I suppose... not too sure really. It all seemed very businesslike... I don't think she connected to me much as a person... very focussed on the job in hand

P17: I wasn't too sure at first... it takes time to weigh people up I think ... or at least I do. Of course, for most of the time, my mind was more on why I was there

Ambivalence included hesitancy and uncertainty about the degree of connection with the nurse. Connection included the degree to which the patient felt perceived as an individual or as a task for the nurse. As ambivalent feelings were all related to single meetings, it is impossible to examine this in any depth. However, in the terms Kralik *et al.* (1997) describe, such ambivalence can lead to the lack of development of the patient/nurse relationship.

The literature refers to the beliefs patients may or may not have about appropriate topics for conversation with nurses. These beliefs are that nurses will mostly stick to issues directly associated with the consultation. These issues are predominantly physical and wider social matters, such as current affairs (von Essen and Sjoden 1991, Jarrett and Payne 1995).

Sticking to consultation issues was the norm in short-term and brief patient/nurse interactions in which the patient's stated need, for example travel immunisation, provided the focus of any conversation. The participants' perceptions of, and reasons for, meetings were linked to a sense of 'connectedness' and significant to them. These perceptions included viewing their meeting as business, as a more complex interaction, or as a complex interaction in a series that included those beyond the health care setting, for example the Department of Social Security (DSS).

In the interactions that were brief and limited to one meeting, the terms of engagement were different. In these instances, five patients were able to comment on the pleasantness of their interaction with the nurse:

P3: Straightforward really... the nurse was very mannerly... pleasant way of conducting things, as you always hope of course. It makes a difference when things are as easy as that

P15: Very nice... no rush or anything like that... time for a wee chat and pass the time of day... and I like that

The nurses concerned identified that this is their usual way of behaving and that they enjoyed it. Exchange of pleasantries, including gentle humour and cheerfulness, was the norm in single meetings described as agreeable by participants. Humour was included as part of social conversation and used often by nine nurses in particular to relieve tension, especially in circumstances where the patient appeared to be somewhat tense, for example, 'I bet you've been looking forward to this all day'.

Participants in my study used humour in a spontaneous and intuitive way. It emerged that shared humour had a transformative and positive role in patient/nurse interaction. Beck (1997) also finds humour transformative in the development of the patient/nurse relationship. As Astedt-Kurki *et al.* (2001) found, I identified that humour played a role in alleviating anxiety, and generating rapport between patient/nurse. Intuition consummated the link between humour and rapport for participants.

Intuition is often referred to as an implicit and core element of nursing expertise (King and Appleton 1997, McCutcheon and Pincombe 2001). However, my participants exhibited clearly intuitive skill in the use of humour in patient/nurse interaction. I observed no instances of humour falling flat.

Patients and nurses engaged in general social conversation. Most often, this included comments about the weather, significant local events and the headlines of current events. The basis of understandings about what may or may not be appropriate topics of conversation is related to participants' perceptions in weighing up each other.

Topics of conversation were different in interaction that was sustained over a period of time, and went beyond the 'clinical', as Morse (1991) describes, and the brief. In this context, patient participants described the centrality of their 'connectedness' with the nurse:

P6: We understand each other I think... she's concerned with me and my diabetes... I appreciate that she cares and has time for me.

P1: We are in tune... she knows when I'm a bit down or bothered about something. She knows I fret of course and gives me a bit of help with it like

Connectedness included feelings of support related to them as an individual whom the nurse had come to know. The basis of negotiation is founded upon feelings of personal engagement with each other. All the participants identified that a sense of engagement was implicit and valued in the prospect of developing and sustaining the patient/nurse relationship. This sense of engagement is consistent with Kralik and colleagues' (1997) themes of 'engagement and detachment', and with Strauss's (1978) view of negotiation as related to individual's *modus operandi* in role as patient or nurse.

6.1.3 Socio-cultural characteristics in negotiation

As part of the weighing up process, participants also noted age and gender in particular and referred to them the most often in interview. Age was estimated by glance and was referred to frequently by patients and nurses. As previously discussed in 4.3, eleven female and seven male patients were participants and all of the eighteen nurse participants were female. None of the patients was surprised that the nurses were female, although two male participants commented that they thought that there were more men in nursing today:

P3: I rather supposed that one at least would be a man in such a large health centre. Having been in hospital I suppose I thought that there would be male nurses here too

P16: You see lots of male nurses in hospitals after all... I haven't seen one out here at all

Patient participants identified that they noted the age and gender of the nurse on first meeting. Reference to age was particularly apparent in interaction with the very young and with older patients. Perceptions of what constitutes older age by nurses were identified by them as someone in late middle age and probably retired. Five nurses linked older age to physical deficits and/or degree of independence. Age emerged as a key characteristic that is taken into account by nurses. It was often the leading question at an inaugural meeting. Woodward (1991) and Fairhurst (1998) identify older age as central in the transformation of social identity in the life course.

Age was prioritised in relation to the construction of social identity in my study. Six patients referred to age when asking nurses for comment on their progress. These inquiries may be a feature of the formation or fulfilment of patients' expectations in relation to their care and its outcomes. At the simplest level, it is apparent in questions associated with health checks, especially if the nurse has not volunteered the information, for example, 'is that normal for my age?' A nurse may offer 'normal for your age' which is a valid comment based on clinical assessment that requires reference to normal ranges and physiological insights and vary with age continuums.

Ten of the nurses also offered comments regarding assessment of 'normal for age and gender' in relation to measurements of blood pressure and pulse, for example:

N1: That's just right for your age

N13: Nothing to worry about there... normal reading for a man your age

N17: Well, in the upper range for your age...

N8: Perhaps a little bit low for a woman of your age

Patients expected information which contextualised for them individually measurements such as blood pressure. In these circumstances, seven instances of 'for your age' were offered to older people (who were generally over fifty-five) than to younger patients.

A sense of recognition of being 'special' emerged, especially if the older patient was independent:

N15: I think you do ever so well... its great that you manage and just get on with things yourself...

N10: She is just amazing... lives by herself at her age [90]... very determined to manage and she's stalwart so she is

Six older patients (over 75 years of age) were congratulated on 'managing' on their own, as illustrated by the examples given. Healthy ageing was viewed positively by nurse participants in the terms Bryant *et al.* (2001) advocate. Independence was a characteristic of patients admired specifically by nurse participants.

Dependence where it occurred was accepted, reflecting the 'problematizing' of older age which Hockey and James (2003) recognise, and the generalisations about increased care needs which Larsson (1999) and Chater (1999) identify.

Informed by Scottish demography and epidemiology (Blamey *et al.* 2002) regarding the profile of the Scottish population by age and gender linked to the occurrence of disease or disability, it was predictable that the majority of those requiring ongoing nursing care related to continuing needs would be older and, indeed, female. This situation seemed to be accepted by nurses and patients who made the same link between ageing and gender in lived experience as Arber and Ginn (1995). The approach of most nurses was modified depending upon the age of patients. Modification of approach was related clearly to extremes of the age continuum, for example, children (especially small ones) and older people. Modifications included taking and giving more time. Whilst seven observations included children, I did not interview them, as identified in 4.1, ethical approval.

Whilst nurses did refer to age in the terms previously described, comments by patients were less explicit. Usually these comments were in response to something that the nurse had said, for example:

N7: At your age you should take things a bit easier

P9: Easy for you young things to say... things have got to get done just the same as they always did you know... nothing new about that bit of life

Whilst this is explicit, it seemed to me to be typical 'patter' which one can hear many times in many health care settings and, indeed, others. In other words, the same platitudes were said in lots of different ways. These stereotypical comments were made in the course of general social conversation and included generalisations about ageing. They reflected, in part, the bleak view of ageing that Chater (1999) presents. What is interesting is that variations on the exemplar dialogue above were confined to female patients. No such comments were made to older male patients. This evidence of linking age and gender invites questions about the gender of patients and nurses, some of which are addressed in chapter 7. In this context however, I suggest that such exchanges suggested shared insights into the lived experiences of women. From the nurses' perspective it also reflected the fact that they saw more older, female patients than older male patients.

Apart from the link between age and gender, most comment by patients and nurses in relation to gender was linked to the reason for the encounter and in general conversational content. These references were most apparent if the reason for the encounter was linked to health screening or gender specific complaints. Reference to gender was most apparent in conversational overtures by nurses with patients they didn't know. This was most evident with male patients. Apart from twice, these conversational comments were confined to references to football:

N13: Did you watch last night... some carry on, exciting though

N9: So! Have you been following the football on the telly too...?
I've no choice with the boys in my house

Most fieldwork was conducted during a period when national and international football was capturing the media headlines. No female patients were asked if they intended to 'watch the game' for example. As an unknown dimension outwith the encounter, I subsequently discovered that one of the female patients I had observed played football for the Scottish Ladies team.

It proved to be considerably more difficult to generate an account associated with SES. Valuations of worth and evaluations of social status were made in indirect ways, as Sayer (2002:1) suggests. In my study, those indirect ways were references to affordability of basics and luxuries, and style of language. Most clues about SES related to references to affordability of bus fares and holidays, and patients and nurses both made such comments. I also noted a range of use of language, conversational content, and accents, which indicated a range of SES amongst patients and nurses. Five nurses appeared to vary the way they talked dependent upon how patients talked. By 'way' and 'how' I particularly refer to complexity of language, including the use of more scientific terms, and accent. Nurse participants avoided the vernacular with patients they identified to be 'middle class' or 'posh':

N11: You can tell what class people are from the way they talk I think... if the grammar is right and they have a posh voice. I know that I talk different with folk like that... posher... you know!

Nurses were reluctant to make much comment about SES. However, they did modify their usual approach to more closely mirror that of patients. Bradley (1996) argues that we construct social hierarchies that are connected to unequal lived relationships. In negotiation of patient/nurse interaction individuals attempt to place each other within a social hierarchy. Placing is meaningful and influential in nurses' performance in communication in interaction.

The ethnicity of patients and nurses was varied. Most participants were from the central area of Scotland with three exceptions, the Scottish highlands, England and Ireland and all three had lived in central Scotland for a considerable time. Two patients were Scottish Asian (P5 and P8) and a further one was a temporary resident from France (P12). The Scottish Asian patients were well known to the nurses they met with and, in both cases, the interaction included discussion of family and local community matters.

A relative attended the temporary resident from France, who was female and elderly. The relative remained silent throughout. The patient replied rapidly, briefly and factually to the questions asked by the nurse who adopted a formal approach from the outset, mirroring that of the patient. The patient offered no extraneous information. The nurse in this case felt that she had to behave in the same style as the patient whose demeanour she found 'forbidding'.

Because of this, the nurse dramatically altered her usual informal style of approach and identified that on this occasion the patient had exerted considerable control over proceedings. The nurse's usual *modus operandi*, especially with regard to control of patient/nurse interaction was abandoned. Using Strauss's (1978:252) conceptualisations, negotiation is constrained by events beyond its context, in this instance, a formal style of patient presentation with which the nurse was unfamiliar and unable to interpret or respond to. Perceptions of cultural difference as a barrier constrained individualised care by the nurse.

6.1.4 Confidence and satisfaction in negotiation

As part of moving towards developing a relationship, the process of weighing up in the negotiating process was often sustained over several meetings. It seemed to be the case that participants were seeking consistency before getting to know each other in any depth. Consistency related to getting a sense of confirmation of the impressions gained at the initial meeting, for example of being approachable, responsive and prepared. Once this process of confirmation had taken place, participants began to share information with each other. This sharing did not necessarily include personal information, although patients were more likely to do this than nurses.

Apart from three, none of the nurse participants shared much information about their personal self, which suggests a sense of professional control, for example, maintaining the 'in role' boundaries of being a nurse which are discussed later in this chapter. Information that was shared related to finding something in common, for example, where people were from, worked and lived. In addition to this common ground, information was sought regarding mutual knowledge, in particular of people and neighbourhood. Finding some common ground to subsequently build upon initiated rapport and is part of placing. Participants identified a range of feelings linked to liking/not liking and the 'weighing up' process which included apprehension and the influence of the attitude/manner of patient/nurse respectively. Discussion of these areas follows.

6.1.5 Power in negotiation

All except four patients identified that attending the nurse for treatment or other care involved some degree of apprehension. This apprehension was principally in relation to knowing what was going to happen or what the outcome of the consultation would be. In the first instance, patients identified a range of feelings:

P11: I've never been sent to the nurse before ... I didn't know if it was the same as going to the doctor and sitting in an office or if it would be like in the infirmary. I didn't know if she knew ... or if I was to tell her... I wouldn't know what to tell her!

P13: He [the GP] never really said what would happen ... he just said she'd check me over and keep me right ... didn't know what would actually happen

These examples illuminate anxieties which range from the most common, the patient not sure of what exactly the nurse would do or ask them to do, to concern that more intimate procedures may be carried out. A further example relates to this concern:

P17: I had a bath and got changed before I went just to cover all eventualities ... as it was I didn't need to take any clothes off ... she checked my blood pressure and that

Wardhaugh and Wilding (1998:215) note that:

The leaving off of personal clothes serves, at a physical level, to induce discomfort, humiliation and embarrassment and, at a psychological level, to represent a loss of identity and feelings of self respect.

In the example given (P17), the patient was not 'in on' the aims of the consultation and so could not develop an effective *modus operandi* based on expectations or experience. This patient was extremely pleased she did not have to take any clothes off (as three other patients explicitly were) and described that she would have felt embarrassed and uncomfortable if requested to do so. Using Foucault's (1979, 1980) terms, Fallowfield (1991) represents these feelings as ones of powerlessness as the patient feels that they will be literally stripped of their identity by the disempowering 'gaze' of the nurse.

These feelings relate to how the person constructs their experiences as patient.

Expanding on this, Nettleton and Watson (1998:17) note that:

The image we hold of our bodies will to a greater or lesser extent impact upon how we experience our bodies in everyday life. It may impact upon our sense of self, our degree of confidence in social situations and the nature of our social relationship.

A patient with little knowledge of how the system works in terms of what will be expected of them, and how to behave during their meeting with the nurse, is likely not only to feel anxious, but also to experience a loss of confidence and control with a resultant loss of dignity.

Foucault (1979, 1980) argued that power was generated within and as part of interaction. He proposed surveillance and regulation of the body to be fundamental to negotiation of, and control in, interaction. He described this as power/knowledge. He also conceptualised 'normalizing judgement' and 'examination' as 'instruments' of power. These concepts can be translated into the participation of, and roles adopted by, patients and nurses in their situated interaction. Nurses examine by observing and assessing patients in a variety of ways. These ways range from noting demeanour, to examining normally undisclosed areas of the body. It is within the framework of their expertise and practice to decide to examine, or 'scrutinise' in Foucault's terms. The nurse's expertise becomes an instrument of power with a patient who does not know how the system works and so experiences a loss of control and self-determination.

In Irurita and Williams's (2001:581) terms, the patient's integrity and dignity are compromised.

Apart from three, patient participants specifically identified that when they met the nurse they had a sense of being scrutinised, and expected to be so:

P2: I had a sense of being scanned, that she was having a good look so to speak. Of course, you expect it and you feel self-conscious. There is a sense of being appraised in some way. It crosses my mind that you might be found wanting in some way.

As an aim and consequence of examination, nurses make evaluations (judgements) based on a continuum of acceptable ranges (normalizing). In this way their experience, knowledge and expertise are translated into examination processes and manifested in subsequent judgements. These judgements are vested in the expert (nurse) and expressed in decisions regarding identification and implementation of specific nursing care. The evaluation of blood pressure provides a simple example of this. The nurse uses her expertise to judge the 'normality' of an individual's blood pressure. The nurse draws on experience and knowledge to do so, for example, the factors affecting blood pressure and knowledge of human life sciences. An outcome of this process is decision-making/judgements. Judgements related to expertise could include, for example, no further action or further monitoring. Only when judgements are expressed to patients do they have the opportunity to become a participant. In this way, judgements become the instruments of power and their implementation locates control of patient/nurse interactions with the nurse.

In Foucault's terms, power is part of the process of interaction: the nurse is surveyor and regulator, and the patient is comparatively powerless and may be concerned about being unsatisfactory in some way. Porter (1996) takes some issue with Foucault's theory of situated power and argues that it leads to confusion in the enterprise of substantive theorising that must include the wider world, for example, institutional/structural influences. Whilst Foucault's (1979, 1980) theorising contributes to understanding of situated interaction, as I have argued, Porter makes a telling point that is relevant to my study. It emerged that in participants' terms, consideration of the wider world offers a considerable contribution to the examination of, and performance in, situated interaction.

Participants identified that examination and surveillance extends to socio-cultural characteristics as they endeavour to locate and relate to each other in their social encounter:

P13: I suppose they can tell a lot from looking at you... how old you are, how you're dressed. You get summed up really – we all do that... even the way you speak... people can tell where you're from. You like to work out folk's background... you place them.

N7: We all weigh people up when we meet them. As a nurse, assessment starts automatically, as soon as you meet a patient you start to note things about them... what they look like... their circumstances perhaps.

In these terms, Foucault's (1979, 1980) conceptualisation of power in situated interaction has proved useful to consider processes of weighing up and the influence of 'gaze'.

However, I have extended this conceptualisation to the meanings and understandings generated beyond patient/nurse interaction and approached it in the terms Porter suggests (1996). These conceptualisations are presented in chapter 7.

'Placing' someone in relation to personal background includes SES and issues such as where someone is from. To make sense of their own and others actions, individuals navigate their way in interaction in the health care setting using a wide range of reference. Siegrist (2000:284) presents the view that from a sociological perspective:

'place' defines a person's social position or social status within a hierarchical stratified structure of opportunities.

Eight patient participants considered placing someone in relation to social position as significant to their navigation in interaction. Socio-cultural characteristics were used as reference points by participants in locating and relating to another, including similarities or differences in social status:

P9: You see what you've got in common... background and suchlike... you'll get on with someone much the same as yourself... you know, things in common... what you work at [employment]

Sharing similar opportunities and resources was linked to social position and meaningful to understanding others. Individual socio-cultural characteristics are central to this process in terms of how everyday meaning is created and sustained in the social construction of reality by patients and nurses.

These concepts are also associated with the negotiation of social boundaries and the creation of new contexts by patients and nurses as described by Lawler (1991). Lawler's (1991) key assertion is that how the body is presented to others can both reflect and reinforce power relations and social inequalities. Scrutiny on presentation described by P2, as 'found wanting', is eloquent of the reinforcement of power and inequalities suggested by Lawler. Shilling (1991) furthers this argument and suggests that the body as physical presentation can contribute to the reproduction of social inequalities.

SES in particular can be deduced from an individual's personal presentation, for example, body shape, speech and etiquette. Shilling's (1991) main theme is that how bodies are presented will affect perceptions of an individual by others. To differing extents, fifteen patient participants commented that they were aware that they would be scrutinised and perceived in certain ways. These participants also expected that this was what nurses would do, as they were interested in the body as part of their professional role. Social inequalities are inherently embodied as they are about the relationship between the social body and social interactions (Nettleton 1995). This led to consideration of how body image and embodiment affect presentation (Nettleton and Watson 1998, Lawler 1991, Shilling 1991). Two patients in particular provided clear examples of their awareness of personal presentation:

P14: You feel somewhat self conscious in that it is your physical form presented for inspection... that is why you are there... bit like a shop window. One is more accustomed to being recognised as self, me – rather than in that way.

P8: I ken I'm overweight and it seems like a weakness when you come to a health place... it puts me at a disadvantage... I'm no model of health. These are my feelings of course... I feel welcome... I know them all now.

How people perceive their bodies is expressed in their experiences as a patient in the health care setting. Concepts of lived body and embodiment linked to control are integrated in negotiation of and developing and sustaining the patient/nurse relationship, and empowerment within that relationship (Turner 1996, Leder 1992, Csordas 1994). The common thread in relation to patients' anxieties about presentation was that they wished to appear 'appropriate', for example, knowing what to do or say, and in particular to meet presumed standards regarding personal hygiene, dress and etiquette. Loss of dignity dominated patient participants' accounts of their apprehensions in need/care interaction. Apprehension was also related to the need to be accepted in the health care setting by behaving appropriately and not doing or saying the wrong thing. Patients' apprehensions were related to dignity, trust and vulnerability. The link between trust and concerns of vulnerability is established clearly in the literature (Redfern and Norman 1999, Irurita and Williams 2001).

A further link emerged in relation to integrity, which conceptually encompasses dignity, trust and vulnerability, to fear of loss of dignity. Fear of loss of dignity emerged as a threat to individuals' integrity and therefore is a constraint in negotiation in interaction. Preservation of integrity is a priority for patients. Four patients stated that they 'didn't want to let themselves down.'

These views were linked to concerns about adequacy of behaviour and understanding what was wanted of them. Principal concerns were that they would do the right thing and not appear foolish. Nurses had no such apprehensions. However, nurses did identify apprehension in relation to complexities of care delivery and concerns regarding care outcomes. Some patients shared the latter concern as illustrated in the following example in which a patient and nurse comment upon the progress of the treatment of a chronic leg ulcer:

N10: Difficult dressing ... we don't seem to be getting very far with it

P4: She [the nurse] perseveres ... just wish it would start to look really different ... I don't see any difference ... I think we're both as fed up as the other!

In this further example, a patient and nurse comment upon the monitoring of elevated blood pressure:

N5: He's been coming every couple of weeks for months and I don't know if we're any further forwards ... it's proving to be intractable [hypertension]

P16: I've been getting it [blood pressure] checked every few weeks and seeing the doctor once a month ... gets on your mind ... I'm starting to get worked up about it the day before now ... its like a vicious circle.
She says now she'll pop in at home and check it there ... do you think she's getting desperate? *(Advised to discuss concerns with practice nurse)*

Participants who had experienced single meetings also expressed the view, as in the examples just given, that the reaction of liking or not and developing rapport was relevant to the sense of satisfaction. Only two of these went on to expand that they viewed confidence as an expectation of need/care interaction.

6.2 Developing and sustaining the patient/nurse relationship

Confidence and sense of well being are ingredients of a patient/nurse relationship characterised by liking and the deepening of their relationship. Morse (1991) describes a relationship such as this as one in which commitment and involvement have been negotiated. The communication, understanding and experiences of patients and nurses are central within that negotiation process. Examination of the literature exposed concerns about the superficiality of communication between patients and nurses. The overarching concern was the neglect of the patient's contribution (von Essen and Sjoden 1991, Jarrett and Payne 1995). I found evidence that patient/nurse knowing each other is central to an invested-in patient/nurse relationship. In the example given next, the patient and nurse reveal the shared feelings in their relationship:

P1: We get on fine ... I've been coming in for six months. We know a bit about each others families and that ... she couldn't do better for me and I do my bit ... I look forward to seeing her every few days and seeing how we're getting on

N11: She comes in early for a good chat ... we can both talk mind!
I enjoy nursing her ... slow progress with the ulcer, but we're getting there

Investment occurs when the relationship is sustained over at least several meetings, but more probably over a considerable length of time. A relationship such as this is characterised not only by familiarity with each other, but also with rituals and procedures. As patients and nurses get to know each other, their relationship becomes one of familiarity, intimacy, reliance and trust. It is in these terms that they have invested in their relationship.

The relationship can therefore become one in which patient/nurse share understandings of what is to be done, how it is to be done and what the desired outcomes for both are. These understandings are not only shared, but predictable and sustained by both. Commitment and involvement as described by Morse (1991) are evident in this process. The patient's needs are being cared for, or enabled to improve, whilst the nurse is caring for them and enabling improvement. These circumstances are satisfying to both, in that the patient has expectations of needs being met and the nurse has expectations of caring effectively:

P16: I'm beginning to feel that her attention is paying off. She's very thorough and I can depend on her to get me on an even keel... I've been really worked up about it

N5: We understand each other much better now and know where we are going... it makes such a difference. I enjoy the satisfaction of it and so does he

Despite the fact that adequate outcomes have not yet been achieved in clinical terms in the example given, a sense of fulfilment and satisfaction is apparent. Clinical outcomes related to need/care are striven for, based on mutual understanding. Kralik *et al.* (1997:407) also identify clear relationships between a satisfactory 'engaged' patient/nurse relationship and achievement of quality of care.

An invested-in patient/nurse relationship contributes to satisfaction and pleasure for the patient as person and the nurse as person.

Integrity, trust and security emerged as important in participants' accounts of these feelings. Investment in the patient/nurse relationship becomes reciprocal, in that it is profitable to patients and nurses in a range of ways and to different degrees, but in particular by preserving integrity and dignity. Investment may at first be in a therapeutic relationship in which care is delivered and patients' needs and concerns are met. The competence of the nurse and the preparedness of the patient to co-operate and participate are central. The nurse has the opportunity to pursue commitment to care delivery and achieve job satisfaction. As shown in the previous examples, the roles of patient and nurse remain distinct and acknowledged by the expectations they have of each other.

A therapeutic relationship may evolve into a deeper relationship in which people become more closely engaged as individuals. In these circumstances, a social relationship has emerged between the person as patient and the person as nurse. This closer engagement is founded upon, and subsequently bound together by, the patient/nurse relationship. In other words, the patient/nurse relationship develops into something more intimate, which includes a sense of partnership, and goes beyond need/care interaction. A sense of sharing a problem or dilemma such as that just described, characterised six of the sustained patient/nurse relationships identified. A sense of sharing is dependent upon confidence in each other. This confidence is related to trust and consequent feelings of security in the relationship and is embedded in the ongoing nature of need/care interactions.

Mechanic and Meyer's (2000) disquiet related to maintenance of integrity, is overcome in the invested-in patient/nurse relationship by the placement of patient's concerns at the centre of need/care interaction.

Four patient participants identified that decisions were made as their relationship with nurses became closer and more intimate. Duration of the relationship is influential in this process in addition to the sustained need for care. Examples of development of confidence are related to decisions about establishing parameters of responsibility and teamwork in a joint project. The best example of a joint patient/nurse project related to an older female patient with a chronic leg ulcer. The nurse and she had known each other for many months and had developed a close relationship in the terms now described. A sense of partnership and intimacy were evident:

P7: We know both what we're doing, I do my bit, and she does her bit. She comes up with wee wrinkles [new ideas], and takes photos of it ... She always asks me how *her* ulcer is getting on. She'll no let anyone else touch it if she can help it. Sometimes we get the photos out and see how we're doing

N9: I'm always keen to see how my handiwork's getting on. I've put a lot into it ...I'll see it through

As the example illustrates, patients make considerable investment in a close relationship and that investment can be identified as purposeful and productive.

The patient clearly felt that the nurse was committed to her care and both appeared to enjoy a relationship that had rewards, including sense of well being, by sharing and satisfaction.

A further point relates to the degree of empowerment of the patient. The patient had, in effect, abdicated decision-making to the nurse, although she maintained a 'finger in the pie'. Abdication of decision-making may be a reflection of trust, but also of the meanings and understandings brought to interaction. This patient was one of those who identified conforming to convention as important to how you 'behaved' in the health centre. Clearly some bargaining had gone on in negotiating the present situation of this patient/nurse. Their encounters over time determined the balance of power and control and the degree to which the patient felt (or wanted to be) empowered.

6.3 Empowerment in the patient/nurse relationship

Empowerment emerged as central in the negotiation of patient/nurse relationship. Negotiation is pivotal to the prospect of investment in the sustained patient/nurse relationship. Barnes and Walker (1998:203) identify that:

Empowerment implies participation in the process of decision-making which causes changes in the nature of the process itself.

On the one hand, including patients as partners/participants in decision-making is seen as empowering. However, on the other hand, the knowledge and skill of the nurse remain as essential ingredients to the patient/nurse relationship if that relationship is to be beneficial and therapeutic. Patients expect to benefit by drawing on that knowledge and skill:

P8: They know what's to be done... the best way. I ask them and I listen to them and follow what they say... that's what you should do

P10: They're the ones with the know how... background knowledge and the hands on skill... you expect them to know what to do and how to do it... that's what being a nurse is

The patient's expectations of, and trust in, the nurses' role and expertise was considerable. In turn, most nurses recognised that they could enhance the quality of their practice by drawing on patients' ideas and experience. The nurses cited next valued the contributions their patients made:

N3: Patients tend to know themselves best. I find that they can often contribute good ideas about how their own care can be approached. Of course, they expect me to understand what an appropriate way forward is and you can take into account what they say as much as possible...

The literature identifies empowerment as a major area in health and nursing research and development (Turner 1995, Fallowfield 1991, Porter 1996). The health and nursing literature focuses on expectations that patient or client participation in decision-making will contribute to service user empowerment. However, participation may not include the prospect of influence and control in policy and practices, as Rose (2003) argues.

As discussed in the literature review, the concept of empowerment is not synonymous with participation in decision-making (Clarke 2001, Rose 2003). With a few exceptions I found that, in the community practice setting, participants were perplexed by concepts of empowerment in terms of utility and practice in need/care interaction:

N6: Patients do participate in their care, and it is my role to let them know what I'm doing and why. In that way they are able to say what they think and be involved... and co-operate I suppose.

As this and four other nurse participants described, involving patients in their care was part of their practice and seemed to be perceived as participation. However, as shown in the example just given, that involvement was viewed as informing the patient to seek co-operation, or as in the example, 'letting them know'. The patient had little or no influence or control.

Antecedents to empowerment are described as increasing available information, depth of knowledge related to outcomes and alternatives, development of communication and interpretation skills, and promotion of opportunities to exert control or influence (Rowlands 1995, Clarke 2001, Ellis 1993, Schulz *et al.* 1995). Whilst I noted evidence of nurses providing information to patients, it proved difficult to establish to what extent depth of knowledge related to outcomes and alternatives of care was accomplished by patients. To do this, the patient/nurse relationship would have to be examined from a different perspective and longitudinally. However, from the data available in my study, I can suggest that the accomplishment of empowerment by patients would require to be facilitated and supported by nurses as part of their 'terms of engagement' in role as patient or nurse. Full consideration of this accomplishment would also include taking into account that patients may have other related resources to draw on, for example, web based information and/or consulting other health care related advisors (two patients briefly mentioned the benefits of aromatherapy).

Additionally, an increase in influence and control by patients through an acquisition of knowledge and skills may contribute to empowerment as a process in the terms that Barnes and Walker (1998) identify, and as an aim of patient/nurse interaction. Much of the wider literature relates these processes to individual, organisational and social environments, especially in terms of inclusion. Skelton (1994) advises that any consideration of empowerment as process requires the inclusion of the cultural and social milieu. The prospect of such inclusion is expanded upon in chapter 7.

Nurse participants identified that translating patients' ideas and experiences into their professional practice is part of their role and they expressed some difficulty with this. Six expressed the explicit view that, whilst they recognised the importance of patients' contributions, they often had difficulty identifying and translating patients' ideas and experiences in practice. Two of the nurse participants related their difficulties in identifying and translating patients' ideas and experiences to their characteristics as an individual and to their style of nursing:

N3: It takes me a while to get to know patients, especially if they don't offer much... you know ... say much. I think they should have a say in their care but at the end of the day, it's my job and my responsibility.

N13: I just feel you can't do much when you hardly know someone. It takes me a while to feel comfortable and I'm sure some patients pick up on that. I always explain what I'm doing - some patients, in fact more all the time, ask a lot of questions and I find that hard to handle sometimes.

Both of these nurses were clearly uncertain about including their patients in the decision-making process. Their uncertainty related to notions of being innovative in their practice, or to expanding the parameters of autonomy to include the patient. In practice, they excluded the concept of the patient/nurse relationship as a social one, and expressed a traditional interpretation of the role of the nurse. In interaction with patients both of these nurses saw their role as directive and dominant. A traditional interpretation of the nurse's role therefore compromises the integrity and self-determination of patients. To varying degrees, the other nurse participants identified that patient empowerment is an aspiration of their practice. Most of the nurses felt that this is only fully achievable in a sustained relationship and one characterised by 'investment':

N16: You need to know the patient over a period before you can really involve them in their care. On the whole, patients expect you to use your skills to work out what is best for them. We can't expect patients to have the knowledge ... I do accept that patients like to know what you are doing and why. Some like to talk about pros and cons, most let you get on with it.

Fifteen nurse participants expressed very similar views to those given in the example. There was a focus on discussing protocols such as wound dressings in the accounts of these nurses. Few of them included wider patient issues and this hints at a reductionist, problem-focused approach to nursing care, rather than needs-centred approach to patient care.

Eight nurses mentioned adherence to evidence-based practice in relation to 'knowing best' as a professional requisite.

However, three nurses disagreed with the typical view expressed by their peers and argued that it is always possible to include patients in the decision-making process. The three nurses who expressed atypical views identified listening to, consultation with and explaining to patients to engender their participation as a priority. They had developed their conceptualisation of empowerment to be a process in practice, whilst their colleagues viewed it as an act. Nurses viewed empowerment either as act or a process. Those who saw its utility in practice as an act referred to a range of practices to involve patients in their own care. I observed that the three nurses who prioritised patient participation did so consistently in brief and sustained interaction with patients. In these terms, a participatory approach to patient care characterised their practice. Engendering patient participation in need/care interaction is a core value of the three nurses identified here.

In relation to patient centred care, Sakalys (2000:1474) emphasises listening:

listening encourages patients to tell narratives of their own experiences of illness rather than telling only medical narratives.

The three nurses I refer to were experienced nurses who appeared to be particularly disposed to exploring patients' needs, rather than deciding what those needs were themselves in relation to problems. They had a determination to avoid a reductionist approach to care and to see beyond the illness or the problem. The patient's account is central to interaction. This was described explicitly as the 'patient's story' by two of these nurse participants:

N14: Listening is the single most important thing. If you listen you get their story, they tell you what's important to them... any worries... and you get their perspective

N1: I'm here for them... it's their story that matters... they need the opportunity to make known all the events, their understanding and their concerns. If you don't listen to them, you put the horse before the cart... I mean I'm here for them not the other way round

Listening to the patient's voice is emphasised in the literature that is concerned with the narrative of patients as a core value of nursing (Liaschenko 1997, Mitchell 1998, Mattingly and Garro 1994). Whilst nurse participants mentioned listening as a necessary skill and included it as an action in their practice, three embedded it in their practice as a core value. Clear examples of placing the patient at the centre of patient/nurse interaction related to inquiring about comfort first, rather than directly referring to the probable source of discomfort or concern, such as a wound. In addition to general inquiries about how a patient felt, further specific inquiries related to comfort of dressings, presence of pain, ease of movement and ability to sleep. Such inquiries led to consideration of meeting the needs identified by the patient rather than an immediate focus on the primary problem. In these circumstances, the nurse's engagement with patient needs is a reflection of awareness of, and insight into, the fundamental problem/s requiring nursing input. The patient initiated and, in essence, provided the agenda for the interaction. The patient's priorities were the focus of care and, in effect, informed the nurses' care planning agenda. In the terms outlined, empowerment is a joint accomplishment of patients and nurses.

Apart from the three nurses I identified as empowering, the other nurse participants explored needs with patients that they were familiar with, in addition to the problems identified as the reason for referral. Exploration of needs appeared to be more of a product of a sustained relationship rather than a deliberate nursing strategy to hear the patient's view and include them in decision-making. Patient participants did express some feelings of powerlessness in the decision-making process in relation to this:

P7: There's nothing I can say ... you're in their hands and you just need to go with the flow... I know she really cares about how I am and how I'm getting on... she knows best

P4: I have to leave it to her of course... I don't know all the ins and outs like she does... I'm in her hands

Feelings of powerlessness were related to expertise in relation to the nurse 'knowing best' and to patient's own lack of knowledge and therefore 'fitness' to participate in any decision-making process. Four patient participants used the term 'in their hands', the hands being those of an expert. The patients valued expertise whilst taking into account that their perceived lack of it put them in a weak position in relation to understanding and acting upon their own needs and problems.

Further, under-explored, questions arise as to the motivation of patients to participate. Patients' motivation to participate related to their beliefs regarding the role of the patient/nurse, which are discussed further in the next chapter.

It emerged clearly that, in relation to balance in the patient/nurse relationship, trust and confidence were essential to the founding of relationships that were capable of empowering patients, whilst not disempowering nurses:

P6: Of course you need to be confident... not just that they know what they are doing... but that they care and that they can be relied upon. After all, in my situation [diabetes mellitus] I have to be able to feel that I can approach them and rely upon them... I'm sure they feel the same... they have to trust me

P16: At first I wasn't too sure like I said but as I'm getting to know her and understand things better. I think we'll get on fine... I feel I can trust her

Occasionally nurses imposed conditions upon their confidence and trust in patients which was related to their compliance with care and/or treatment.

The imposition of conditions was true of seven nurse participants, who to a greater or lesser extent, felt that trust is an essential prerequisite of their relationship with patients that included the prospect of participation in patient/nurse interaction by patients:

N18: Most relationships are give and take, but if the patient is to be at the centre of what's going on and playing a part you have to be confident that you can rely on them... doesn't work otherwise

N7: It's a two way process of course... patients have to feel that confidence in you as a nurse. Likewise, we need to feel we can rely on patients... to enter into it and co-operate.

Both patients and nurses related trust and confidence to empowerment by referring to taking part, co-operating and reliability. Notions of participation and contribution underpinned their views. However, implicit in their views is the notion of entering a bargain - you do your bit and I'll do mine.

The bargain proposed by patients and nurses therefore had conditions. Those conditions were subject to implicit and explicit negotiation. Implicit negotiation is part of getting to know each other or 'weighing up'. The implicit process also included perceptions of complying with the expectations of the role of patient or nurse. Explicit processes related to whether or not patients and nurses had fulfilled their commitment to the ongoing demands of the patient/nurse interaction. The best examples of this were patient compliance with protocols such as blood glucose monitoring or diet, or nurses meeting commitments to provide information. The complete fulfilment of the bargain is most likely to occur in a relationship that has been invested in.

Nurse participants associated confidence and trust as integral to an at least satisfactory relationship with patients. The effectiveness of the nurse with regard to achievement of desired outcomes in need/care interaction is dependent upon confidence and trust. Underpinning confidence and trust is the suggestion that patients and nurses involved in an ongoing relationship wanted to be liked and trusted. However, none of the participants mentioned these issues specifically. In the same vein, the concept of self-esteem is often linked to confidence, but was not mentioned specifically by participants. Wanting to be liked and trusted linked to self esteem is conceived as pivotal to individuals in role as patient or nurse. These concepts were elusive in my study as participants reserved their thoughts. Taking account of this, I was unable to examine fully concepts of self-esteem and trusting and being trusted in my small study.

Despite this, it seemed to me that they were influential upon the properties and subcategories of both categories of this study.

Binnie and Titchen (1999:182) identify that patient centred nursing that embodies inclusion in decision-making is, 'challenging, enjoyable and satisfying'. However, they also identify that its achievement is complex and often stressful for nurses. Six nurse participants mirrored these views and illuminated the tension that may be incurred in the process:

N16: It can be very difficult to include patients in making decisions... after all nursing is about assessing problems and deciding the best course of action

The tension emerged from the core values of the nurses and nursing. The tension is between the values of a reductionist, problem based approach or inclusive, patient centred, needs based, approach to care (Malin and Teesdale 1991, Barnes and Walker 1998).

6.4 Conclusion

Patients and nurses brought considerable assets and resources to patient/nurse interaction. Those assets and resources were related to negotiation, developing and sustaining a relationship, and empowerment.

The investment by patients and nurses in their relationship was contingent upon negotiating their relationship, developing a relationship and sustaining a relationship, and was related to empowerment. The category of Investment is enlightening in terms of the potential of shared meanings and understandings that include the social dimension brought to, and interactive within, patient/nurse interaction. The potential lies in patients and nurses being able to commit to, and become involved in, participation in interaction that focuses upon addressing and connecting patient need and nursing care. The subcategories and key properties of Investment illuminate the value of connecting situated and wider social meanings and understandings to inform and enhance patient/nurse interaction.

I found that developing and sustaining the patient/nurse relationship required continual negotiation and commitment. Patient and nurse needed to know each other, based on a sense of sharing, participation and involvement that goes beyond need/care interaction. Current conceptualisations of knowing the patient focus on situated patient/nurse interaction (Tanner *et al.* 1993, Radwin 1996, Luker *et al.* 2000). However, these conceptualisations have mostly overlooked the duality of experiences of patient/nurse having a relationship and the social dimension of patient/nurse interaction. 'Knowing each other' contributed to the prospect of investment in patient/nurse interaction by patients and nurses. Participants identified that 'knowing each other' contributed to positive experiences in the sustained patient/nurse relationship.

The value of the invested-in relationship in which patient and nurse know each other lies in shared understandings, a sense of fulfilment and satisfaction emerging from patient/nurse interaction and the outcomes of care. A sense of partnership was valued, 'we both know what we are doing', and connected to a purposeful and productive investment in which individuals performed in role as a patient or nurse, and as a person.

Negotiation in patient/nurse interaction required related processes of weighing up, developing rapport, understanding and responding positively to each other. For example, a favourable response was likely to be based on having something in common and feelings of approachability and mutual understanding. A less favourable response was likely to be based upon mixed feelings about approachability and understanding, for example 'not too sure at first'. The complexities of negotiation included the interaction of socio-cultural characteristics as central to how meanings are generated in patient/nurse interaction, and to making sense of individual and others' actions.

A process of placing someone in terms of socio-cultural characteristics was important to locating others in the social world and relating to them in patient/nurse interaction. Relating to each other in the social world was founded upon acting and reacting in the process of weighing up. Participants described clearly the importance to them of seeing what they had in common with the other on meeting.

My argument is that the process of placing initiates acting and reacting in patient/nurse interaction and so is very influential within it. From the patient's perspective 'they can tell a lot from looking at you' and from the nurse's 'automatically ... start to note things'. The process of placing is more important in patient/nurse interaction than previously recognised and I discuss it further in the next chapter.

I have also argued that negotiation in interaction between patients and nurses was unequal in a range of ways that lack emphasis in other research. Concepts of the 'lived body' and embodiment linked to social inequalities were embedded in the negotiation of the patient/nurse relationship, as referred to in the arguments of Lawlor (1991) and Shilling (1991). Patient participants described feeling 'self-conscious', 'scanned' and 'inspected' and related these feelings to being put at a disadvantage in patient/nurse interaction. One patient participant explained this disadvantage as concern about being 'found wanting'. Confidence and sense of control were linked to embodiment and, as a further connection, preservation of integrity was identified as a key concern by patient participants in particular. Issues of what constrains or enables negotiation are discussed further in the subsequent chapter.

The development of the patient/nurse relationship was characterised by trust, agreement about their respective roles and required commitment by patient and nurse.

The development of the patient/nurse relationship was dependent upon it being sustained, and by continuing regard. I argued that sustaining a relationship required patient and nurse to co-operate and participate in care together, taking into account that whilst the patient may participate in care, they may do so superficially, the control remaining with the nurse. In these circumstances, the patient usually sensed they were being looked after whilst the nurse was enabling care. This mutually satisfying state of affairs required the generation of trust and confidence, 'we are in tune'.

In the category of Investment I have established that trust, integrity and self-determination are not only important concepts in patient/nurse interaction, but also that they are closely linked in the meanings and understandings of individuals within and beyond patient/nurse interaction. The preservation of the patient's dignity and self-determination was central in the confidence and partnership building process. In Investment, a sense of partnership was important in decision making processes, and purposeful and productive. Before a commitment is made to a negotiated, therapeutic relationship, patient and nurse needed to recognise, acknowledge and understand each other's roles. A sustained relationship that could be characterised as 'invested-in' was often driven by a joint project, and in participants' terms was therapeutic and mutually satisfying.

Negotiation of agreement regarding the balance of power and control emerged as an accomplishment of patients and nurses within their interaction. The balance of power may be weighted and counterbalanced by the investment patients and nurses make in their negotiated relationship. The examples given in 6.1.5 and 6.3 show that patients and nurses have views ranging from 'the nurse knows best' to patients contributing their own ideas as to how their needs could be met. The power or potential of participants to behave in certain ways in interaction have been addressed as emergent concepts in my thesis.

I argued that what enables and constrains the negotiation of empowerment was important in patient/nurse interaction. From this conceptualisation, empowerment and negotiation emerged as key concepts linked to participation and involvement in patient/nurse interaction. In the category of Investment, I have identified the positive contribution that using the concepts of empowerment and negotiation together makes to understanding of patient/nurse interaction.

The inclusion of patients in the decision-making process about their care as enabled participants requires a non-reductionist philosophy of care to be expressed in nursing practice. Three nurse participants identified that they started with the patient's view rather than focusing on identifying and assessing needs from their professional perspective.

I established that translating the patient's ideas and experience into professional practice poses difficulties for most nurses. In these terms, how nurses conceptualise their roles and those of patients emerged as a key issue in the decision-making process, as Clarke (2001) and Rose (2003) identified.

Prerequisites to empowerment established in the literature included depth of knowledge related to outcomes and alternatives and the promotion of opportunities for patients to exert control or influence (Rowlands 1995, Schulz *et al.* 1995, Clarke 2001). However, in conceptualising their role in practice, nurse participants identified that it was up to individual practitioners whether and to what extent patients were included in the decision-making process. Nurses therefore served as gate-keepers to patient empowerment. Connected to nurses' gate-keeping in practice was the notion that professionals control the agenda in any debate about patient empowerment (Rose 2003). In these terms, nurses hold the gate to the development of sharing power with patients both in arguments about professional development and also in practice.

I found considerable evidence that pointed to how the nurse may exert power and control, for example, by issuing instructions and directing interaction with patients. The examples of control by nurses occurred during the initial encounters of patients and nurses and in single meetings as described at the beginning of this chapter. They were linked to approachability, development of rapport and ambivalence and reciprocity in patient/nurse interaction.

In this chapter I have shown how the participants identified the assets and resources they brought to need/care interaction. I have also shown how the category of Investment is enlightening in terms of the potential of shared meanings and understandings that include the social dimension brought to, and interactive within, patient/nurse interaction.

The further meanings and understandings participants bring to patient/nurse interaction are now examined in chapter 7, Experience. As part of those arguments, I draw upon the understandings about patient/nurse interaction generated through discussion of the category of Investment.

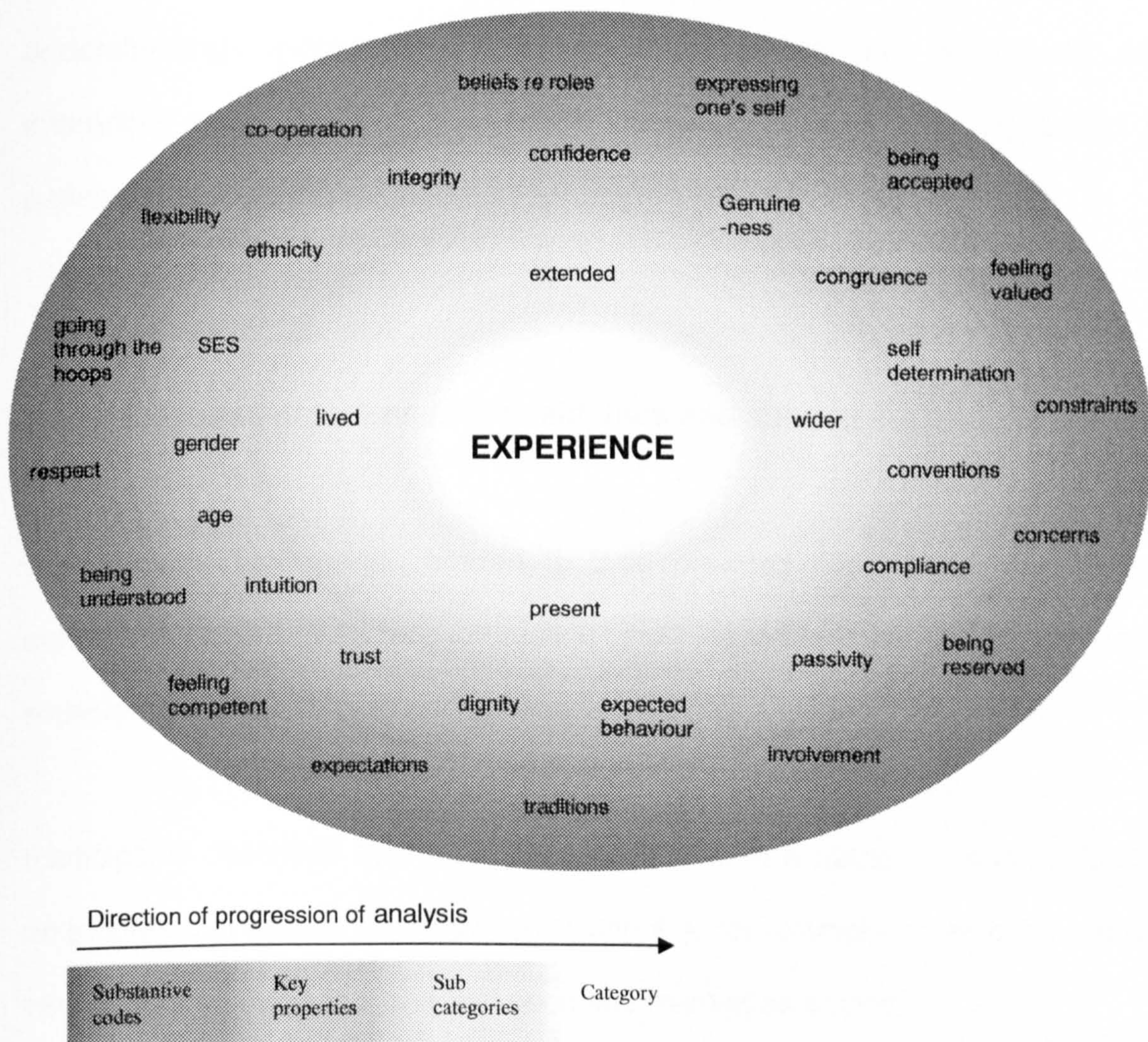
Chapter 7 Experience

The category of Experience is generated from the historically crafted meanings and understandings that individuals bring with them to patient/nurse interaction. People draw upon subjective experiences as they live life, including interaction. Historically crafted meanings and understandings serve as pathways between the past, and performance in interaction in the present. In this way, the past and present meanings and understandings are combined as each individual continually constructs their reality and performs in interaction. The inclusion of the comprehensive narrative of patient and nurse participants is central to examining their meanings and understandings and the influence of socio-cultural characteristics from an interaction perspective. The accounts of my participants included historical and contemporary perspectives on their experiences and I have used their terms to identify the subcategories. This category captures and expresses the depth and texture of experiences of individuals in relation to their social construction of reality. Experience embodies the complexities and dimensions of participants' construction of reality.

I use the subcategories of Experience: extended (7.1), wider (7.2), present (7.3) and lived (7.4) experiences of health care and nursing as illustrated in appendices E 5 - 8, as sections within this chapter.

The key properties and the contribution of the substantive codes are integrated in my discussion. The construction of my substantive theory is also integrated throughout. As before, rather than conserve discussion of issues and gaps in the substantive literature as related to Experience until the conclusion, I have included it throughout the chapter.

Figure 3: category of Experience



I argue that the encounters of those engaged in patient/nurse interaction were imbued with historically crafted meanings and understandings generated from experiences within and beyond the health care setting. The influential and important historical contexts include individual lived experiences and experiences in health care, nursing and other institutions. Those diverse experiences are important influences in performance as, and in the social construction of reality of being, a patient or nurse. Beliefs and expectations regarding power and control in navigation and negotiation are constructed in individuals' *modus operandi* in interaction. I also argue that the socially constructed meanings and understandings related to socio-cultural characteristics are brought to, and interactive within, navigation in health care and nursing and negotiation in patient/nurse interaction.

7.1 Extended experiences of health care and nursing

Patient/nurse participants referred to their previous experiences outwith the context of current need/care interaction and I have identified this as extended experiences of health care and nursing.

Participants described their previous experiences in a range of ways, including anecdotes that related to behaviour. Patient 4, for example, is an older patient who described behaviour she had seen and learned as a child.

Her beliefs about the patient/nurse relationship appeared to be very conventional in terms of accepting the nurse as expert and as in control of the situation:

P4: I was brought up to follow what they told you. You just let them get on with it... they were the experts and of course you wouldn't dream of saying anything unless you were asked.

P4: You were well warned before you went to mind your manners and speak when you were spoken to... the doctors word was almost law... my mother would never have queried anything

Other patient participants identified a compliance with the authority of the doctor and recognised that they tended to transfer this to their current interaction with nurses. These participants all acknowledged that their behaviour was related to the customs and practices they had followed in their youth. As they described it, going to see the doctor was an important social occasion, which they had to manage in terms of how to interact. They commented further that they thought they still behaved in the much same way as they did in the past, for example:

P17: It's habit... you're no wanting to show yourself up ... it's the way I was brought up... you were expected to behave yourself properly when you went to see the doctor or suchlike.

N9: You've got be polite and respectful and tie in with what they say... after all that's what you're there for... they're the ones in the know. We were always brought up to respect people in authority

Clearly, doctors are identified as having considerable social status and are therefore accorded social authority, rather than solely fulfilling a caring role as expert. The evidence supporting this view is extensive in the literature (Turner 1995, Nettleton 1995).

The patient participants deemed it important to present themselves in certain ways or 'properly' and identified appropriate behaviours, mostly related to manners and dress as described in chapter 6. Two patients also considered complying fully with care as an important part of managing their social identity as patient. The participants described that in patient/doctor interaction each played roles, facilitating the other in achieving an acceptable balance of compliance and control respectively. These processes were also used in patient/nurse interaction:

P9: You don't ask them ... they tell you what's best. You're in their hands... I've no doubt they discuss you and sort it out between them [practice nurse and GP] it's important to be a good patient.

In effect, this meant that in these circumstances the nurse controlled patients' behaviour in patient/nurse interaction. The nurse was most influential in the conduct of any meetings and subsequent care management, and the patient would comply. As counterpoint to this, nurse participants expected the patient to be involved in their care to some extent. The involvement nurses expected ranged from asking questions and seeking information, to involvement in decision-making. Four patient participants described behaviour that was passive in need/care interaction. Their role as patient is an expression of belief systems related to their role as patient in patient/nurse interactions learned in the past, and expressed in the present. In Parsons' (1975) seminal terms, the sick role assumes that the individual wishes to regain health and so not only seeks medical help but also co-operates fully with it.

Individuals would perceive co-operation as an obligation and associate it with being a good patient, as P4, P17 and P9 do. In contrast to this, Strauss *et al.* (1985) emphasise that the patient has 'work' to do in terms of taking responsibility for their illness, and health professionals may conceptualise this responsibility as acting appropriately. Acting appropriately relates to who will do what in respect of patient participation in management of their own care. The key issue is role. The patient has responsibility for their own health and well being whilst living their everyday lives, outwith the context of interaction in the health centre. However, a central question arises: how much do individuals as patients delegate their everyday responsibility and how much do nurses assume it in patient/nurse interaction? Negotiation of responsibility is a feature of patient/nurse interaction and the 'division of labour' Strauss *et al.* (1985) conceptualise. Links to concepts of negotiation and empowerment, in particular claims to expertise and 'ownership' discussed in chapter 6 are evident.

Parsons' (1975) and Strauss *et al.* (1985) conceptualisations of the sick role are interesting in a range of ways in the context of my study. The age of participants encompassed the time during which the debate about sick roles, and therefore the role of health care professionals, has unfolded in time from Parsons (1975) to Strauss *et al.* (1985). It can be argued that the links between social change, for example social welfare policy, and changes in health care, for example the divergence in development of the NHS, interact.

Furthermore, social and health care changes interact with changes in attitudes and beliefs expressed in performance as patient or nurse. Viewing the patient as service user and the nurse as independent expert exemplifies this interaction (Schulz *et al.* 1995, Wilkinson 1999).

Needs provide the foundation of interaction between patient/nurse and may be viewed in a range of ways. Needs are mostly related to illness rather than to health and, in the terms of the participants in my study, expectations related to health care continued to be an ambiguous element in patient/nurse interaction. That ambiguity is related to the illness meanings invested in the current need/care encounter. As summarised, older patients in particular described an aspiration to fulfil the role of 'good' patient in the event of ill health, which is redolent of Parsons' (1975) conceptualisation.

Gerhardt (1987) describes perceptions of need expressed in actions by consulting the doctor or nurse, as shaped by the social setting - the community practice setting in my study. In relation to conceptualising the social construction of reality, three patients identified the setting as influential in how they managed their social identities and interacted in the context of need/care interaction. Community practice settings were described by participants as changing considerably over time.

The three patients who identified compliance with the authority of the doctor, noted the changes as the health centre being an approachable, multi-disciplinary environment, however, they continued with the conventions of presentation and performance as patient they had learned in the past. Decisions regarding patient care mostly continued to be viewed as entrenched in the domain of the doctor (Roberts and Krouse 1990, Gwyn and Elwyn 1999). The entrenchment of expertise is extended in the perceptions and beliefs of ten patients regarding those they identified as health experts, principally nurses.

Nurse participants acknowledged the perceptions and definitions of being a 'good' patient by some older people and identified them as influential in creating an imbalance in the patient/nurse relationship. The impact of such imbalance was felt to be in terms of reduced communication and collaboration in patient/nurse interaction. It is evident in my study that the construction of a less active role as patient continued to be embraced by ten patients and six nurses. Some patients preferred a less active role in their care, which was accepted to a lesser extent by nurses:

N16: I know how things have changed. The older generations were brought up to respect authority and do as they were asked with few questions. Some patients are still like that today... despite best efforts

N2: Its quite frustrating really because on one hand you want them to do well, but you do want them to be involved at the same time... you can be too good... its important to discuss the patients concerns rather than work out what they might be.

The feeling of agreement of ten patient participants in my study was 'leave it to the experts'. In Strauss's (1978) terms, the patient should have the option of avoiding involvement in negotiation about their care in relation to decision-making. 'Leaving it to the expert' should be perceived as an alternative mode of action. Nurse participants implied that if a patient is not a 'good' one within the parameters of their professional beliefs, the prospect of developing a therapeutic relationship would be compromised. Important to resolving this compromise is establishing what kind of helping/caring relationship patients and nurses valued. Clarifying this inter-subjective process is central to patients and nurses negotiating their relationship. The feeling of agreement that the patient should be active to some extent in interaction with the nurse was mostly expressed by patients who were younger or by those who had had sustained contact with community health services over the years.

Sustained contact facilitated change in perceptions of responsibility in those who had been brought up with traditional beliefs about the role of patient:

P7: I suppose the whole way of it has changed when you think back over the years... it just happens as time passes. I don't think you're aware of it at the time... it's like everything else... washing machines and colour telly and computers

These issues, of what the patient's role might be, clearly linked to those that arose in discussion of empowerment in the previous chapter, in particular in relation to balance of power. Participants identified that the degree of compliance in patient/nurse interaction had changed in step with major changes in health care provision and with approaches to care and treatment.

Six patient participants made some reference to these changes and a further five expanded on the theme.

Four nurse participants also mentioned their experiences of change in a range of ways, including references to the professional and, to a lesser extent, personal:

N2: Over the years nursing has changed a lot. I can remember when I first started [nursing] there were so many illnesses they could do nothing about... they didn't understand them. Think about all those operations for stomach ulcers! We used to keep people in bed for days and convalescence was such a drawn out process. Nursing was such a slog.

N11: When I was a child it was all very different. I remember going into hospital when I was child and my parents weren't even allowed to stay with me. Hospitals were formal places with strict rules and doctors were gods. When I qualified the approach was very much a pathological one... and nursing used a bio-medical approach. The old *cliché* was true – the patient was an illness not a person. I think it has changed now.

Two older nurses provided the examples above and their reflections characterised considerable changes in health care and nursing in the United Kingdom in the last thirty years. Various references were made to changes in nursing itself. These comments related to the professional careers of nurse participants in terms of changing roles and emerging opportunities, such as practice nursing. N2, N11 and N18 discussed how these issues had been influential in their approach to nursing and patient care and provided different perspectives, principally about how the patient had been regarded:

N11: I think it has mattered a great deal to me how things have changed. It is important that things have moved on. There is much better understanding of who the whole patient is rather than just what's up with them... and only looking at problems. The whole emphasis has changed to community care and that is a good thing

N2: When people talk about the good old days they forget just how bad things could be... things like not knowing what was going on or being asked... you certainly were not a client... and as a nurse, the same was true half the time.

N18: Older patients can remember the old days and that has a lot to do with how they react when they are ill or need some care. I'm sure they sometimes don't understand and want to be fixed... whatever is wrong with them sorted.

Despite the assertions by these nurse participants that things have changed in a range of ways, it could be that they were promoting the ideals of practice rather than accurately describing change. The evidence persists in the literature that the patient is often viewed as presenting as problematic from a bio-medical perspective (Takman and Severinsson 1999). Peterson (1988) notes that providing physical care often dominates patient/nurse interaction. Hewison (1995) also identifies the prevalence of routinised task related care.

Nurse participants provided perspectives on how approaches to care and management had evolved:

N8: Nursing and medicine are obviously very different today, in fact even since I was born... my mother was in hospital for seven days when she had me! I have always found a tension between using a holistic approach and what patients expect. They look to your skill and expertise and seem perplexed sometimes when you widen your assessment [beyond the physical].

N18: I do approach care from a holistic perspective... some patients, usually older ones want to concentrate on the physical problem... usually more than I do!

The inclusion of psychosocial aspects in assessment was the prevalent feature included by nurses in their conceptualisation of contemporary care. Their conceptualisation related well to patient participants' identification of nursing as being more than just physical care. Irurita and Williams (2001:581) identify that 'the state of being whole' is linked to preservation of integrity. Participants expressed the view that experiences in health care would be diminished if patients were not viewed as a whole person. Whilst four nurse participants expanded on issues of development and change, as shown in the previous examples, the points they raised were also identified to a lesser extent by the other nurse participants. This suggests the approach to caring by nurses may be different from that expected by patients. Those patients are likely to be older and familiar with historical, traditional bio-medical models of care, as a reflection of their life experiences, which have influenced their expectations of what nursing is. My arguments are supported by previous work which found that patients placed more importance upon nursing skills related to tasks, rather than interpersonal aspects of care that included a holistic approach (Larson and Ferketich 1993, von Essen and Sjoden 1991, Greenhalgh *et al.* 1998). Related issues are those which arose in chapter 6, in particular the terms of engagement of the patient/nurse in their interaction, including concepts of empowerment.

In the terms of the nurses just cited, whose approach to care went beyond bio-medical matters, a tension between their approach and patients' understanding of nursing and health care is identified:

P1: Well I suppose it is different now... years ago when you went to the doctor or if the nurse came they sorted out what was wrong with you... like when I had my operation years ago. Now they're interested in all the rest as well... like how you are in yourself and that.

P11: I haven't seen the doctor for years... I didn't even realise they had practice nurses... took me a while to understand what her drift was [role and approach]. I suppose I thought the doc would give me some tablets and keep an eye on it [hypertension] ... but she asks me all sorts about lifestyle and all that. She does more than just check it like I thought she would... she takes her time... very good

In need/care interactions, nurses' interpretation of nursing 'the whole person' commonly prevailed over patients with expectations of a bio-medical approach to caring. The accomplishment of nurse participants seemed to be to win patients over to their approach to caring, rather than it being explicitly explained to them and agreement established. In other words, patients generally 'caught the drift' through co-operating in patient/nurse interactions as P11 did.

Patient participants mentioned experiences of health in broader terms. They referred to changes in the health service, including health and care in the community:

P15: I think its much better now... you used to worry about going to the doctor... it was a big event, nerve racking in fact... you only went if you were really poorly. Nurses never came into it much. Our doctor years ago was a bit fierce... he used to look over his specs at you.

Now you feel like it's for you [health centre] and no like you're out of place. The nurse does some things and the doctor does other things... they listen now

This patient's comments relate to issues of empowerment. In the example, the patient makes it clear that fifty years ago the GP had been perceived as a powerful individual who controlled not only the interaction, but also the patient's response in the event of illness. The principal response was lack of confidence to present oneself for medical consultation. P15 expanded on this and she believed that the doctor had to be almost persuaded that you were ill and worthy of attention. Importantly, being listened to is identified as critical to the consultation process. Bury (2001:268) sums this up thus:

Patients' illness narratives, once almost silenced by a paternalistic if not overtly authoritarian medicine, suddenly find a new voice.

Whilst P15 expressed this view most fully, seven other patients commented in similar vein to a lesser extent. They felt attended to and that they could more readily voice their views and concerns. In the environment of the health centre, with doctor or nurse, they felt valued as individuals and as participants:

P4: She's a genuine lassie... puts up with my stories and moans and groans... she doesn't make me feel like a silly old fool

P8: We work things out... even if it's a daft thing. I like the way they remember you... and relax you really

N5: This place is for everyone, for patients... it has to be a comfortable place to come for all of us... that's its purpose

As in these examples, it was important to patients to feel that they could express themselves without pressure and in comfort, and nurses welcomed that.

Although four nurses can be described clearly as formal in approach, the patients they had formed a relationship with felt initiating a discussion of any concerns would be well received. Interestingly, the two patients just cited [P4 and P8] identified that it is important that, in addition to listening, nurses also accepted that patients needed to tell their story without feeling 'silly' or 'daft'. In terms of confidence and trust, this related to patients' concerns about preservation of integrity and the importance placed upon behaving appropriately and being accepted.

The terms 'genuine' and 'sincere' were used by eleven of my patient participants when describing practice nurses, for example:

P6: It matters that you feel that there is complete openness... nothing hidden... otherwise you couldn't trust in what was going on... it's mutual of course

P2: I wasn't sure at first... you have to get over that hurdle of feeling scanned like I said... but once I was in I felt she genuinely understood what I said and how I felt about having it done... and I felt quite a bit better

Patients valued genuineness in interaction with nurses. Genuineness is linked to approachability and associated feelings of openness, which were considered important. A sense of mutual understanding between patient/nurse of being genuine is related to trust as part of the negotiation of their relationship. It can be surmised that a lack of genuineness will jeopardise trust in the patient/nurse relationship.

Nortvedt (2001) and Widang and Fridlund (2003) argue that trust is central in a patient/nurse relationship that places the patients' concerns at the centre. Nurses recognised the relationship between genuineness and trust and they all mentioned it in one way or another, for example:

N3: Patients need to know that you are sincere in what you say and do otherwise how can they trust you...
... and if they don't trust you then you've failed. I think patients pick it up when you don't mean what you say and say what you mean

N17: It's not a question of not telling them something... it's a question of them believing you mean what you say... like saying you accept what they say or understand

Taking into account their personal diversity, patients and nurses felt genuineness to be part of the foundation of their relationship and linked it to trust. Burnard (1992:73) recognises the importance of genuineness in the caring relationship, and cautions against 'fake interest'. The nurse participants made the connection that understanding between them and their patients would be compromised by lack of trust. Additionally, patients were sensitive to any prospect that their voice would not be heard and valued.

In summary, my participants linked their experiences in health care in the past to experiences in the present day. In doing so they referred to changes in health care, nursing and the roles of patients and nurses. Older patients in particular identified that complying with the authority of the doctor remained part of their social identity as a patient.

Nurse participants recognised that a patient's emphasis upon the 'expert' 'knowing best' created a power imbalance in their relationship. Patient/nurse participants provided a range of views and beliefs about their respective roles in a therapeutic relationship.

It emerged from participants' accounts of changes in health and nursing that experiences in, and understandings of, need/care interaction and health care should be contextualised in terms of individuals' social identity and experiences. Finally, the therapeutic patient/nurse relationship is underpinned by trust. The nurse being genuine is a prerequisite in a therapeutic patient/nurse relationship in which the patients' concerns were at the centre.

7.2 Wider experiences of health care and nursing

This subcategory emerged from four patient participants referring specifically to experiences they had had with other institutions including the Department of Social Security (DSS) or Social Work (SWD) and I have identified this as extended experiences of health care and nursing. Three other participants also referred to experiences related to interaction with other professionals, in particular social workers. These home based experiences are addressed in 7.2.1 followed by discussion of institutional related experiences in 7.2.2.

7.2.1 Home based experiences

The experiences of P7, P15 and P1 related to home visits by social workers as part of assessment processes related to social needs. All three identified that these needs were home based and related to the support services of the SWD. All three had home help. In addition, P1 received meals on wheels every 3rd week when her daughter worked night shifts. These three patients were attending the health centre regularly to see the practice nurse with ongoing care needs. These participants all described their initial reluctance to accept help counterbalanced by the fact that they could not cope with certain activities in the home:

P7: The nurse was worried about me coping and suggested I might like a bit of help at home. Of course, I did'nae like the idea that I couldn't manage myself. I can do the every day things... make the bed and dust and that... its the heavier work.

What seemed to tip the balance in favour of accepting help was the desire to maintain their homes to an accustomed and acceptable standard. All three expressed concern about keeping up appearances and 'not letting things go':

P1: I don't want to let things go and the place end up in state... I always kept it nice... I can't stand it not being right. I've always been proud of keeping a nice home for the family... it matters...

P15: Folk of my generation were raised that way... the home was the centre of your family... you know... the hearth. Folk could tell what kind of family you were by what home you came from... we were always well kent [known] as respectable.

These views related to the customs and traditions they had maintained throughout their lives.

Keeping up appearances in the home was an important aspect of their social presentation and expressions of personal values, in this case the importance of respectability. Respectability in this context referred to living standards that could be recognised by others as conventional. Conventions included a home being recognised as such, and standards of cleanliness. A further aspect of social presentation is the link between home and the individual. The prospect was that you were judged on the home you came from, and the home made the person. The implication made was that you could surmise what a person might be like according to what home and family they came from. These meanings and understandings related to social interaction in terms of 'placing' someone according to his or her environment, in addition to other factors. Popay *et al.* (2003:4) argue that individuals understand their social experiences with special reference to 'place' or community, the social construction of reality in Berger and Luckmann's (1967) conceptualisation. The importance of 'placing' someone was mentioned by, or alluded to, by thirty-one participants in connecting home and wider experiences in health care and nursing.

P7 and P1 stated that they felt it would be the 'beginning of the end' if they could not achieve desirable living standards and expressed the anxiety they felt about the consequences of not managing at home. Managing was in the context of housekeeping matters in addition to health needs. The 'end' meant institutional care of some type, nursing home or residential care:

P7: It goes through your mind... if you can't cope – you'll end up in a home. There's no way I could take that... life wouldn't be worth the living... it would be over

P1: I hope the day never comes that I can't stay at home... it would mean you were useless, done. I know there are nice places, but I'll manage here

Independence is the central concern of the patient participants. Their beliefs were that independence is dependent upon remaining at home. These beliefs permitted them to accept support at home as a requisite of independence, in effect a necessary evil. The concerns expressed by Hockey and James (2003) and Larsson (1999) regarding generalisations about increased care needs in older age and 'problematizing' it, are evident in the views and understandings of P7, P15 and P1. The three patient participants identified that, for them, it was a very significant event to be referred to the social work department for home assessment. The significance was in relation to an outsider coming into their home to look and ask questions related to their welfare. They expressed concern that their independence and dignity seemed to be in the balance. Dignity in this context related to concerns about loss of self-determination. Self-determination and independence were linked in the meanings they applied to social care. Widang and Fridlund (2003) find that self-respect is central to personal confidence and feeling secure. Self-respect and confidence were primary concerns in the self-determination of the three participants cited in this section. The three participants felt that the home assessment was some kind of test to be passed. Dignity and confidence would be lost if they didn't measure up in some way.

A sense of obligation to the nurse by the patients emerged however, which led to their co-operation in the assessment arranged for organising home help. In other words, having agreed that they needed support, they would follow it through:

P1: Its no easy being asked if you could do with some help... the nurse said she could get someone from the social to call. I'm grateful for her concern... of course she understands how I feel... says I should be resting my leg and being careful... so I've got to go by what she says

The terms of referral were important to accepting assessment and subsequent provision of help. The participants valued independence and knew they had to accept support to sustain it. In the example cited, P1, the patient was pleased to acknowledge the health benefits the nurse used to support her suggestion. She also wanted, in the terms of her definition, to be a 'good' patient and follow recommendations for her welfare. Continuing contact with the nurse was an important part of patients' acceptance of help at home coupled with the fact that they felt consulted and satisfied with the arrangements made. I surmise that the emphasis on health benefits by this patient helped her to come to terms with accepting help in the home. The patient trusted the nurse, and continuity of care and their relationship, was important to her. The patient developed trust in the process of referral, which in her terms embedded the nurse in her social support network. The nurse's expertise was extended from skills and procedures to the domain of social care. In the patient's eyes, care had extended from the natural practice setting of need/care interaction, and diffused into the social setting.

The patients described resultant depth and strength in their relationship with the nurse. This re-negotiation of their relationship had an impact on patient/nurse interaction, in particular the patient's sense of participation and empowerment:

N11: It's never easy suggesting that someone needs help at home without implying that someone won't manage... but you have to do it and try to be as positive as possible... I always emphasise the positive side of it all like with [as with P1].

The inclusion of positive aspects of any support accepted, ameliorated the sense of inability to cope with all the attendant concerns previously outlined. The nurse participants concerned with these three patients mentioned the importance of emphasising positive aspects as illustrated in the example given. Accepting the principle of needing help in the home as a positive measure aided participation in the process of assessment.

All three of the patient participants noted that they were asked a lot of questions during their home assessment, which they answered as part of the agreement, in other words meeting their obligations:

P7: I was asked lots of questions... and I answered best I could... she was just trying to work out what the problems were and see what they could do for me... I got one for two hours a week and it makes a difference... it still doesn't feel right someone doing my work, she does it different.

One participant mentioned that she was very pleased that the assessor wasn't a social worker:

P15: I thought it was a social worker that would come and I wasn't too keen on that... they can do all sorts... she might have said I should go into a home... they can do that you know. A co-ordinator about the home help came so that was all right.

Superimposed on issues of loss of independence and dignity, were concerns regarding the role of social workers in relation to the organisation of social care. The patient participants viewed social workers as the adjudicators between independence and institutional care (residential care or nursing home), by drawing on anecdotal evidence mostly from their peers:

P1: Well I wasn't too sure... thought I'd be careful what I said I didn't want her thinking I couldn't cope at all. Maybe then she would've got carried away and think I shouldn't be at home

The participants anticipated that evaluation might allude to where they should receive care rather than what support they required at home. These concerns were dispelled by the explanations of the home help co-ordinator at the time of the visit and subsequently by each patient's nurse. Importantly, retaining independence was uppermost in the participants' minds partnered with concern about the outcome of being assessed. In Strauss's (1978:238) terms, the stakes in the negotiation of help in the home are high for the patients, their construction of independence is at risk. Furthermore, in relation to concerns about assessment, social workers seemed to represent powerful social structures beyond the participants' experience, understanding or control. Conversely, these participants did not suggest that they saw nurses in the same way, and this is supported by the views they expressed about valuing continuity of their relationship with them. The patient participants believed social workers to be powerful in terms of access to support and in the determination of their future. Despite these feelings, they all participated in the assessment process as, for them, the positive outweighed the negative.

The participants accepted that social support as described would be important to remaining able to live in their own home. Bauld *et al.* (2000:321) highlight a main issue in older persons' satisfaction with home based social services:

The nature of social care means that relationships between users, carers and workers are an important component of the user's experience of services, much more so than in health care settings.

Much of the literature supports the view that the quality of care services supporting an individual in the home is linked to quality of life and therefore perceived as of primary importance (Nocon and Qureshi, 1996, Carr-Hill, 1995). Sustained and continued experiences of the health centre services, in particular nursing, may make a further contribution to quality of life, as my participants suggested by valuing continued relationships with the nurse.

It must be acknowledged that only a small number of patients expanded upon wider experiences. However, they presented extensive accounts of their experience. In addition to this, they all expressed largely positive views. The importance and value they placed upon the nurse's involvement was significant to the experiences they described. In light of the impact on patient/nurse interaction, the issue of the extension and diffusion of nurses' practice deserves considerably more research attention as part of the social dimension of understanding wider experiences of health and social care.

7.2.2 Institutional experiences

Four patient participants P11 P13 P17 and P8 referred specifically to experiences they had had in other institutions including the Department of Social Security (DSS) or Social Work (SWD). These references were made during interviews and emerged around the issue of knowing what to do as *modus operandi* in the health centre when meeting the nurse and in need/care interaction. The references of these participants followed on from comments about formality/informality and developing rapport in particular. They described the rituals they felt obliged to follow if they were to achieve the purpose of their visit to either DSS or SWD:

P11: Its like take a number ... like at the counter in Tesco ... wait your turn, go where you're telt ... dae what you're telt ... an away.

P13: You have to just go through the hoops or you'll get nowhere... they've got a way of working ... you fit in ... get the business done, that's it

The participants believed that certain behaviours were appropriate in similar settings. They identified similar settings as including DSS, SWD and the Health Centre in which you presented with actual or potential needs. Whilst they identified that systems related to basic organisation were essential, for example, to avoid queue jumping, they felt a sense of resignation about going through pre-determined hoops. What you did and how you did it was not open to negotiation. The participants all expressed difficulties with this in a range of ways. In particular, they disliked 'being a number' and having to 'go along with it'.

In other settings it appeared to them to be realistic and appropriate to expect a degree of flexibility and to share courtesy. The example of good practice cited by two patients was their local library.

Four participants identified that it is reasonable to be asked to 'sit down there' or 'go there', especially if you were a novice in such a place as the DSS. However, the key issue seemed to be that you would probably be left to pick up clues from others and copy what others did:

P17: I didn't have a clue what to do... couldn't really make head nor tail of it. Eventually I could see some were waiting to have forms checked, some were being called... eventually I worked out that folk at one side were waiting to make inquiries like me... so I moved and sat at the end... there was no sign up. I was there for two hours... nothing you could do... everyone was busy.

The participant above describes clearly the process of working out what to do in an unfamiliar setting, as did others. In order to navigate their way through the unfamiliar, they drew on wider experiences, a process that served them only to a limited extent. The key issue that perplexed them was the lack of signposts, which they expected to be there by custom and practice as in other settings, such as the library. These signposts were not only the physical, for example, lack of inquiry signs, but also lack of human communication. They missed the opportunity to interact face to face. The participants noted that there often seemed to be a lack of social engagement with fellow clients and staff in DSS and SWD.

In effect, the lack of information and supportive actions, for example, effective signposts or human communication, hindered individuals' opportunities to problem solve by drawing on experience and insights. The alternative, and available, action was to be passive and compliant in a process over which they felt they had little control, as clues to aid *modus operandi* were largely concealed (Strauss 1978:242). The understandings generated by the experiences described contributed to participants' beliefs about their competence in institutional settings and the control that could be exerted in settings that they identified as similar, such as the health centre. Beliefs about parameters of personal control were related to the individual's experiences and beliefs about how to navigate in an institutional setting. These beliefs were influenced by individual interpretations of how to behave conventionally, 'going through the hoops' as my participant put it.

Berger and Luckmann (1967) propose that individuals navigate in the social world by identifying and typifying recognisable patterns of activity. By this process, individuals can predict how their activities will be evaluated and reacted to by others. Berger and Luckmann (1967:47) argue that:

The social reality of everyday life is thus apprehended in a continuum of typifications, which are progressively anonymous as they are removed from the 'here and now' of the face-to-face situation.

How individuals have 'apprehended' interaction in a range of places contributed to the complexity of patient/nurse interaction. The experiences identified in the accounts of my four patient participants support my argument. They had had considerable experience in other institutions, namely DSS and SWD. None mentioned experiences in other health care institutions, for example, out-patient departments in hospital. Other patient participants did not identify experiences in other institutions in any detail and had different ways of engaging in the processes of interaction in the health centre and with the practice nurses. These ways of engaging emerged from beliefs about the roles of patient/nurse and are discussed elsewhere.

The health centre environment was identified as different from others as more facilitative than other settings to interact in. In addition to this, the wider experiences and resources participants brought to patient/nurse interaction were diverse. In relation to participation in complex social settings, Lave and Wenger (1991:47) note that:

the production, transformation and change in the identities of persons, knowledgeable skill in practice, and communities of practice are realised in the lived in world of engagement in everyday activity.

Identity is constructed through negotiation of meanings in interaction, which are generated and sustained through diverse experiences in social settings, as the lived experiences of individuals described in this section suggested.

Seven patient participants in my study had navigated their way through these processes at home and in institutions. In terms of interaction between client and institution, these institutions were structured by discourses of power and participation related to individuals. The meanings patient participants had generated were expressed in interaction with a practice nurse in the health centre as described.

Patient participants felt that at times their sense of self was undermined. One patient participant used the term 'diminished' in relation to being a number [P11] 'like at the counter in Tesco'. The sense of being undermined or diminished was particularly true of those who described the encounters significant to them outwith the health centre. The significance of these encounters was both the link between the reason for the visit, for example seeking benefits, and the effect the adherent navigation processes had on them. The demands and challenges of organisational structures and processes compromised their sense of self-determination. Coyle (1999) describes similar processes in relation to the meaning of dissatisfaction with health care. In her grounded theory study, she identifies concepts related to experiences described as 'disempowering, dehumanising and devaluing'. The meanings identified by Coyle can be extended to include the diverse encounters and experiences individuals have in other institutions as service users.

The inclusion of these meanings is important to understanding the generation and construction of meanings in situated interaction, especially by the patient in a health care setting. My findings suggest that those more complex social meanings are substantially embedded in the negotiation of patient/nurse interaction. Consideration of those more complex social meanings expands understanding of patient/nurse interaction.

Nurse participants did not include the meanings identified by patient participants in their accounts; however, they did include reminiscences of nursing including their own personal and professional experience. They shared aspects of identity in the present as practice nurse. These identities had layers related to their personal characteristics and background expressed in the style of their professional practice and interaction. Those layers included the encounters and experiences they had had in diverse health care settings, especially in acute hospitals. These layers were under-examined for several reasons. The nurse participants did not go beyond essentially superficial reflective accounts of past and present practice, although some included experiences prior to becoming a nurse, as cited in this section.

7.3 Present experiences of health care and nursing

In discussing their present experiences, participants revealed how they created and sustained meanings and understandings of health care and nursing by talking about their changing expectations and beliefs and relating them to the present day.

I identified in 3.2 that subjective meanings and understandings are brought to performance in interaction (Garfinkel 1967). In relation to this perspective, Plummer (2001:39) identifies that meanings emerge in local contexts and situations through interaction with others, and wider historical understandings are drawn upon to do so. Plummer (2001) relates the emergence of meanings to Garfinkel's conceptualisation of achievements in every day life in which meanings are created and sustained in performance in interaction. For my participants, creating and sustaining meanings and understandings emerged in, and of, interaction as it took place, as Garfinkel (1967) proposed. In the process of creating meaning within interaction, patients and nurses draw upon the past to perform in the present – an evolutionary process in which the past articulates with the present. In this process, some past meanings are sustained and new meanings are created about how to perform in interaction.

Patient participants identified the differences between attending a doctor's surgery in the past, and attending a health centre now. Their expectations and beliefs have or are changing as a consequence of their contemporary experiences. The health centre has in their view become accessible and responsive to those it serves, principally by the diminishing of the paternalistic and authoritarian care environment:

P9: It's daft when you think about it... only going to the health centre when you're ill... its not called the illness centre. Years ago health didn't come into it much at all... as they say, the future of the community depends on health. At least now, things are more open... like mental health. Nurses have much more to do now... they're trained for it ... they work along side other people like the doctor rather than separate.

Comments such as those above represented a largely positive view of changes in community health care, and identify what were seen as positive aspects of the evolving role of the practice nurse and changes in that of the general practitioner. In consideration of negotiation of working practices related to social processes of interaction between nurses and doctors, several aspects of the literature contribute. In particular, Allen (1997) and Svensson (1996) articulate the nature of these evolving roles in relation to each other as a blurring process. The blurring process is in terms of who does what in a division of 'caring' labour as the role and expertise of the nurse extends. The blurring of roles has implications for the patient in terms of understanding interaction with individuals with a range of professional expertise in the health centre. Porter (1992) finds that nurses are becoming more assertive in their relationships with doctors.

Considering this, Porter further suggests that a more positive view of their extending caring role is linked to negotiation of wider nursing practices. Some of the tasks/practices formerly the doctors', for example, women's health screening, are now the nurses'.

Wiles (1997) notes that patients find practice nurses knowledgeable, skilled, accessible and approachable. However, Wiles also finds a range of patient views regarding expertise in the health centre, in particular that patients might be confused by what expertise is and with whom it lies. These views were explicitly echoed by five patient participants whilst others (as in Wiles's study) were won over by the competence of practice nurses:

P6: I wasn't sure at first... I was used to the doctor monitoring me. But I got used to the nurse and she knows how to adjust things and we sort them out [blood glucose levels]

P13: Its just that you're used to something else... the doctor always sent for you and checked you over and did the [cervical] smear. The nurse does it now and it's just the same... no bother

Three patients stated that they would rather see a doctor in circumstances where a medical condition was subject to regular review, for example, diabetes mellitus. Phillips and Brooks (1998) and Coyle *et al.* (1993) find that patients such as these, and those who require specific advice regarding their health, would rather consult their GP:

P2: I just have more confidence ... I prefer medical advice and expertise

P7: I don't doubt her proficiency in lots of ways... I'm used to dealing with the doctor ... I just believe the doctor is the best person in my circumstances

Bury (2001) observes that views such as these do not necessarily express an adherence by patients to a reductionist bio-medical approach, or to hierarchical notions that the services and person of the doctor are superior to those of nurses. Rather, these views may represent a sense of security generated by familiarity with the doctor as provider of care. In my study, it appeared to be a reflection and acknowledgement of an increased emphasis on patient based care in general practice, linked to being listened to: a feature of empowerment. A further feature of empowerment was contributing in patient/nurse interaction. Pooley *et al.* (2001:324) observe that being able to talk is as important as feeling listened to.

Circumstances do prevail where traditional caring relationships are found appropriate following a process of negotiation in which the patient's views and preferences are accepted, as in my previous examples. Patient participants also made specific comments that referred to changes in the way care is provided and by whom, such as practice nurses in the health centre and the roles they fulfil. The differences mentioned included 'well woman' work and health promotion:

P18: I was quite taken aback at all that was going on... I only come in now and then to get my jabs updated [immunisation] if I'm travelling. I didn't know there was such a thing as a well man clinic! I suppose I've always been used to going to a health centre only if you were ill

Amongst those who had not seen a practice nurse before, there was lack of awareness as to the extent and range of expertise that they had. It follows that patients might therefore not be aware of the change in roles and expertise of others, in particular GPs. Additionally, there was a lack of awareness of the range of services the health centre provided. These services included health promotion clinics. My findings harmonise with those of Phillips and Brooks (1998) who also find that patients valued practice nurses highly when they had seen them on previous occasions and had been satisfied with their care. For my participants, satisfaction was most explicitly related to experiences in well women clinics. I did not observe or interview at these clinics, apart from interviewing one woman who returned to see the nurse for different reasons. This was in due consideration of the sensitive and intimate nature of such consultations and examinations.

Further reminiscences by patients included change of roles, such as that previously described, and expansion of services in the community health setting and technological developments. Further comments were made about keeping healthy today and how different care management was. Comments related to care management were mostly made by patients who were at least over thirty-five. The expressed view of fourteen patient participants was that health care was or should be about health rather than addressing illness, which is congruent with two key objectives of contemporary social policy, promoting health and combating inequalities in health (Blamey *et al.* 2002).

7.4 Lived experiences of health care and nursing

In addition to extended, wider and present experiences, the diverse experiences and resources of patients and nurses included the dimensions of age, gender, SES and ethnicity. The literature is extensive regarding the influence of each upon the experience of health and illness, including situated and wider interaction. Bradley (1996) views age, gender, SES and ethnicity as interacting dynamics and as part of lived sets of social relationships. Her views are particularly influential in examining the lived experiences of patients and nurses.

In chapter 6, some reference was made to age, gender, SES and ethnicity in terms of how participants attempted to locate each other in the social world as part of negotiating their relationship. Embodiment emerged as a further dimension of lived experiences. It was included in the accounts of ten patients and twelve nurses exemplified thus:

P17: You're aware of how you look when you come in here... every picture tells a story... your age, what you're wearing... if you look fit. I think you are conscious of your body here, that's what's going to be looked at... that's my shop window

P6: You can come over as well in yourself... depends how you handle yourself and how self-conscious you are I suppose

P4: I feel decrepit... and look it... a fat old woman that's what you see first when you look at me

N12: Sometimes the way I look is the way I feel... tired and so on. The mind's willing but the body's weak. The same is true of patients... being uncomfortable or in pain

These examples include reference to, and link with, physical and emotional embodiment. The meaning participants emphasised was vulnerability in relation to health and self-evaluation. Some further links were made between embodiment and self-esteem. Embodiment was referred to most specifically in relation to older age. Taking into account that age, gender, SES and ethnicity have been referred to throughout chapter 6, each of them are discussed separately in this section in order to achieve clarity of presentation. These discussions are followed by an overview of these factors as dynamic.

7.4.1 Lived experiences and age

Participants noted the age of each other in the weighing up process. Almost all comments related to age were about older age and the implicit message seemed to be that younger age is taken for granted in a range of ways, including health. Wider comments about age were related to assessment of normal parameters in clinical assessment, for example, blood pressure. It was also related to older age and independence with a sense of being 'special' attached to those circumstances. Nurse participants positively endorsed these circumstances whilst patient participants welcomed them as a source of pride and satisfaction.

Loss of independence is regarded as a critical factor in lived experiences. The nature of this critical factor is quality of life related to change and to the ageing process:

N6: Independence in older age is something to be applauded of course... some patients do need support but sometimes they see that as frustrating and difficult

P1: I try not to be pessimistic but if you're no independent, you lose something you're used to all your life. I've got used to having a bit of help and it makes a difference... just so long as I can manage... that's all that matters

Being seen as different and needing support linked to older age was seen as increasingly important to patients and nurses. Nurses explicitly prioritised it and patients were aware of it in need/care interaction. Issues of quality of life related to changes in social circumstances and included transformation in role of patient and of nurse:

P4: Well... when you get older, you expect to slow down and maybe have some problems like I do. It makes things different... as they say old age doesn't come itself and I'm glad it's taken into account

N16: Assessment of the elderly is important to identify any potential or emerging problems early... its not that you anticipate there will be problems, but just in case...

That transformation in role is apparent in need/care interaction in a range of ways. Seven patients who were over 65, mentioned awareness of older age in the context of potential or actual needs and the possible implications of growing older, as previously discussed. Nurse participants identified that considering age became central to their patient assessment and approach to care with older patients, although they used the stereotypical term 'the elderly'.

Patient/nurse participants were alert to the possibility that growing older could disrupt everyday life. The representation of age as hazard can be placed within Foucault's (1979, 1980) conceptualisation of surveillance and control which refers to watching out for the occurrence of deficits and attempting to control them. Representation of age as hazard is consistent with the bleak view of growing older Chater (1999) discusses.

In relation to meanings attached to older age, Woodward (1991:18) conceives that:

We cannot detach the body in decline from the meanings we attach to old age.

Growing older may be associated with concerns about the supposed inevitability of physical frailty. The patients discussed in 7.2 identified these concerns clearly. Whilst none of my participants stated explicitly that frailty is inevitable, they conveyed that advancing age is not only embodied, but also linked to social identity as Chater (1999) argues. Age is part of social identity and as the body changes with age, so identity is transformed. Hockey and James (2003) argue that identity is transformed in a range of ways, as one grows older. Instead of a 'life cycle' approach, Hockey and James (2003:5) advise that ageing is a:

social as well as physical process which is infinitely varied and variable.

Viewing ageing as a social process challenges the generalisations in the social construction of 'ageing identities' highlighted in the literature (Arber and Ginn 1995, Chater 1999, Hockey and James 2003). The increase in surveillance and control by nurses of older people contributes to the diminishing of the existing social identity of a person and the generation of a new one. Three patient participants described this sense of feeling diminished, including the embodiment of age thus:

P14: As you get older you are self conscious of it... you are important to your family of course but I suspect that's all... the world is a different place now and it doesn't seem like my world... its changed and I've changed. I'm slower and greyer

P9: When you retire you've done your bit and most think you're past it... I know fine that sometimes folk think that... because you're not rushing about like you used to and doing different things... pottering

P10: It infuriates me that on occasion people treat you differently because you are older, look older. I consider myself entirely capable and useful...

Interestingly, older patient participants themselves linked the embodiment of age with the sense of feeling diminished. The sense of being diminished might lead to those who are older being, and feeling, less valued, as P10 contributed, in terms of 'usefulness'. Some participants had experienced negative stereotyping of ageism although none expanded upon this issue, beyond linking being called a 'pensioner' and usefulness.

To a greater or lesser extent, all of the older patient participants identified in this section conveyed self-consciousness about growing older. Their self-consciousness was related directly to the embodiment of ageing. They commented upon 'looking older' being 'less able' and 'feeling older'. P1, P4 and N15 made comparisons between how they used be and their present sense of self in these terms. In addition to references to independence and feeling valued, associations were made with attractiveness:

P1: I don't bother so much now...I don't want to look like mutton dressed up as lamb... some do

P4: All these wrinkles and saggy bits... you wouldn't look twice at me now... plenty used to mind, I've had my day!

N15: I like to look smart and make an effort to look my best. You have to make the most you can of yourself and take a pride in your appearance... you owe it to yourself

Further links were made to looking appropriate for age, a further reference to age and embodiment. The participants cited also articulated how they have experienced their bodies in the process of adaptation to growing older as embodiment. Fairhurst (1998:272), links the tension between 'growing old gracefully' and 'mutton dressed as lamb' to physical and sexual attractiveness, and identifies that they are related to the meanings conferred upon growing older. The participants' views were broadly similar to this, however, they also suggested ageing to be a constraint upon continuity of social experiences, which presented an additional meaning.

7.4.2 Lived experiences and gender

Patient participants were not surprised on the whole to find that the practice nurse was female:

P10: I know there are men in nursing... my wife says that nurses here are female because of all the women's stuff they do... nurses are mainly women anyway... I think they should be... seems more natural

Eight further patient participants specifically commented that they thought nurses should be female. The construction of nursing as caring and gendered as female is a consistent finding in the literature (Staden 1998, Crowe 2000).

P17: Well, women are carers... that's what they do... children, family and that... its only natural that they should be nurses

Caring was seen as a 'natural' attribute of being female. The dominant meaning presented by patient participants was in relation to caring as female behaviour and 'womens' work'. Women's work was associated with home based activities of caring for children and others. Nursing itself identifies caring as the primary task of the nurse with associated discourses of nurturing, caring for and helping others and emotional work (Smith 1992, Staden 1998, Poole and Isaacs, 1997).

N8: Patients expect you to be female I think... especially in the community because they know you are involved with the whole family... you've got the experience that matches up with the job... I'd say you need to be female for most of it. I wouldn't say men can't do it but lots of nursing is female

The gendered construction of nursing and caring may be maintained and reproduced by the (conventional) expectations of patients and nurses, for example, linking female, nursing and family as a natural social phenomenon.

The participants in my study included reference to these issues in their views on gender and nursing. The other patient participants seemed to be ambivalent about the gender of the nurse. As previously discussed, they linked the role of nurse to knowledge and expertise, whilst acknowledging that they considered some aspects of practice would be best served by a female, in particular, intimate procedures:

P2: Examinations like that [cervical smear] are very intimate and you do feel exposed. I much prefer a female doing it, nurse or doctor... I would feel very self-conscious and flustered if it was a man.

This expression of preference in relation to same gender of the nurse is well supported by previous studies (Coyle *et al.* 1993, Brooks and Phillips 1996, Kerssens *et al.* 1997). My findings were clear that most women prefer nurses to be female for matters concerning gynaecological and reproductive health in particular.

Nurse participants encountered a wide range of different people in their practice. In their comments about this, they most often linked gender and age. Twelve of them commented upon their expectations that a significant number of their patients who required on-going care would be older and female. Twelve nurse participants connected age and gender as central experiences of older age. Only two made links to the connections of lived social experiences of age and gender in Arber and Ginn's (1995) terms. Encountering older women with health care needs with whom they would have considerable interaction was anticipated by nurses:

N2: Its ironic really... women care all of their lives, for kids and husbands and older relatives even... no wonder they say they're done [weary] sometimes.

N9: I see more elderly women than men... I suppose their wives are looking after them at home. A lot of the elderly ladies I see are by themselves... they don't have someone at home to help them or look after them. Its often the case that women are the ones who do that for others... and then they're left alone of course

Nurses anticipated that they would see more older women than men with needs and that many of these women would live alone. The three patients in 7.2.1 exemplified this. The nurse participants' comments presented the belief that these women would often have been carers themselves. Older female patient participants confirmed their view:

P4: I'm by myself now. I looked after my man when he was ill for a year or so before he died in the hospital... I've only myself to look to now... changed days... its no easy sometimes

P9: I've been a widow for ten years... of course for years there was the family and him. My family is still about ... but I'm by myself... just like my mother ended up.

The lived experiences of patients confirmed the assumptions and expectations of nurses. The patients' experience was also linked to attendant concerns regarding loss of independence.

Older female patients acknowledged that they had been carers throughout stages in their life and now they considered themselves to be alone and self caring. Patients and nurses did not make further connections to SES or financial circumstances.

Comments about 'managing' were linked to the actual or potential emergence of health and social needs as discussed in 7.2.1, and the spectre of loss of independence was not couched in economic terms. Despite this, patients alluded to the concepts of age and gender as related constraints in their lived experiences. These constraints were social isolation, 'being left alone' and the exigencies of health and social care.

Four older female patient participants and one male also referred to the benefits of further resources, which were life enhancing. Their comments included mention of networks of close friends and supportive family. Six nurse participants also mentioned these networks as a positive aspect. The concept of healthy, fulfilling, older age Bryant *et al.* (2001:940) identifies was therefore included in part in the terms of reference of five patients and six nurses. The views of the participants support the construction of nursing as a gendered occupation. In addition to this, and in light of participants' views about intimate female procedures, the role of patient is gendered too. The expression of a relationship between nursing tasks and gender proposes a division of labour between nurses, discrete areas of nursing practice are gendered.

7.4.3 Lived experiences and socio-economic status

As described in chapter 6, it was difficult to generate an account related to SES. The literature is deficient in research that examines perceptions and beliefs regarding SES in social relationships in health care (Sayer 2002). Some participants did mention SES in a range of oblique ways, for example, in relation to aspects of cost of living, such as bus fares, as previously mentioned in chapter 6.

Five nurses appeared to vary the way they talked to approximate the way that patients talked. Varying way of talking was particularly true when patients were thought to be 'well spoken' or 'posh'. Variations included increased complexity of language and avoidance of the vernacular:

N5: If they [patients] speak correctly... you know... not common. I speak like they do because you have to come over well... I suppose its about communicating at their level... a level they would appreciate

N11: Some patients are very articulate and well spoken... and you need to take that into account when you are dealing with them... I suppose you want to be on the same wavelength socially.

Being on the 'same wavelength' is important to the nurse participants and they linked it to being perceived as appropriate in role as nurse and being appreciated as such. Social wavelength included protocols of language and expectations nurses had of patients.

The nurses categorised patients in relation to SES as part of 'weighing up' and appeared to modify their approach accordingly, which was reflected in their style of interaction. None of the nurses who identified this stated otherwise:

N8: Maybe ask more questions and want to explore everything which is fine... if they're more middle class they're more *au fait*... connected... know what's what... and you feel you should fit in with that

Three nurse participants mentioned the fact that patients they perceived to be middle class or professionals were usually more independent in terms of feeling responsible for their own health. They considered them to be often more knowledgeable and well informed about their health and any specific condition than they or the GP were. Five nurse participants linked this degree of understanding to the opportunities in life linked to SES, which they related to family background, education and employment. These opportunities as resources for health were perceived to provide the basis of confidence and competence, in essence *savoir-faire* in a wide range of social settings including health care. The five nurses also expressed the belief that, consequentially, such patients would have had better health and illness experience. In addition to awareness of best lifestyle options, that better experience would be a reflection of the patient's knowledge and ability to articulate their needs and concerns. Ten nurses anticipated that middle or professional class patients would be more articulate and demanding and seemed self-assured about considering this as a dimension of interaction. Eleven nurse participants explicitly linked 'opportunities in life' to health. They identified Bradley's (1996:46) 'unequal lived relationships' as central to health experience.

Patient participants were less forthcoming about their perceptions of SES. There was little evidence that they attempted to categorise nurses in relation to SES. It was also difficult to establish if patients modified their approach in the way that the nurses described previously did, which was linked to how participants went about negotiating their relationship from its initiation, including the 'terms of engagement' described in chapter 6. These terms of engagement included the prospect that, more often than not, patients would follow the nurse's lead in relation to how the encounter was approached, whilst nurses usually followed the patient's lead in conversation.

Only two patient participants referred directly to SES as part of their thoughts about expectations of the nurse. Both of those met the nurse with brief and uncomplicated needs. They expected the nurse to be female as a reflection of the framework of understanding they had constructed in advance of their visit. As part of this framework, they also expected the nurse to be approachable. That approachability was related to being like them, including SES as well as a range of other factors. In other words, part of the important process of 'placing' someone in a social hierarchy in relation to their own SES, as previously described.

7.4.4 Lived experiences and ethnicity

References to ethnicity by nurse participants were few. Their comments included mention of the diversity of patients they might encounter. Nine nurses identified that they saw minority ethnic patients from time to time. It emerged that their interpretation of ethnicity related predominantly to people of Asian or Chinese origin. This interpretation of ethnicity reflected their personal and professional beliefs and experience. Three other nurses presented contrasting views and related ethnicity to concepts of culture:

N14: Ethnicity includes race but it's more about culture regardless of race... I've got ethnicity... I was brought up to understand the world in a certain way... everybody is, whether you're from here or Manchester or Turkey. We're all from different cultures... Pakistan has as many different cultures as here. It's never considered, it should be.

N1: People assume it's all to do with race and focus on the minority bit ...being Asian or whatever. Culture is more than that... everybody has culture

The inclusion of culture went beyond race and referred to traditions and shared ways and understandings of community life. These nurse participants also considered that cultural identities might be layered:

N12: People always look at the difference and make assumptions. [P5] was born and brought up in this country and her parents before her... her grandparents came here as a young married couple years and years ago. She is Scottish and Asian and all the rest... we've more in common than we don't.

Further suggestions therefore were that cultural identities might be shared and include differences.

Bradley (1996:119) identifies that ethnic identities are multi-layered in a multi ethnic society and highlights that shared culture is a central issue in appreciating diversity:

P14: I think that what often happens is that people assume there are differences and concentrate on them without any insights... religion is a good example of that. They think they are doing the right thing but they are making so many assumptions before they know the person... they think ethnic minority and away they go.

Nine nurse participants' comments were dominated by reference to minority ethnic as being non-white or non-European with English as a second language. In this process, a range of assumptions was included about what ethnicity was, and overlooked concepts of culture. These nine nurses presented an ethnocentric view of culture. Their assumptions included stereotypes of race linked to religious orthodoxy. A tension emerged between the majority of nurse participants portraying nursing as a lived social relationship and not taking into account concepts of culture other than their own. Apart from three, nurses identified their view of culture as ethnocentric.

Three patient participants were identified as minority ethnic by nurses, beyond the wider comments of the three nurses previously identified in this section. P12 who was French and female was referred to in chapter 6 in terms of the considerable control she exerted in interaction with the nurse. Her control was in terms of her formality and 'forbidding' demeanour as the nurse described it. The nurse was daunted by the patient's style in interaction:

N7: I wonder why she behaves like that... so abrupt... frightening in fact. Surely, it wasn't because she was French?

The suggestion that style in interaction is related to nationality appeared to be an effort to understand a patient whose approach seemed to be very different. The difference that dominated was that of nationality, rather than the key properties identified in chapter 6. I was unable to interview this patient who consented to being observed with the postscript 'that is all'.

P5 and P8 described themselves as Scottish Asian. They and their families had become well known in the health centres over the years as members of their local communities. These women therefore had considerable experience in the practice setting and had the opportunity to develop relationships with the staff, including nurses, which was important to both of them. P8 described the importance of feeling known and understood. She expanded on this a little:

P8: Sometimes I'm not confident and it is good to get help and find out what to do... first it was with my children and now with the grandchildren... and other ways

P5 also expressed confidence in the services she had engaged with whilst acknowledging she was known by the nurses:

P5: I have seen the nurses from time to time, they are very helpful and approachable. I have never felt different as a Scottish Asian as I have in other or more unfamiliar places sometimes. If they see me as different, I am unaware of it... I know them of course

P5 and P8 were interviewed in the process of theoretical sampling of participants in my study. These patient participants were part of local communities and used the health centre as a resource for their families in the community:

P8: I like the fact that my family health centre is near by and the nurses are approachable. I see the doctor too... but there is usually no need... unless we are ill of course

P5: I bring the children and of course go to the well woman clinic. The nurses are good at providing information and advice... keep you up to date... healthy living and all that

Their comments related to interaction with the nurse were in the same vein as those of other participants in relation to the comments made and the issues they raised.

7.4.5 Interacting dynamic of age, gender, SES and ethnicity as lived experiences

Age, gender, SES and ethnicity have an impact upon patient/nurse interaction as a dynamic process, described by Bradley (1996) as dimensions that cannot be separated in consideration of their effects within social relationships. Embodiment provides a further dimension, which seems to be imbued with particular significance in relation to health, ageing and gender. In the social relationship of patients and nurses, similarity was meaningful to the participants who were attempting to place each other in the social world:

P11: I suppose I knew the nurse would be like me... just an ordinary working person ... and you expect them to be women here, used to it in fact... it's a vocation for women I think. I know men do do it, but not many

Stereotypes about occupation and gender, including stereotypical assumptions about age and SES, were embedded in the social meanings attributed to nursing.

Patients' assumptions about the gender and SES of nurses were met in most cases. Likewise, as previously described, nurses' assumptions about patients' age, gender and SES were often met, as patients with on-going care needs would be female, older and most likely not of middle or professional SES.

The age of patients is related to concepts of dependence versus self-determination, and linked to embodiment of older age and transformation of social identity. It was difficult to fully establish the part SES played in negotiation in patient/nurse interaction beyond the general comments previously identified, the most important of which were patients commenting on nurses being like them in the context of approachability in negotiation of their relationship. It can be surmised that, as part of the weighing up process by some patients, similarity in SES is transformed into lack of social distance:

P7: You can tell if they're like you... I get on best with folk that are just the same as me... you're more at ease and probably look at things the same way

In these circumstances, the traditional low occupational status of nursing translated into sameness and shared understandings for those patients from similar backgrounds.

Similarity in perceived SES is associated with assessing social identity of others and therefore central to interaction, which could be an important feature of the negotiation of, and/or investment in, the patient/nurse relationship.

Apart from the suggestion regarding patients' perceptions, nurse participants referred to SES more explicitly than patients and made further connections to age and gender. These connections may be a reflection of their perceptions of the role of patients and nurses with respect to health inequalities, but the context of their comments was the degree to which those patients perceived as more middle class would exert more control in need/care interaction. Their response was to change the way they approached such patients:

N12: You modify your approach according to the patient's style... I think they are probably more in the know and ask more questions...

N1: You do think about if the patient can relate to you and you to them... it's important to keep that in mind, especially when you first meet them and haven't got to know them. As you get to know them you work out what they want... amounts of information and advice and so on

Assumptions were made by nurses that 'middle class' patients would have the confidence, knowledge and skills to be influential in negotiating patient/nurse interaction. Conversely, I found no evidence that those of lower SES were accorded, or exerted, less control in need/care interaction.

7.5 Conclusion

Understanding the history of individuals' experiences makes a significant contribution to insights into the complexity of meanings and understandings embedded in patient/nurse interaction in community practice settings.

The meanings and understandings patients and nurses brought to their interaction were crafted from extended, wider, present and lived social and health related experiences. Those experiences were influential in the social construction of reality and performance in patient/nurse interaction. The complexity of meanings and understandings brought to patient/nurse interaction contributed to the development of the social identity of individuals as patient or nurse.

The subcategories and key properties illuminate the value of Experience in relation to connecting situated and wider social meanings and understandings of patients and nurses.

In extended experiences, patients' and nurses' beliefs and expectations were linked to changes in their respective roles from the tradition of compliance, 'you're in their hands', to the prospect of a negotiated relationship, 'we work things out'. Gwyn and Elwyn (1999) and Dixon-Woods (2001) identified that medical hegemonies continued to be influential in health care. The tradition of medical hegemonies was common, in that some patients and nurses did not appear to value collaboration with others as central in need/care interaction. If there was negotiation of the balance of power in patient/nurse interaction, it was founded upon approachability, genuineness and trust. Establishing or clarifying the nature of a therapeutic relationship valued by patients and nurses was fundamental in patient/nurse interaction, particularly in terms of who 'knows best'.

Who knows best was linked to the negotiation and clarification of expertise between patient and nurse. It emerged that addressing how needs should be met was linked with the meanings and understandings participants had about the responsibilities of members of the health care team in the community practice setting. Beliefs as to who is expert and who could best meet their needs were related to the patients' views and preferences about bio-medical or contemporary participatory approaches to care.

Patients' uncertainty about roles and expertise led to lack of confidence in participating in need/care interaction. Both patient and nurse participants identified caring in illness and in health as an underpinning principle of care in the community practice setting. Understanding of changes in roles and expertise was located in participants' present experiences of health care and nursing. For those patients who had not used the community services for some time, there was confusion and ambivalence about who did what. I found that confusion and ambivalence created challenges in constructing a performance as patient. Those challenges are more important in patient/nurse interaction than previously recognised.

I argued that *modus operandi* in need/care interaction was connected to the social construction of reality which emerged from interaction beyond the community practice setting. Individuals' wider experiences were related to home or institutional settings.

Participants were concerned about receiving support services at home. Their concerns were about feeling or being perceived as 'useless, done', and linked to dignity, independence and self-determination. The stakes in negotiation emerged as key issues of power and control, related to the meanings and understandings of self-determination Nortvedt (2001) identified. Importantly, I found evidence that, for those referred to community social services, continued interaction with nurses in the community was valued as supportive and thus an extension and diffusion of the nurse's practice. Preserving a relationship with the nurse was important to patient participants and valued as social support that went beyond need/care interaction. These findings contribute a further dimension to the arguments of Carr-Hill (1995), Nocon and Qureshi (1996) and Bauld (2000) about the importance of the relationships between service users and professional carers to the quality of experience and care outcomes.

Wider institutional experiences such as DSS and SWD presented challenges in terms of *modus operandi* in negotiating patient/nurse interaction. Four patient participants raised issues that they had confronted regarding navigation in other institutions. Not knowing what to do, unfamiliar rituals and in the absence of any information or guidance, going 'through the hoops', contributed to a sense of lack of control and disempowerment. Several patient participants transferred the passive behaviour they had become resigned to adopting in other institutions to patient/nurse interaction, for example, 'wait your turn, go where you're told ... dae what you're told'.

The meanings and understandings generated by learning how to navigate in these institutions were brought to, and influential in, patient/nurse interaction in community practice settings. These meanings and understandings were influential in terms of self-presentation, and engagement and performance as an active or a passive participant. How individuals have experienced and understood interaction in other institutions contributed to the complexity of situated patient/nurse interaction: an insight missing in previous research.

Participants identified the construction of cultural meanings and understandings as a continual project and provided insights into the struggle that transformative process presented. The inclusion of cultural concepts of traditions, shared understandings and understandings of life and living by participants in their accounts suggested that the social dimension in interaction was important to them. Participants' cultural terms included reference to socio-cultural characteristics in interaction in health care and nursing, for example in the process of 'placing' someone, or 'seeing if someone is like you'. Seeking and finding similarities in socio-cultural characteristics created a sense of affinity between patients and nurses.

Performance as patient or nurse was an achievement in which social meanings were created and sustained. I found that the exclusion of individuals' cultural and social realities neglected the importance of the scope of concepts of self-identity and self-determination in patient/nurse interaction.

Participants' experiences of age, gender and SES as socio-cultural characteristics were central to, and influential in, their experiences of health care and nursing. The evidence to support this view was abundant in the literature (Bradley 1996, Field and Briggs 2001, Hockey and James 2003). In my study, participants linked socio-cultural characteristics of age, gender and SES in their accounts of their experiences of, and in, health care and nursing. The meanings participants accorded to age, gender and SES in their everyday lives were culturally constructed and mediated the way in which patients and nurses understood each other and interacted. I identified the significance of the process of placing in terms of socio-cultural characteristics in patient/nurse interaction in chapter 6.

SES emerged as important to participants' placing each other in a social hierarchy. Assumptions and generalisations linked to stereotypes of age and gender were implicit in their encounters. Older age in particular was seen as a constraint emerging from the social construction of ageing in terms of feeling/being valued. In the lived experiences of participants, SES was linked to *savoir-faire* in navigation in health care and nursing, and was linked to awareness of opportunities and resources for health. It was clear that nurses modified their approach in interaction as related to their perceptions of SES. These modifications were identified as 'getting on the same wavelength ... socially', and complexity of language and explanations.

Transformation in social identity related to socio-cultural characteristics was a key issue in patient/nurse interaction and was linked to embodiment and empowerment. Gender and age were linked by participants as part of the transformation in social identity and as a further constraint in lived experiences.

Transformation of social identity led to an initiation or increase in surveillance by patients and particularly by nurses, with independence as a central concern - regardless of whether or not any need is apparent or has been identified. Resources, in particular social networks, had the potential to overcome the constraints associated with growing older. Ellefsen (2002) discussed dependency as disadvantage from the patients' perspective. I found that concerns emerged that were related to perceptions of the problems associated with older age and generalisations about increased care needs or dependency.

I have argued that the comments of nine nurse participants suggested strongly that their views were associated with cultural stereotypes. Their view is consistent with arguments in the literature that diversity is often not given weight in discussion of culture in health care (Ahmad 1996, Gerrish 2000). I found that an ethnocentric view that focused on differences created boundaries and constraints in patient/nurse interaction, 'people always look at the difference and make assumptions'. It emerged from the accounts of several nurse participants that the construction of culture with reference to ethnicity had the potential to be flexible and dynamic.

However, they identified that individualised care of minority ethnic patients was hindered by a narrow universal approach to culture that did not take account of diversity or shared meanings and understandings.

The majority of participants appeared willing to extend their understanding of each other in patient/nurse interaction. Examples of this willingness were in relation to changing expectations of involvement and participation in care, awareness of the experience of embodiment and empowerment, and the prospect of negotiation as a process within patient/nurse interaction. I have shown that the inclusion of the comprehensive narrative of patient and nurse participants is central to examining their meanings and understandings and the influence of socio-cultural characteristics from an interaction perspective.

My conceptualisation of Experience is enlightening with regard to the diverse and complex social meanings and understandings constructed from extended, wider, present and lived experiences. My conceptualisation provides insights into the situated negotiation process and wider structural influences that are significant in patient/nurse interaction.

In my concluding discussion, I show how my categories of Experience and Investment together make a contribution to sociologically informed understandings of patient/nurse interaction in community practice settings.

Chapter 8 Concluding discussion

I set out to investigate patient/nurse interaction in a community practice setting with the aim of contributing sociologically informed understandings. I used grounded theory methodology to achieve my aim because it facilitated discovering detailed insights into the unknown about patient/nurse interaction. Participants' meanings and understandings are embedded in the data from which my categories of Investment and Experience were generated, and in the substantive theory I have constructed.

In using grounded theory, I found that there are benefits to using the traditional methodology of Glaser and Strauss (1967) and Glaser (1978) in such a way as to overcome the potential compartmentalisation of the elements within category construction, which I came to view as a hazard to discovery and emergence. The benefits are the preservation of the context and diverse contribution of participants' meanings and understandings. For example, the meanings and understandings of my participants about how they formed reactions to people traverse and are included in the categories of Investment and Experience. Compartmentalisation is a hazard to discovery and emergence in that it leads to a one dimensional perspective in analysis and so the interrelatedness of elements of analysis is lost.

In my experience of constant comparative analysis, viewing elements of analysis, for example substantive codes, as having a singular application does not recognise the compound contribution each may make to the whole analysis. In the category of Investment for example, the substantive code of 'rapport' makes a contribution to the key properties of 'integrity', 'self-esteem', 'dignity', and 'intimacy'. These key properties contribute to subcategories of negotiation, developing and sustaining the patient/nurse relationship and empowerment. Thus, the substantive code of 'rapport' makes a contribution to all the subcategories in Investment.

My particular approach to analysis adds to the strength of category construction. I have shown that there are benefits to viewing elements of analysis as construction building blocks – from substantive codes to subcategories. Building blocks of analysis should pull together and so contribute to the strength of category generation by their combined effort exerted in the whole. For example, in the subcategory of empowerment in the category of Investment (appendix E4), substantive codes of 'sharing', 'responding' and 'getting to know each other' all have their own meaning which they contribute to the key property of partnership. Alone, the power of each of these substantive codes is isolated by the limitations of their definition. Together, as interrelated concepts, the substantive codes support and increase the meaning of the key property of partnership in the subcategory of empowerment.

The same support and increase in meaning occurs when the interrelated concepts of the key properties are distilled to clarify the character of each subcategory in Investment. In other words, in isolation, the contribution of each element in analysis is limited and its full potential and value are not realised as they should be in a comprehensive, robust inquiry. Thus, the contribution of each analytic element has a function in the strength of purposeful category construction and the substantive theory generated.

My review of previous research identified the key issues about patient/nurse interaction which informed my research questions. My categories of Investment and Experience were generated from that foundation. Before discussing my substantive theory, I briefly summarise the key existing insights and concepts from the literature that were used to drive my analysis.

In the literature, communication and associated concepts of trust, intuition and integrity are linked to examining what happens when patient and nurse meet and interact, and develop their relationship. Insights into communication from the patients' perspective, including their meanings and understandings, need to be developed (Morse 1991, von Essen and Sjoden 1991, Jarrett and Payne 1995). Concepts of trust (Johns 1996, Lotzkar and Bortorff 2001), intuition (Easen and Wilcockson 1996, McCutcheon and Pincombe 2001) and integrity (Irurita and Williams 2001, Walsh and Kowanko 2002) are influential in patient/nurse interaction.

A gap exists in the literature concerning linking trust, intuition and integrity as synergistic concepts. I used concepts of trust, intuition and integrity in my examination of reciprocity in the patient/nurse relationship to contribute to addressing the gap in present theorising about patient/nurse interaction. Integrity is linked to 'preservation of self' in the literature and identified as important to the sense of personal control and involvement in patient/nurse interaction (Irurita and Williams 2001). In the literature, dignity is 'missing' with regard to definitions or conceptualisations in practice, although links are established to trust and vulnerability (Mairis 1994, Williams 2001, Walsh and Kowanko 2002). Lack of connections between trust, intuition and integrity are also reflected in the gaps in the under-development of conceptualisation of self-determination in patient/nurse interaction (Morse 1991, Allen 2000b, Rose 2003).

I also identified in my review of the literature that conceptualisation of knowing the patient in nursing theory attempts to place the patient's interests and concerns at the centre of individualised care (Tanner *et al.* 1993, Radwin 1996, Luker *et al.* 2000, Attree 2001). In my study, concepts of knowing the patient as a person contributed to exploring the meanings and understandings related to navigation and *modus operandi* in patient/nurse interaction, particularly from the under-explored patients' perspective.

Existing conceptualisations of commitment and involvement (Morse 1991), and engagement and detachment (Kralik *et al.* 1997), were of considerable value in my exploration of the processes within patient/nurse interaction. The conceptualisations of Strauss (1978), in particular *modus operandi*, provided an important way of looking at patient/nurse interaction, including the social dimension.

The literature that examines what empowerment might be, suggested that I should investigate the challenges that it presents as a meaningful process in interaction for patients and nurses (Aranda and Street 1999, Dixon-Woods 2001, Williams 2001, Leino-Kilpie *et al.* 2001, Traynor 2003). Other researchers suggest that examining empowerment from the perspective of participation should include reference to the expertise of both patients and nurses (Clarke 2002, Mitcheson and Cowley 2003, Rose 2003). Empowerment is critiqued by others in terms of the difficulties and barriers it presents (Martin 1998, Pill *et al.* 1999, Lewis and Urmston 2000). Meanings and understandings of negotiation and empowerment in patient/nurse interaction emerged as subcategories of Investment, and were drawn upon in the category of Experience.

Age, gender, SES and ethnicity emerge clearly in the literature as social constructs and as a set of lived relationships (Turner 1999, Forbes and Wainwright 2001, Hockey and James 2003).

From this position, I related the 'dynamics of inequality' identified by Bradley (1996), with self-esteem and the construction of social identity. The role that socio-cultural characteristics play in relation to advantages/disadvantages and/or constraints and boundaries in experience and performance is clear in the literature (Blane *et al.* 1998, Baggott 2000, Popay *et al.* 2003). The influence of socio-cultural characteristics of age, gender, SES and ethnicity were important in my analysis of navigation and negotiation in patient/nurse interaction. I also examined how experiencing, navigating and negotiating in relation to socio-cultural characteristics in the social world by individuals was brought to, and important in, their performance in patient/nurse interaction.

Having briefly summarised existing insights and knowledge and related them to my research questions, I move on to discuss what I have discovered in 8.1. Based upon the substantive key issues raised in the literature as just briefly outlined, the research questions were:

What happens when patient and nurse meet and interact?

What meanings and understandings can be identified in patient/nurse interaction?

What is the influence of socio-cultural characteristics in patient/nurse interaction?

How can the meanings and understandings and the influence of socio-cultural characteristics identified in patient/nurse interaction be explained?

I use my research questions to present my substantive theory. In the first section 8.1, I show how I have addressed those questions in discussion of my conclusions. In the second section 8.2, I use my conclusions and substantive theory to identify the implications of my study to inform practice and propose areas of further research.

8.1 Substantive theory

My work helps to redress the imbalance in existing insights about patient/nurse interaction which are mostly about the acute practice setting and often focused upon illness. Whilst the reasons for encounters between patient and nurse may differ between health care settings, my substantive theory contributes insights about interaction that can be related to any practice setting. In the community practice setting, where most health care is sought and delivered, the terms of engagement of being a patient or a nurse are different from those in acute settings, principally because they are not driven by pressing care needs. The focus and environment in acute practice settings is different because patient care and treatment needs are, by necessity, in the foreground. The purpose of patient and nurse meeting is more in the background in the community practice setting. Interaction in the community practice setting is more often by choice and that is one reason why interaction is different.

With a continuing relationship in the community practice setting, the opportunity is there for patients and nurses to develop some understanding of an invested-in patient/nurse relationship and the role of experiences.

I have shown the emphasis that patients and nurses put upon placing in the social world and acting and reacting to each other in relation to age, gender, SES and ethnicity. I have demonstrated that social meanings and understandings and socio-cultural characteristics are more influential in the experience of being a patient or nurse than previously recognised. Locating people socially, then moving on to acting and reacting underpins the reality that patient/nurse interaction is often more of a social meeting in the community practice setting. Socio-cultural characteristics are an influential part of the process of locating each other from the beginning of the patient/nurse relationship.

My discussion of the social dimension of interaction contributes to knowledge about the social construction of reality by, and the performance of, patients and nurses. I have shown that an invested-in relationship goes beyond the situated context of patient presenting with needs and nurse providing care and has a personal aspect. Patients and nurses value a relationship which goes beyond need/care interaction and has a personal aspect in which they share and come to know each other. This is particularly true where patient and nurse have a joint project in relation to ongoing care needs.

I found that the social meanings and understandings created and sustained in experiences within and beyond interaction influence negotiation and empowerment in patient/nurse interaction. I found that negotiation and empowerment are connected as a developmental process within patient/nurse interaction. Through negotiation, empowerment can be preserved in the domain of the patient as a person rather than being 'given' by a nurse, for example by empowering 'the diabetic'. I also found some evidence that, in the context of need/care interaction, an individual in the role of patient may not want to be 'empowered' *per se*. Viewing negotiation and empowerment together as a developmental process as just described should contribute to making the concept of empowerment in health care more meaningful for patients/the public and for nurses in their involvement and participation in health and health care as I discuss in 8.2.

Negotiation and empowerment are connected in the social construction of reality of being a patient or nurse. The meanings and understandings related to the social assets, resources and experiences in interaction are valued qualitatively in patient/nurse interaction. The value of understanding the potential of a social relationship for benefiting patients, practice and policy lies in improved understanding of participation and involvement within and beyond situated need/care interaction.

I now present my detailed arguments in three sections which are related to my research questions. In 8.1.1, I concentrate upon what happens when patient and nurse interact and the meanings and understandings that can be identified in patient/nurse interaction. I argue that navigation processes, *modus operandi* and the developmental nature of negotiation have a social dimension which is valued qualitatively by patient and nurse in their interaction. In 8.1.2, I focus upon the influence of socio-cultural characteristics in patient/nurse interaction. I argue that in the social construction of reality of being a patient or a nurse, socio-cultural characteristics are brought to, and interactive within, performance in interaction in health care and nursing. In 8.1.3, I focus upon how the meanings and understandings identified in patient/nurse interaction can be explained. I argue that empowerment is a social process with the potential to support inclusion in patient/nurse interaction as related to *modus operandi* and performance.

8.1.1 What happens when patient and nurse meet and interact, and the meanings and understandings that can be identified in patient/nurse interaction.

When patient and nurse meet, the developmental nature of negotiation in their interaction is an important dimension of the patient/nurse relationship. Interaction in other institutions is significant in navigation processes in patient/nurse interaction and *modus operandi*.

I have contributed to understanding of the social construction of the patient/nurse relationship by examining the meanings and understandings brought to, and interactive within, patient/nurse interaction. Strauss (1978) emphasised the developmental nature of negotiation and his conceptualisation of *modus operandi* provides a valuable means with which to explore the connections between patient/nurse interaction and wider social contexts.

I found that negotiation in patient/nurse interaction goes beyond the explicit and superficial, for example a clinical procedure, as Morse (1991) and Jarrett and Payne (1995) argued. From my investigation into the meanings and understandings in patient/nurse interaction it emerged that the negotiation of power and responsibility are closely related to issues of self-determination. In essence, negotiation provides a framework that continually drives the development of the patient/nurse relationship, from drawing board to delivery, and all places in between. Viewing negotiation as a process, which includes *modus operandi* and the constraints upon it, extends insights into the performance of patients and nurses in their interaction. The literature I reviewed in chapter 2 draws attention to the need for conceptualisation of negotiation as a process in patient/nurse interaction (Wuest 2000, Durham 1999). However, I found that conceptualisation must also address the developmental nature of negotiation in the context of developing and sustaining the patient/nurse relationship, and take into account issues of Investment and *modus operandi*.

The developmental nature of negotiation in patient/nurse interaction is also related to concepts of empowerment, which I address later in 8.1.3.

I discovered that extending the social dimension of knowing the patient to include situated and wider experiences and knowing each other was fundamental to understanding the processes that may enable or constrain patient/nurse interaction. Knowing the patient can be expanded conceptually by using the substantive codes and key properties of Investment and Experience which emphasise the social processes and dimensions of patient/nurse interaction. Knowing the patient is related to recognising and advancing the patient's contribution in communication in interaction beyond the superficial. If communication lacks depth, including the social dimension, negotiation of the patient/nurse relationship is compromised. Extending knowing the patient to include the social dimension by exploring situated and wider meanings and understandings is fundamental to understanding the processes that may enable or constrain patient/nurse interaction.

I have added to current conceptualisations of trust, dignity and integrity in patient/nurse interaction by identifying a relationship between the social construction of identity as a person and as a patient or a nurse. My conclusions substantiate the relationship between trust and issues of vulnerability and genuineness proposed by Redfern and Norman (1999) and Irurita and Williams (2001), and expand them by establishing a further link to self-determination.

I found that the generation of trust and confidence and the preservation of integrity were related to the development of mutual understanding between patient and nurse. Patients in particular considered that the development of mutual understanding as essential to satisfactory experiences in interaction in the community practice setting.

I established that a personal, social dimension is valued in the invested-in patient/nurse relationship. Including a personal, social dimension in theorising about patient/nurse interaction as I have done, complements the positive aspects of engagement between patient and nurse outlined by Kralik *et al.* (1997), and moves their conceptualisation forward. Intimacy and trust characterise the invested-in patient/nurse relationship, in which expectations are met and reciprocated, and a sense of fulfilment achieved. In such a relationship, the patient and nurse progress from being in their respective roles and a personal dimension emerges as Investment. If the patient and nurse have different views of commitment and involvement, there are implications for satisfaction with need/care interaction.

There is variation in the depth of patient/nurse relationship that may be developed. Taking into account that patient/nurse interaction may be brief, I identified that some relationships of longer duration were not developed, sustained and ultimately invested-in.

I found that commitment and involvement, as Morse (1991) described it, were not fulfilled in such a patient/nurse relationship. Importantly, if participants have different views of commitment and involvement, the likelihood of a 'joint project' being established is diminished with consequences for the quality of patient/nurse interaction. Firstly, the patient may prefer and value a deeper relationship. Secondly, giving expression to a philosophy of care that values patient participation and involvement may be compromised for the nurse, with resultant consequences for job satisfaction.

8.1.2 The influence of socio-cultural characteristics in patient/nurse interaction.

I found that performance as a patient or a nurse is initiated and achieved via processes of acting and reacting to each other in relation to socio-cultural characteristics. In this way, the socio-cultural characteristics of patients and nurses are a significant part of the interactive processes within patient/nurse interaction. The social construction of reality of being a patient or a nurse is related to the socio-cultural characteristics that they bring to their performance in interaction. In the arguments that follow, I make a case that the meanings and understandings of individuals and their socio-cultural characteristics are conceptually related, and interdependent in patient/nurse interaction.

I discovered that the processes by which patients and nurses act and react to each other in interaction were initiated by placing and were pivotal to their terms of engagement. Placing someone in relation to socio-cultural characteristics of age, gender, SES and ethnicity was important to patient and nurse when they met and interacted. Placing was central to how patient and nurse located and related to each other in the social world in particular. As Siegrist (2001) and Sayer (2002) theorise, my participants made evaluations of social status indirectly. Those evaluations of social status were meaningful for patients and nurses in their interaction. Placing in relation to socio-cultural characteristics was particularly influential to the establishment of negotiated parameters of power and control in interaction, and the development of the patient/nurse relationship. Placing was also important in terms of linking home and wider experiences with health care and nursing. In that process, meanings and understandings related to an individual's family/home, or environment as Popay *et al.* (2003) described it, were significant to understanding the social experiences of others.

I found that nurses prioritised placing patients in relation to socio-cultural characteristics in their scrutiny upon meeting patients. Nurses displayed some discernment in that process, which endorsed the characterisation of social and health inequalities as embodied, in for example older age or body shape. In this way, socio-cultural characteristics provided navigation points in negotiation in patient/nurse interaction.

Patients described being scrutinised as an exposing process, and some evidence emerged in my study that it enhanced apprehension and vulnerability and affected self-esteem, as Wardhaugh and Wilding (1998) and Irurita and Williams (2001) suggested. I discovered that if being scrutinised is experienced as an exposing process, patient/nurse interaction is adversely affected. Nurse participants made judgements based on their scrutiny, which represented a relationship between presentation of the body, embodiment and need/care interaction.

I found that apprehension about change in social identity adds a dimension to the constraints of growing older. Older patients identified and linked age and gender in their concerns about losing independence. In my study, age and gender, particularly female, were possible constraints in lived experiences linked to reduced economic means and social opportunities. Nurses related age, gender and SES to actual or potential emergence of health and social needs of patients. However, I found that patient participants emphasised apprehension about loss of independence and self-determination. Their apprehension was not only about increased need, but also about changes in social identity.

I found that caring tasks were identified by participants as divisions of labour: nursing and homemaking were gendered as female. Nursing as caring was mostly constructed as female by patients.

This construction was sustained by the conventional expectations of patients and nurses that caring tasks were the domain of women. The examination of gender and nursing also exposed within and between group issues: 'within' representing nursing as a whole, 'between' as sub-groups in nursing. The nursing (caring) profession was constructed by participants as female as a within group process, nurses/nursing is female. However, a between group process in terms of gender also emerged as elements of nursing practice were also constructed as female by participants, for example, reproductive health and understanding social needs.

Nurse participants, whose understanding of culture was dominated by race and religion, mostly neglected concepts of culture in interaction. Nurses' lack of exploration and inclusion of concepts of culture restricts the depth of, and sensitivity to, meanings and understandings in patient/nurse interaction. Different cultural experiences were not recognised by most nurses as part of understanding interaction, or diversity was not valued and/or included. Minority ethnic patients considered that being known in the health centre and to the nurses there, led to them being understood and expressed no expectation or belief that cultural understanding might form part of their interaction. Despite this lack of expectation by minority ethnic patients, I suggest that lack of consideration or inclusion of cultural meanings and understandings may create difficulties in incorporating the patient's ideas and experiences in interaction.

8.1.3 How the meanings and understandings identified in patient/nurse interaction can be explained.

The meanings and understandings identified in patient/nurse interaction can be explained by exploring the social construction of reality, performance and *modus operandi* of patients and nurses.

I have concluded that empowerment is an element of the social construction of reality and performance in patient/nurse interaction. Empowerment also plays a central role in processes of negotiation in patient/nurse interaction. Debates in the literature focus upon empowerment as an act or process in health care and nursing (Skelton 1994, Leino-Kilpie 2000, Traynor 2003). I have advanced the debates about empowerment in that I have discerned the tensions in viewing it as act or process by exposing and interrogating the challenge it presents for participation and involvement in need/care interaction for patients and nurses. I found that empowerment is more than involving patients in decision making or self-regulation, for example management of diabetes mellitus, as frequently exemplified in the literature. Patients and nurses had a range of expertise and experience interfaced with varying expectations of participation in interaction and decision-making.

Confusion about the definition and use of empowerment underlies difficulties of definition and practice of empowerment for nurses. It was clear in the literature that empowerment as a concept is problematic with regard to who felt they had the right to claim ownership of it or possess it in patient/nurse interaction (Barnes and Walker 1998, Lewis and Urmston 2000). It was evident that, apart from three exceptions, nurse participants in my study viewed empowerment more as an act that was dependent upon their expert actions. Dependence upon nurses' expertise excludes patients from being empowered through a transparent process of negotiation.

I discovered that problems in the variability of meanings and understandings attributed to expertise and experience presented a hurdle for patients and a dilemma for nurses in interaction. In particular, a nurse identified as having a reductionist approach to care may only tune in to an illness narrative, rather than the sum of the patient's experience told as meaningful to them as an individual and relevant to the current need/care interaction. I found that lack of engagement of the nurse in processes to facilitate patients expressing their meanings and understandings increased patients' feelings of insecurity and vulnerability. Patients identified feelings of powerlessness in constructing and expressing their meanings and understandings without the engagement of the nurse in that process. Similarly, nurses had difficulty with translating patients' meanings and understandings into their professional practice.

I discovered that the positive aspects of empowerment are not evident to nurses. The philosophy of care adopted by nurses was individual to them and expressed in their approach to care. In this way, nurses determined the degree to which patients were enabled to be active participants in their own care. Therefore, nurses largely served as gate-keepers to empowerment. I found that feelings of being rendered powerless in their own care reduced self-determination and disempowered patients. My participants referred to participation in, and contribution to, the decision-making process as central to their understanding of empowerment, which is contrary to the view of Clarke (2001) and Allen (2000b). The view that nurse participants expressed was linked to their beliefs regarding the role of patient/nurse, and the power and control associated with those roles. Achievement of a collaborative, partnership approach was dependent upon the nurse identifying and removing the constraints created by viewing empowerment as an act or a process in interaction. Generating opportunities to enable the patient to develop insights into care outcomes and alternatives was influential to the patient and nurse becoming partners in interaction.

Meanings and understandings of self-determination emerged in Investment and Experience as a more important issue in the conceptualisation of involvement and participation of patients in their own care than has been recognised before. Conceptualising the process of reconciliation of the expertise of patient and nurse as central to self-determination as I have done, advances and challenges debates about empowerment as act or process in their interaction.

To achieve unity of purpose, a purposeful reconciliation between the aims of receiving care by the patient, and meeting needs by the nurse was required. There may however have to be not only awareness of, but also an active appetite for, empowerment by participants, for such a reconciliation to take place.

Performance in the patient/nurse relationship is dependent upon negotiation of what style of role was preferred and valued in interaction: from traditional to contemporary. If norms and values are not met, or consensus arrived at by patient and nurse, in terms of meanings and understandings of roles, tension ensues in interaction that may damage the patient/nurse relationship. I found that some participants experienced some uncertainty in striving to make sense of the challenges of the changing health service, including roles and expectations. A service user led service in tandem with notions of empowerment is cited as the model of best practice to be valued in health and social services in the United Kingdom (Scottish Executive 2001a, Department of Health 2002, Scottish Executive 2003a, Scottish Executive 2005). Transformation at the coalface of health care and nursing was ambiguous for patients and nurses. Structural and situated influences in health care and nursing are evolving and values are transforming from biomedical to biopsychosocial (Gilleard and Higgs 1998, Mead and Bower 2000, Dixon-Woods 2001). I found that in that transformation process some associated core values may remain the same whilst others alter.

I discovered that ambiguity lay in the perceptions of some patients and nurses that decisions concerning treatment and care continue to, and indeed should be, embedded in the traditional domain of the doctor, rather than the nurse. Others qualified their beliefs about this and located the doctor's power in the realm of medical diagnosis and treatment in a multi-disciplinary team, and referral to other experts, including nurses. Few participants considered the doctor as a resource in service user led health care services.

In relation to *modus operandi*, I have concluded that the complexity of patient/nurse interaction must include consideration of how individuals experience interaction in a range of places, because they bring those meanings and understandings to patient/nurse interaction. The meanings and understandings identified in patient/nurse interaction include attitudes and beliefs about independence interfaced with the perceived threat of formal intervention by, for example, the Social Work Department. Whilst only seven patient participants referred specifically to the situated experiences they had had in other care related institutions, they provided detailed insights that appear to be overlooked in health care and nursing. These insights into *modus operandi* make a contribution to sociologically informed understandings of performance in patient/nurse interaction. The experience of those patient participants was notable in that they identified that sustained and positive experiences in the health care setting had ameliorated their concerns regarding social work assessment.

Maintaining a sense of independence was linked to self-determination in the terms identified in the categories of Investment and Experience. The amelioration of patients' concerns was based upon trust in the nurses who had referred them. Importantly, patients' continued experience of nursing services was valued beyond the health care setting, which suggests that positive experiences in one place provides the impetus for confidence in interacting in other contexts, such as home help assessment at home.

I discovered that experiences of patient participants beyond health care settings, in particular DSS, were less favourable. These mostly unsatisfactory experiences were related to difficulties in processes of navigation. In relation to *modus operandi*, participants described that they had difficulty in identifying recognisable patterns of activity that they could engage with. Difficulties in navigation resulted in a loss of sense of control, self-esteem and empowerment. Participation and involvement in patient/nurse interaction were jeopardised for those who had experienced feelings of being powerless in other institutions. Organisational structures and processes compromised the self-determination of clients by imposing formalities, routines and rituals that appeared to be mostly impenetrable to them.

Capturing and expressing the depth and texture of experiences in the social construction of reality, moves towards better understanding of the complex range of meanings and understandings brought to patient/nurse interaction.

Individual experiences of health and social services were influential in perceptions of conventions, roles, and *modus operandi*. Whilst health and social services are very relevant to this argument, further depth of this dimension could lie in experiences in other institutions, for example, education, religion and judiciary related (probation and/or prison).

8.2 Implications for further work

The utility of my research is addressed in this section and completes my thesis. I include here proposals as to how my substantive theory as discussed in detail in 8.1, may be used to inform firstly practice in 8.2.1, and secondly areas of further research in 8.2.2.

8.2.1 Informing practice

My conclusions in this section refer to developing policy in Scotland and to the implications of my study for the relevant stakeholders in health care. I discuss the implications of my study for stakeholders within the framework of the move towards multi-professional and common, fundamental working practices in Scotland. Following this, I discuss the implications for nursing practice in the community practice setting and then in undergraduate nurse education.

The key stakeholders are the public/patients, and nurses, midwives and allied health professions/professionals (NMAHP) and policy makers. The public/patients have a stake in that they have beliefs and expectations about how their health and illness needs should be met. The public/patients expect to be part of the process of considering options for, and decisions about, change. NMAHP is an umbrella term which encompasses those professions who contribute to improving the health of the people of Scotland, and to health services. Policy makers are also stakeholders in that it is they who are dynamic in developing policy to meet the health needs of the population. In consultation with the public/patients and NMAHP, policy makers generate the frameworks that determine service delivery and developments in response to the health and illness needs of the public/patients in Scotland. Also by this means, the agenda for the practice and education of, and research by, all health professionals is set.

My study is consistent with the definition of research and development for NMAHP by the Chief Scientist Office (Scotland):

... structured activity which is intended to provide new knowledge which is generalisable (i.e. of value to others in a similar situation) and intended for wider dissemination. www.show.scot.nhs.uk/cso/
(2004)

In the light of policy developments and the related changes in practices, my substantive theory is of 'generalisable' value to the public/patients and NMAHP seeking insights into what involvement, participation and empowerment might mean in need/care interaction. Its particular value lies in insights into performance and *modus operandi* within interaction. In relation to policy, almost every Scottish and UK policy and white paper published in the last five years emphasises the involvement and participation of the public/patients in the planning and design of services (Department of Health 1998, 1999, 2001, 2002, Scottish Executive 2001a, 2001b, 2002, 2003a, 2003b, 2004).

Contemporary health policy in Scotland has consistently referred to involvement, participation and empowerment as key features of a responsive service (Scottish Executive 2001a, 2003a, 2003b, 2004). The thrust of health and social policy in Scotland is in the process of substantial change. '*A national framework for service change in the NHS in Scotland: building a health service fit for the future*' known as the Kerr Report (Scottish Executive 2005), is exciting the imaginations of the public/patients and NMAHP. The rationale for the changes proposed in the Kerr Report is the need to respond to the rapidly changing health needs of the population and to prepare the health service in Scotland to meet future challenges (Scottish Executive 2005, volume 2:v). Those challenges are to evolve a model of care that integrates primary and secondary health care, and social care. To address these challenges, a community focus is emphasised throughout the Kerr Report.

The main changes identified in the Kerr Report are firstly to engender the participation and involvement of patients, carers and local communities. Secondly, the proposed changes refer to empowering individuals and communities to enable them to increase control over and improve their health. It is also proposed to create partnerships between health professionals and the public/patients (Scottish Executive 2005). Understanding of the social relationship between the public/patients and NMAHP will be important if partnerships are to develop as policy suggests they should in the community setting.

The key drivers of change in Scottish health policy are as follows. Firstly, health education strategies should be anticipatory and preventative to address inequalities in health. Secondly, enhancing self care is part of the anticipatory and preventative agenda and involves the individual in taking action to maintain health and prevent or manage illness. Support for the public/patients to manage their own health needs and to help others is also advocated. Thirdly, there should be a systematic approach to caring for patients with ongoing needs at home or in the community and to reduce hospitalisation (Scottish Executive 2005, volume 2: vi).

Health inequalities in Scotland are sharper than elsewhere in the United Kingdom (Hanlon *et al.* 2001, Blamey *et al.* 2002). The social inequalities of particular concern that impact upon health are SES and the effects of living in remote and rural locations. The evidence regarding the relationship between lower SES and health is abundant (Acheson 1998, Blamey *et al.* 2002). Approximately 20% of the Scottish population lives in remote or rural locations with consequent implications for access to and by health services. With these key drivers in mind, a major shift to a community focus is proposed, whereby the majority of health care will be delivered where people live, including their own homes.

The implications for stakeholders are as follows. A community focus designed to best meet the health and illness needs of the population of Scotland will require a major shift in understanding of health delivery for all stakeholders in partnership. In this policy context, my study has implications for a range of stakeholders in relation to the agenda for health in Scotland regarding involvement and participation. For the public/patients, a change in policy will mean a focus upon meeting their individual health care needs where they live to streamline and improve their experiences in health care services. That focus will be related to anticipatory and preventative strategies, and to meeting specific and/or complex illness needs as they arise. For NMAHP, the emphasis is upon multi-professional working using and generating shared understandings in partnership with the public/patients.

Those understandings are related to the drive towards integrated care delivery and care coordination (Scottish Executive 2003a, 2003b, 2004, 2005). Integrated care by NMAHP is part of policy and provides a mechanism with which to coordinate care, reduce fragmentation of care and improve quality of care. In an integrated care approach, every relevant discipline contributes to a person centred approach. The public/patients can anticipate that in the future a member of an integrated care team serving their community will co-ordinate their care, not necessarily a nurse or a doctor.

My conclusions regarding the social dimension of navigation, negotiation and empowerment in interaction, will be of value to public/patients and NMAHP striving to generate shared understandings in a new way of collaborative working in the community setting. Those understandings will relate in particular to how public/patients and NMAHP might be involved and participate in an integrated approach to care. My findings regarding the challenges of empowerment will be of value in informing the processes of enabling individuals and communities to negotiate and increase control over and improve their health. For instance, the challenges of empowerment must be met in interaction in health care consultations between NMAHP and individuals in the community. For example, such a consultation could be between a person concerned about mobility and leg ulceration, and a physiotherapist. Central to meeting the challenges of empowerment in interaction is NMAHP prioritising participation and involvement by the individual in their own care.

Prioritising by NMAHP in this way will involve them in generating a detailed assessment that focuses upon individual's meanings and understandings about control over their health and health care needs. Negotiating the role of each other in need/care interaction should emerge as part of the process of such a focused assessment. Taking account of the importance of individuals' experiences and expectations will be fundamental to adopting an integrated care approach in which involvement and participation are central. As I have identified, social meanings and understandings are important in individuals' performance and *modus operandi* in interaction.

The substantive theory I have generated into the social dimension of need/care interaction offers NMAHP insights with which to reconstruct their *modus operandi* in light of the challenges they may face in working in partnership with all stakeholders in an integrated approach to care in the community. As the Kerr Report specifies, the challenges will include viewing the 'patient as partner'. Understanding of the complexity of processes of negotiation and empowerment will play a central role in supporting patients to be a partner in their own care. Those challenges will also include changes in fundamental working practices within an integrated care framework. In particular, NMAHP will no longer work in comparative isolation in relation to their skills or professional domain of practice. The integrated team will draw upon and share common skills with some resultant overlap of domains of practice.

My conclusions allow new features of interaction to become visible or recognisable to all stakeholders. However, my conclusions are of particular interest to nurses in the community practice setting. If nurses can see ways in which they can enable need/care interaction which were not visible to them before, it may encourage them to engage with the challenges presented by the participation and involvement agenda. Further challenges will be presented by the model of care recommended in the Kerr Report, in particular an integrated approach to care by NMAHP. For example, in working in an integrated approach, nurses will need to have complex insights into the meanings and understandings of negotiation patients may have generated by interacting with a range of health professionals, and how that will be influential in their performance as a patient.

My study suggests that for nurses to meet patients' needs effectively, the influence of socio-cultural characteristics in patient/nurse interaction should be given greater emphasis than it presently receives. I found valuable evidence regarding the important role of socio-cultural characteristics within patient/nurse interaction that informs practice, education and policy. This evidence has particular relevance in relation to the focus in policy upon the health inequalities experienced by those of lower SES. The influence of socio-cultural characteristics within interaction can be related to the direct involvement and participation of individuals in the processes of enhancing self care and health care structures.

Recognising the role of socio-cultural characteristics in interaction has an important contribution to make in addressing the challenges of meeting the social inclusion agenda in particular.

The implications of my thesis for nurse education are as follows. The evidence base for practice is stressed in nurse education as necessary for competence as a nurse. The thrust of undergraduate nurse education in Scotland is exemplified in the four domains of standards of proficiency to practice (NBS 2000). Those domains, which relate to, and link with, academic and practice based work, are professional and ethical practice, care delivery, care management and personal and professional development. At present those domains, each with specified standards of proficiency, direct students to aspects of patient/client care which are context specific, for example 'high dependency care skills'. The context of care and the tasks the nurse does, rather than patient/person centredness, drive the learning and teaching of students. The principles of patient or service user involvement and participation, as emphasised in health policy, are not explicitly contextualised in health care delivery for students or indeed their academic and practice teachers/mentors.

On the basis of my research, I consider that the domains of standards of proficiency for eligibility to the NMC Register should be revised to include the social dimension of patient/nurse interaction. In my view, the social dimension of patient/nurse interaction is a domain of practice and merits the development of standards of proficiency in that area. Furthermore, the standards of proficiency to be acquired by students should include sociologically informed understandings of patient/nurse interaction and the influence of socio-cultural characteristics. To place the patient and interaction as central to students addressing and achieving evidence based proficiency in practice, the complexities of patient/nurse interaction need to be understood in greater depth and texture. My research illuminates the importance of understanding the meanings and understandings expressed in, and the role of, socio-cultural characteristics in patient/nurse interaction. My argument is that my findings and substantive theory are useful to the student who must engage with contemporary approaches to involvement, participation and empowerment in health care and nursing, and the priorities for health agenda. As with Registered nurses, their engagement in this way must extend to include sociologically informed understandings. It is in these ways that I suggest that sociological insights should be explicitly located in frameworks of pre and post registration/graduation curricula as related to specified standards of proficiency.

8.2.2 Areas of further research

My proposals are contextualised by 'Choices and challenges: the strategy for research and development in nursing and midwifery in Scotland' (Scottish Executive 2002). The emphasis in that strategy is to improve services for patients and service users and involve them in that process. The strategy recommends drawing upon a range of evidence to generate a comprehensive picture of patients' and service users' experiences and perspectives. The substantive theory I have generated makes a meaningful contribution to this evidence by addressing the social dimension of patient/nurse interaction. My proposals for further research draw upon the substantive key areas I have identified in this thesis. Reflecting upon my substantive theory as discussed in 8.1, it is evident that whilst I have generated new insights I have also contributed usefully to linking and expanding existing ones.

In light of the focus in policy upon integrated pathways in social and health care, generating deeper and extensive insights into navigation and negotiation processes is a rich and valuable area to investigate. I found evidence that interacting in different institutions is influential in *modus operandi* and the meanings and understandings that individuals bring to their performance in need/care interaction. I have suggested that this phenomenon may affect interaction in a range of institutions and is not presently visible to nurses.

Applying my perspective, research to examine navigation and negotiation processes in further depth would contribute to expanding insights into patients and service users' experiences. It would be valuable to investigate the experiences of individuals who have interacted in a range of institutions. As I suggested earlier, those institutions could include education, religion and judiciary related (probation and/or prison).

The interaction career of those who have interacted in a range of institutions should be mapped in detail to generate rich descriptions of their experiences, meanings and understandings. The key research questions should include:

What meanings and understandings are generated from interaction in a range of institutions and how do they in turn interact?

What is the influence of those meanings and understandings in *modus operandi* including navigation, negotiation and empowerment?

I would anticipate that this research would make a significant contribution to understanding the performance of service users in involvement and participation in health care and in other services. I also consider that there would be significant value in exploring the relationship between navigation, negotiation and empowerment. At present, theorising in health care and nursing about navigation, negotiation and empowerment is under-developed, fragmented and, importantly, not usefully joined up.

My suggestions for research in this area are based upon the ambiguities and challenges I found that these areas present to patients and nurses. The ambiguities and challenges I identified earlier could be investigated to arrive at conclusions and recommendations regarding rebalancing power and control in need/care interaction.

Further work is also needed on the social construction of being a patient particularly by expanding sociologically informed understandings further. That work would advance theories of self-determination and empowerment, and related concepts such as trust and integrity. In that research, a focus on the social meanings and understandings that connect health inequalities and the experiences related to the factors of inequality, with the social inclusion agenda would be valuable. The value would be to enhance understanding of individuals' situation and performance, and also inform policy, practice and education for health and social institutions. To develop understanding of the social dimension in nursing and health care, the social experiences of individuals within communities need to be connected with health related opportunities, resources and outcomes. In other words, I envisage the value of an emergent map from that work to link the social dimension in health care and nursing with social inclusion. Such a map could provide the basis for joined up thinking in social policy and health care practice.

Further work is also needed to investigate the interaction of socio-cultural characteristics within interaction upon which I have made a beginning by arriving at some conclusions about the influence of weighing up and placing. Investigation in this area should centre upon situated interaction in a range of settings and include a range of client groups. This research should focus upon examining the indirect ways we act and react to each other in relation to socio-cultural characteristics. Examination of how we evaluate each other in terms of the influence of the dynamic of socio-cultural characteristics in patient/nurse interaction should be integrated in that research. Building on my thesis in the terms just specified would make a significant contribution to develop further sociologically informed understandings about patient/nurse interaction.

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| | | |
|-------|-----------|-----|
| Date: | Location: | ID: |
|-------|-----------|-----|

Study participation consent form

The purpose of this study is to help me to understand the relationship between patients and nurses.

Information will be gathered by *observing* and *interviewing* patients and nurses.

Not everybody will be interviewed. Interviews will be tape-recorded. Your identity and contributions will be *confidential* and known only to me.

You are free to ask questions before and during participation. You may withdraw from taking part *at any time* if you wish. All information I gather will be securely stored and destroyed on completion of my study.

***I understand the nature and purpose of the study
and I am willing to take part***

Signature:

Date:

Thank you

Kathleen M Stoddart, RGN RCNT RNT BA MSc
(PhD student, University of Stirling)

✓ Nurse participant characteristics (interviews)

| N | F | M | W/UK | ME | 20 – 35 | 36 - 50 | 51 - 60 | SES |
|----|---|---|------|----|---------|---------|---------|-----|
| 1 | ✓ | - | ✓ | - | ✓ | | | 3 |
| 2 | ✓ | - | ✓ | - | | | ✓ | 3 |
| 3 | ✓ | - | ✓ | - | ✓ | | | 2 |
| 4 | ✓ | - | ✓ | - | | ✓ | | 3 |
| 5 | ✓ | - | ✓ | - | ✓ | | | 3 |
| 6 | ✓ | - | ✓ | - | | ✓ | | 3 |
| 7 | ✓ | - | ✓ | - | | ✓ | | 3 |
| 8 | ✓ | - | ✓ | - | ✓ | | | 2 |
| 9 | ✓ | - | ✓ | - | ✓ | | | 3 |
| 10 | ✓ | - | ✓ | - | | ✓ | | 3 |
| 11 | ✓ | - | ✓ | - | | | ✓ | 2 |
| 12 | ✓ | - | ✓ | - | | ✓ | | 2 |
| 13 | ✓ | - | ✓ | - | ✓ | | | 3 |
| 14 | ✓ | - | ✓ | - | | ✓ | | 3 |
| 15 | ✓ | - | ✓ | - | | | ✓ | 3 |
| 16 | ✓ | - | ✓ | - | | | ✓ | 3 |
| 17 | ✓ | - | ✓ | - | ✓ | | | 3 |
| 18 | ✓ | - | ✓ | - | | ✓ | | 3 |

N = nurse participant. F = female. M = male. W/UK = white British.

ME = minority ethnic.

(Estimated) SES = socio-economic status (Office of National Statistics 1999)

Shaded = semi structured interview

✓ Patient participant characteristics (interviews)

| P | F | M | W/UK | ME | 18 – 40 | 41 – 65 | 66 – 80 | 80 + | SES |
|-----|---|---|------|----|---------|---------|---------|------|-----|
| 1 | ✓ | | ✓ | | | | ✓ | | 6 |
| 2 | ✓ | | ✓ | | ✓ | | | | 1.2 |
| 3 | | ✓ | ✓ | | | | ✓ | | 2 |
| 4 | ✓ | | ✓ | | | | | ✓ | 5 |
| 5 | ✓ | | | ✓ | ✓ | | | | 4 |
| 6 | | ✓ | ✓ | | | | ✓ | | 3 |
| 7 | ✓ | | ✓ | | | | | ✓ | 5 |
| 8 | ✓ | | | ✓ | | ✓ | | | 4 |
| 9 | ✓ | | ✓ | | | | | ✓ | 4 |
| 10 | | ✓ | ✓ | | | ✓ | | | 2 |
| 11 | | ✓ | ✓ | | | ✓ | | | 3 |
| *12 | ✓ | | | ✓ | | | ✓ | | 1.2 |
| 13 | ✓ | | ✓ | | | ✓ | | | 2 |
| 14 | | ✓ | ✓ | | | | | ✓ | 1.2 |
| 15 | ✓ | | ✓ | | | | ✓ | | 7 |
| 16 | | ✓ | ✓ | | | ✓ | | | 3 |
| 17 | ✓ | | ✓ | | | ✓ | | | 5 |
| 18 | | ✓ | ✓ | | | | ✓ | | 3 |

P = patient participant. F = female. M = male. W/UK = white British.

ME = minority ethnic.

(Estimated) SES = socio-economic status (Office of National Statistics 1999)

Shaded = **semi structured interview** *observation only

Observation

| Date: | Location: | ID P : ✓ Consent: | ID N : ✓ Consent: | Duration: |
|-----------------|-----------|----------------------|----------------------|-----------|
| Presentation: P | | | Presentation: N | |

Descriptive notes

Reflective notes

Memo

Informal Interview: Tape No:

| | | | |
|--------------|------------------|---------------------------------|------------------|
| Date: | Location: | ID: ✓ Consent: | Duration: |
|--------------|------------------|---------------------------------|------------------|

| Area of inquiry | Possible topics to cover |
|------------------------|---|
| Personal background | <p>Age Gender Occupational background of self and family (SES) Ethnicity</p> <p>Area and length of residence Why? (e.g. work) Local connections & interests</p> |

| | |
|--------------------------|---|
| Health Centre experience | <p>As patient or nurse Length of time</p> <p>Nature of experience (e.g. professional or as patient/family care)</p> |
|--------------------------|---|

| | |
|-------------|--|
| Interaction | <p>How do you form your reactions when you meet people And why</p> <p>What factors contribute to your impression of the patient/nurse</p> <p><i>Situation and feelings</i> <i>Previous experience</i> <i>Age and gender</i> <i>SES</i> <i>Ethnicity</i></p> <p>How does rapport with the patient/nurse develop What could effect rapport</p> |
|-------------|--|

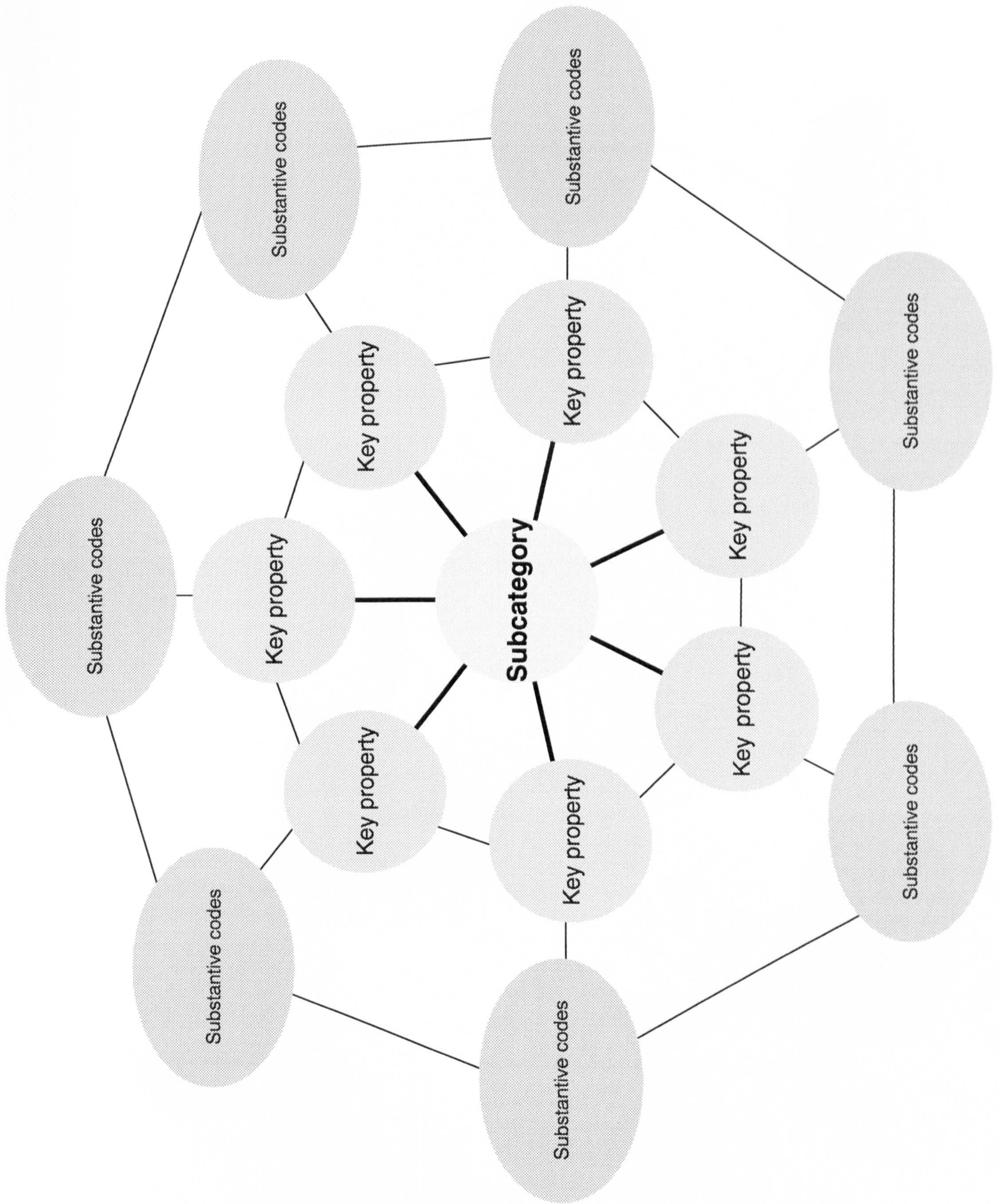
Issues arising from observation:

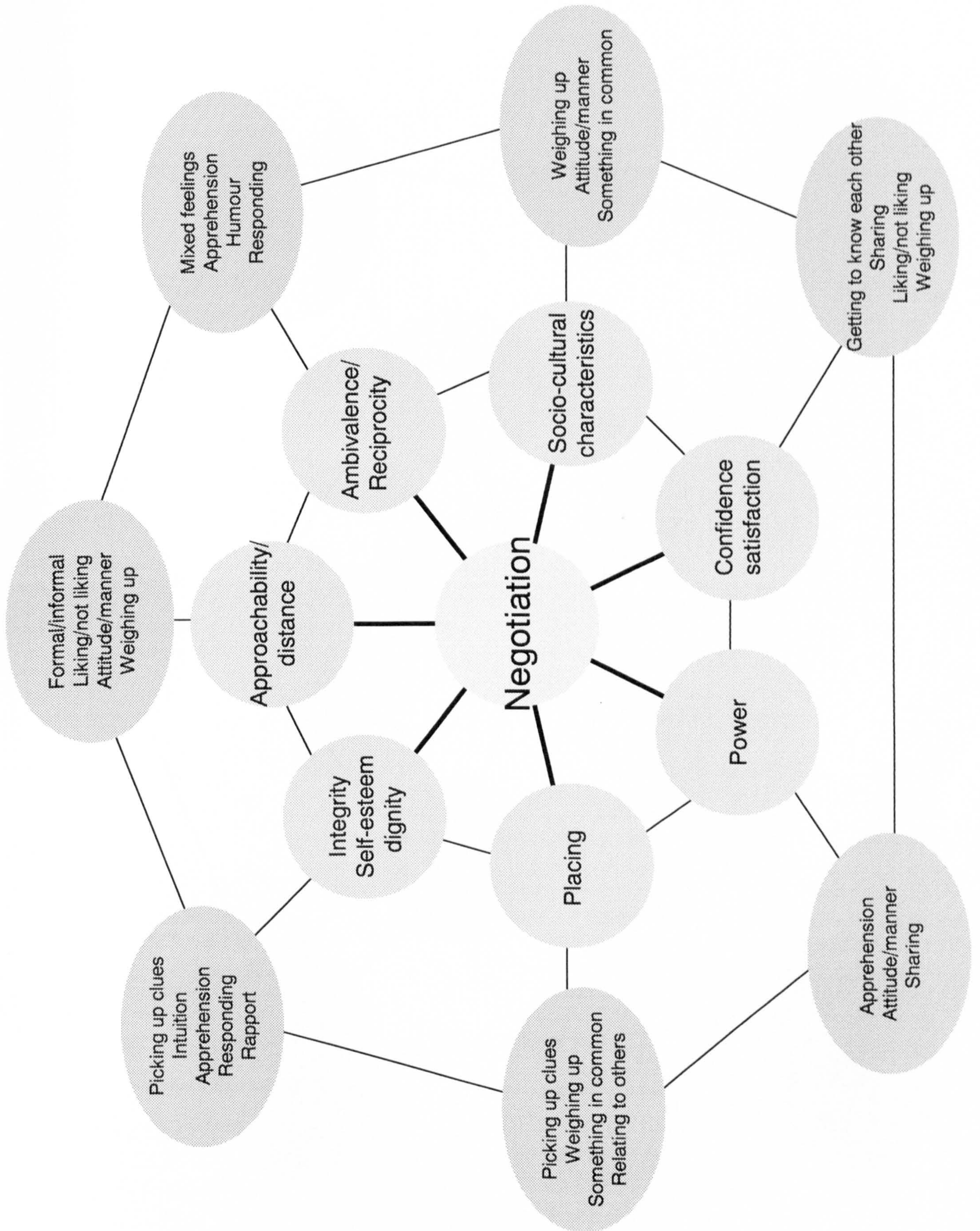
Notes:

Interrelationships between elements of analysis

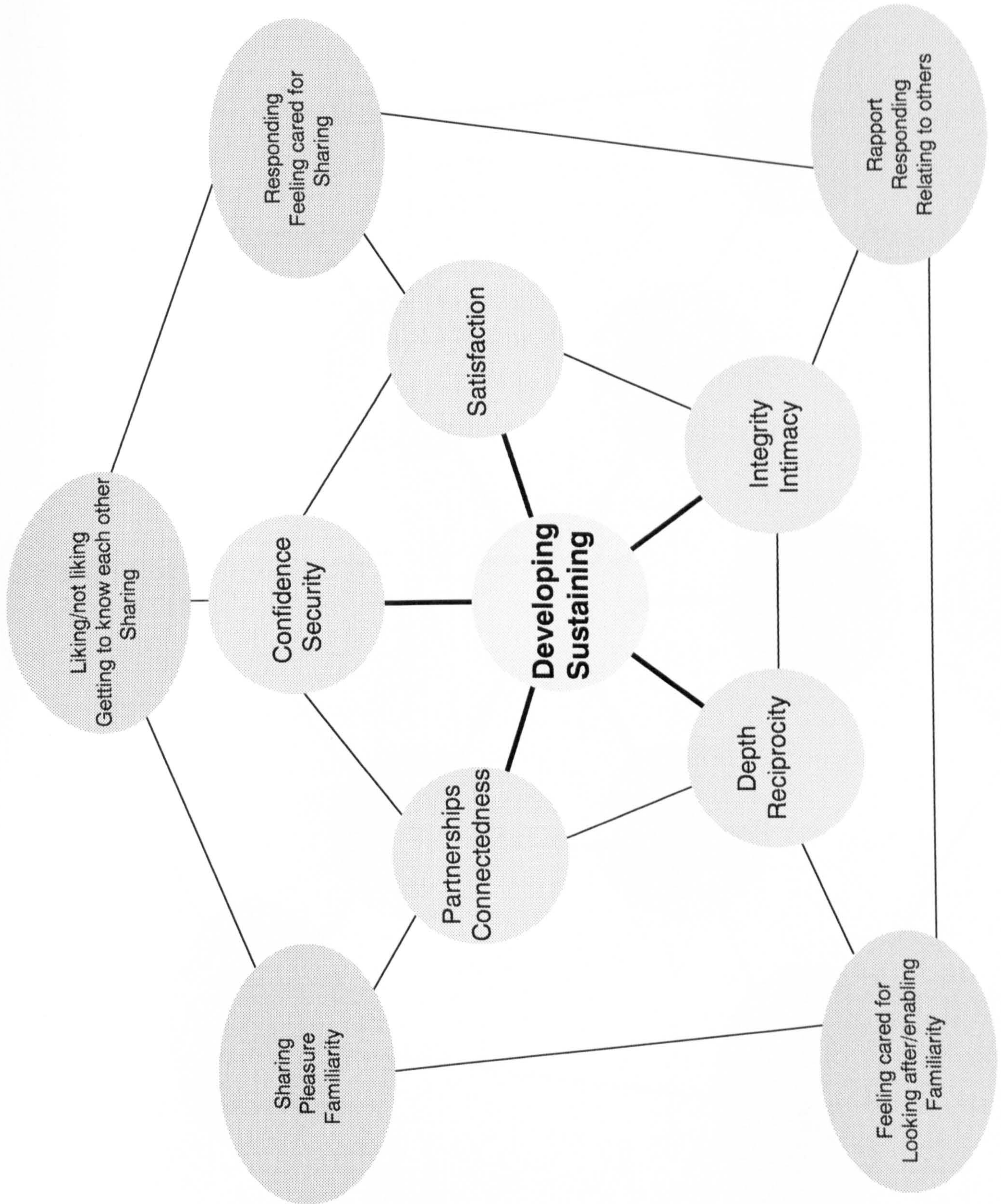
Appendix E displays diagrammatically the interrelationships and pathways between the elements of my analysis from which the categories of Investment and Experience were generated. The presentation of these diagrams is in the same style of representation of 'darkness into light' as illustrated in figures 2 and 3. Additionally, these diagrams are in a spider's web format in which interrelationships can be tracked back and forth. For example, in E2 'relationships between substantive codes, key properties and subcategory in Investment: negotiation', some substantive codes are discussed in the thesis in relation to power. In that discussion, integrity is also mentioned which is another key property with related substantive codes identified within E2. Some of the key properties in appendices E2 - 8 are clustered to simplify the tracking process within each diagram as much as possible.

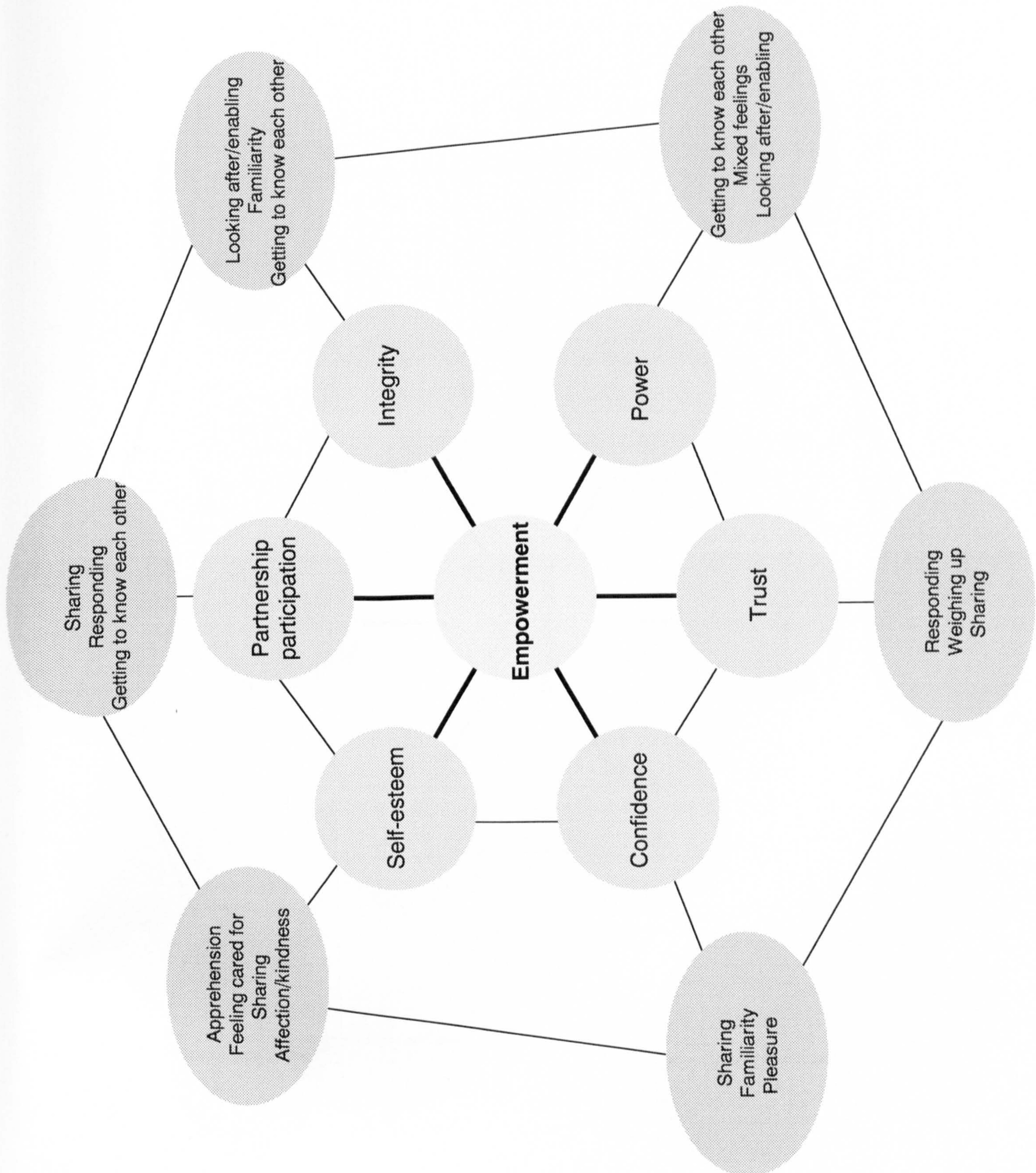
- E1 Shows the relationship between substantive codes, key properties and subcategories. I use the framework shown in E1 to present E2 – E8.
- E2 – E4 Show the substantive codes and key properties with the strongest interrelationships to every subcategory of the category of Investment.
- E5 – E8 Show the substantive codes and key properties with the strongest interrelationships to every subcategory of the category of Experience.



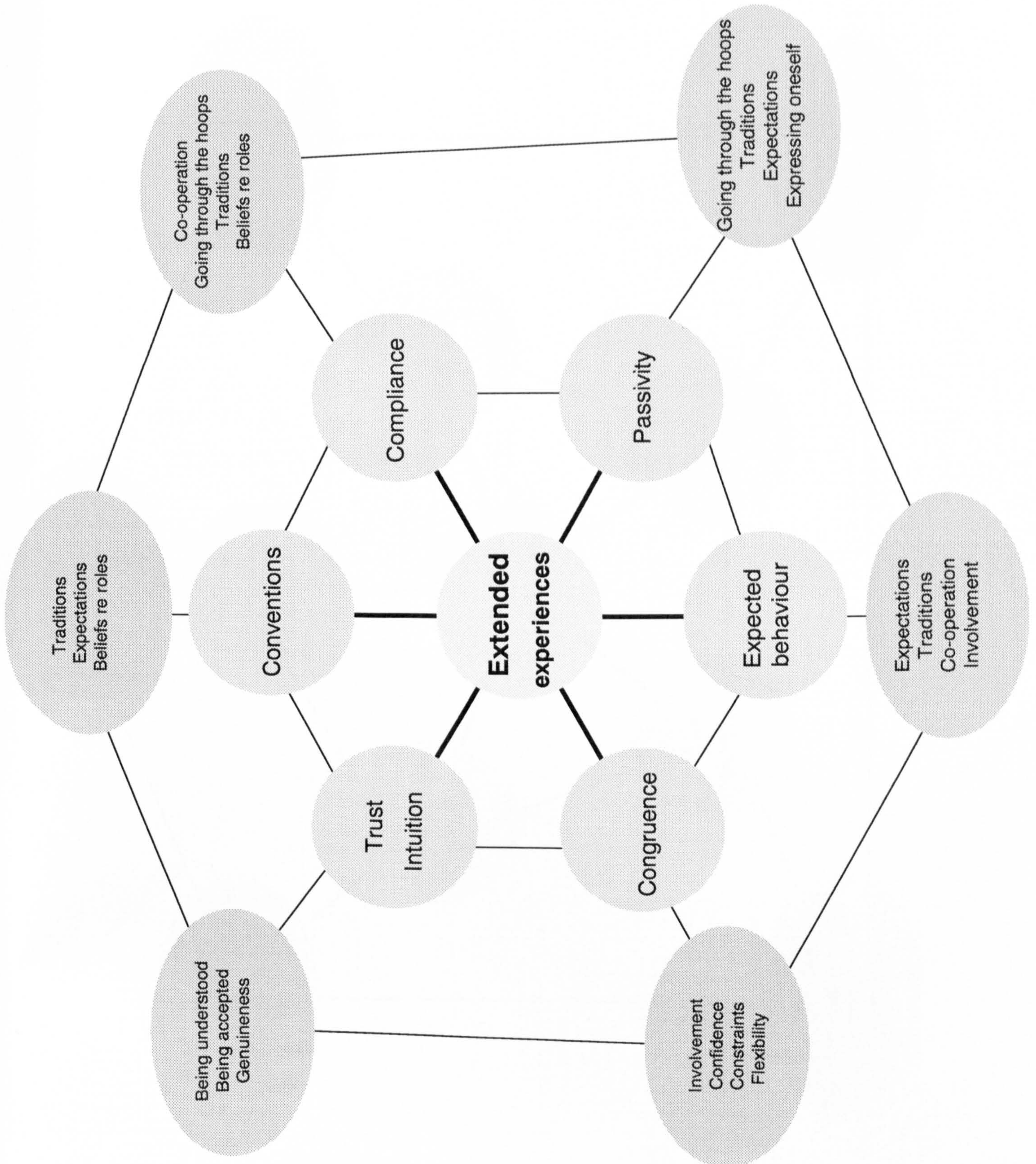


Relationships between substantive codes, key properties and subcategory in investment: **developing and sustaining the patient/nurse relationship**





Relationships between substantive codes, key properties and subcategory in Experience: **extended experiences**



Relationships between substantive codes, key properties and subcategory in Experience: **wider experiences**

