ACUTE CARE NURSE PRACTITIONERS’, PHYSICIANS’ AND STAFF NURSES’ RELATIONSHIPS WITH PATIENTS: A DESCRIPTIVE, COMPARATIVE STUDY

By

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy

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ABSTRACT

Acute care nurse practitioners (ACNPs) are a new addition to the Canadian health care system, having been introduced in the Canadian health care system in the late 1980s. While some authors have suggested that nurse practitioners offer “something special” to patient care, no evidence to date has substantiated this claim. The findings of this grounded theory study offer a theory (Acute Care Health Professional-Patient Relationship (ACHPPR) Theory) to describe how three types of health care professionals establish relationships with patients in acute care settings (Figure 7).

This qualitative study explored relationships that ACNPs, physicians and staff nurses establish with patients in a large urban multi-site university-affiliated hospital. Six quartets (patient, ACNP, physician, staff nurse) were recruited and interviews, using a semi-structured guide were audio-taped and subsequently transcribed verbatim.

Each type of relationship was found to have a unique focus; ACNPs focus on making connections with patients, physicians focus on managing patients’ diseases and staff nurses focus on meeting patients’ needs. In order to establish relationships with patients, readiness conditions must be met. Health professionals use strategies to influence the achievement of readiness conditions as well as to move forward with relationship development. Each type of relationship varies in the range of potential intensity that can be achieved, which is influenced by various dimensions. Relational intensity ranges from the uncommon clinical relationship, which focuses on the patient’s disease, through the more typical professional relationship characterized by a comfortable rapport and then finally to the most relationally intense, but rare, personal relationship. If a relationship reaches professional or personal levels of relational intensity, relational products become evident. When comparing these three health professional-patient relationships, similarities and differences have been identified. Analysis of patient interviews yielded themes that substantiate the ACHPPR theory.
The ACHPPR theory offers a beginning understanding of the complementary nature of three types of health professional-patient relationships in the acute care setting and has the potential to influence practice, education, theory development and future research related to ACNP-patient relationships.
DEDICATION

I dedicate this dissertation to my friend Elizabeth Jane Goulding (1958 – 2004). She always offered unconditional love and friendship and continues to be the ‘wind beneath my wings’.
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My sincere thanks to the acute care nurse practitioners, physicians, staff nurses and patients who volunteered to participate in this study and share their wisdom and experiences with me. There would have been no study without them.

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LIST OF ABBREVIATIONS

ACHPPR Theory: Acute Care Health Professional-Patient Relationship Theory
ACNP: Acute Care Nurse Practitioner
APN: Advanced Practice Nurse
HCP: Health Care Professional
NONPF: National Organization of Nurse Practitioner Faculties
NNP: Neonatal Nurse Practitioner
NP: Nurse Practitioner
PA: Physician Assistant
PCNP: Primary Care Nurse Practitioner
RN: Registered Nurse
CHAPTER 1 - INTRODUCTION

Acute care nurse practitioners (ACNP) are a relatively new addition to the Canadian health care system, having been initially introduced in neonatal intensive care units in the 1970s and then more widely in other acute care settings in the 1990s (Ford, 1997). ACNPs are advanced practice nurses who work collaboratively with patients, families and other health care professionals to provide direct care to patients. By way of definition, “an advanced practice nurse [is] educated at the master’s level with both a theoretical and an experiential focus on complex patients with specialized health care needs” (Richmond & Keane, 1992, p. 283). ACNPs typically practise in acute care settings, caring for patients who are hospitalized or attend affiliated ambulatory clinics, addressing their health care needs across the continuum of health and illness (Pong, Sloan, Caty, & Rukholm, 2006). As it is a new role, it is beneficial to evaluate it from a variety of perspectives. While the ACNP role has not been studied extensively, research to date has used predominantly quantitative methods to evaluate the concrete tasks and functions of ACNPs (Hoffman, Tasota, Scharfenberg, Zullo, & Donahoe, 2003; Kleinpell, 1997; Rosenfeld, McEvoy, & Glassman, 2003; Rudy et al., 1998; Sidani et al., 2000), ACNP impact on broad indicators of health status such as length of stay and mortality (Bissinger, Allred, Arford, & Bellig, 1997; Carzoli, Martinez-Cruz, Cuevas, Murphy, & Chiu, 1994; Spisso, O'Callaghan, McKennan, & Holcroft, 1990), ACNP impact on population specific outcomes such as clinical indicators and cost (Byers & Brunell, 1998; Goksel, Harrison, Morrison, & Miller, 1993; McMullen, Alexander, Bourgeois, & Goodman, 2001; Mitchell-DiCenso, A., Pinelli, & Southwell, 1996; Weinberg, R.M., Liljestrand, & Moore, 1983) and ACNP role implementation and evaluation (Cummings, Fraser, & Tarlier, 2003; Ingersoll, 1995; Shah, Bruttonesso, Sullivan, & Lattanzio, 1997; Sidani et al., 2000; van Soeren & Micevski, 2001). Emphasis on studies such as these which evaluate effectiveness and functionality is inevitable as there are always quality and safety concerns when introducing new patient care roles.

A number of authors have suggested that nurse practitioners offer something different in the way they provide patient care (Courtney & Rice, 1997; Donohue, 1995; Sullivan, 1982). Despite these anecdotal reports, there has been no research to substantiate any unique elements of practice that ACNPs may bring to health care encounters with patients in the acute care environment. While studies reporting ACNP roles and responsibilities are available, only two studies could be identified that used qualitative methods to explore the ACNP role and the findings were predominantly related to ACNPs’ self described perceptions of their role, its
implementation and the effectiveness of its integration into the system (Balkon, 2000; Canadian Nurses Association, 2006; Geier, 1998). Although primary care nurse practitioners (PCNP) were introduced in 1965 in the USA (Silver, Ford, & Stearly, 1967) and substantial quantitative evidence exists to support their effectiveness, there are very few studies that address the affective and expressive dimension of the PCNP role with patients. This is of interest because one of the identified strengths of nurse practitioner practice is their ability to combine advanced clinical expertise with interpersonal skills so they can focus on individuals in the context of their families and social environment (Keane & Richmond, 1993).

The demand for ACNPs in acute care settings has increased and there is some evidence to support their ability to provide quality patient care (Ford, 1997). A few studies have shown that select patient outcomes are enhanced when care is provided by nurse practitioners (NP) (Sidani et al., 2006) but it is unclear why this might be. The interpersonal dynamic of ACNP practice, specifically the relationships they develop with patients, may be one element of ACNP practice that differentiates their practice from the practices of other health care practitioners.

The nature of relationships that ACNPs have with patients is a clinical issue about which little is known. There have been no studies about the relationships that ACNPs have with patients and no comparative studies addressing the similarities and differences in the relationships between patients and three different care providers; staff nurses, physicians and ACNPs. To explore this dimension of ACNP practice, a qualitative study using grounded theory method was designed. Prior to undertaking this qualitative study, it was necessary to examine the origins of the ACNP role, education and socialization of ACNPs and related research evidence. Empirical literature addressing PCNP-patient relationships was also analysed and summarized. To establish a basis for understanding relationships, philosophical perspectives of Martin Buber and work by scholars with related perspectives (Jourard, Campbell, Paterson and Zderad) were reviewed and used as a philosophical lens. It was anticipated that the findings of this study would yield a valuable perspective on the practice of ACNPs with implications for practice, education, research and theory development.

**Research Questions**

1. What is the nature of relationships that ACNPs develop with patients?
2. What is the nature of relationships that staff nurses and physicians develop with patients?
3. How are the three health professional – patient relationships similar and different?
CHAPTER 2-BACKGROUND

Acute care nurse practitioners have been discussed in the literature with increasing frequency in recent years. An ACNP provides care to patients who have multiple, complex needs and who are acutely or chronically ill. ACNPs usually practise in specialty areas and are expected to “think critically, perform diagnostic reasoning, case management and advanced therapeutic interventions” with patients in their care (Piano, Kleinpell, & Johnson, 1996, p. 289). ACNP roles have been described and evaluated in relation to the standard of care provided, the satisfaction of other health care providers and from the perspective of practising ACNPs in relation to identified barriers and facilitators of role implementation. In order to develop a comprehensive understanding of ACNP-patient relationships, it was essential to understand the context from which the role has emerged and within which it is currently situated. Literature was reviewed related to the history of nurse practitioners, their education and socialization, practice patterns and role effectiveness, with attention paid to any descriptions of unique aspects of their practice. Since there are limited studies that explore ACNP-patient relationships, empirical literature examining primary care NP relationships in general was also reviewed.

Nurse practitioner practice has been investigated both qualitatively and quantitatively, often evaluating the effectiveness of their replacement functions as compared with care provided by physicians. Nurse practitioner-patient encounters have been studied qualitatively predominantly in primary care settings. In fact, the vast majority of the studies have not focused on NP-patient relationships but rather on aspects of their care that can be measured, counted or described in detail. It is hypothesized that something different occurs when nurse practitioners engage with patients.

History of Nurse Practitioners

Nurse practitioners were first introduced in Colorado in 1965 to address the health needs of under-serviced and vulnerable populations (Davidson & Lauver, 1984; DeAngelis, 1994; Silver et al., 1967). This expansion of the traditional nursing role was envisioned as an opportunity to maximize the scope of nursing practice, promote effective utilization of nursing skills and knowledge and provide quality health services to populations close to home in a cost effective manner. Once introduced, neither medical nor nursing leaders universally accepted the role. While some physicians argued that this expanded practice was actually practising medicine without a license, others saw NPs as physician substitutes in the context of a primary care physician shortage in the USA (Ford, 1992). Similarly, many nurses claimed that these nurses
were “mini-doctors” and traitors to the nursing profession (Brykczynski, 2000). It is interesting to note, however, that some of the ‘expanded role’ functions which have been recently introduced were common to nursing practice in the early 1900s. In fact, over time nursing practice has expanded and contracted in response to a variety of societal factors and influences (Brykczynski, 2000).

Canada was not far behind in preparing and introducing primary care NPs. The first program, established at Dalhousie University in 1967, was a certificate program to prepare nurses to work in remote northern nursing stations (Worster, Sarco, Thrasher, Fernandes, & Chemeris, 2005). Other programs were developed including one at McMaster University in Ontario. Despite the publication of a joint statement in support of the NP role by the Canadian Medical and Nurses Associations, NP education was discontinued by the mid-1980s. It has been proposed that the declining interest in the role at that time was a result of perceived physician oversupply, lack of legislative changes, lack of public interest, lack of support from both medicine and nursing and lack of funding mechanisms (Canadian Nurses Association, 2006; Canadian Nurses Association & Canadian Institute for Health Information, 2005; Worster et al., 2005). However, despite these societal influences, approximately 250 PCNPs continued to practice in Ontario (Worster et al., 2005). The PCNP role experienced a resurgence in Canada in the 1990s as public pressure for increased access to primary health care services mounted (Canadian Nurses Association, 2006; Canadian Nurses Association & Canadian Institute for Health Information, 2005). Primary care NPs are recent additions to the primary health care system in other parts of the world including the United Kingdom (Horrocks, Anderson, & Salisbury, 2002), Australia (New South Wales Department of Health, 2006) and New Zealand (Canadian Nurses Association, 2002).

Acute care nurse practitioners were introduced later. The case for the introduction of ACNPs into acute care environments was articulated clearly by Richmond and Keane (1992). They suggested that five factors led to the need for ACNPs in the USA; changes in medical residency programs, consumer difficulty in accessing appropriate levels of healthcare, limited public access to physicians, need for a ‘bridging of the gap’ between need and access, and a desire to decrease fragmentation of care related to the complexity of health needs and the system in general. Other authors concur while adding the need for cost containment in acute care (Bond, Wilkie, Simpson, Levine, & Whitney, 1996; Watts, R.J., Hanson, Burke, Gallagher, & Foster, 1996). In Ontario, in the mid-1980s, similar issues were emerging in health care settings. Medical residency training program sizes were reduced and political and hospital leaders were
seeking safe, cost effective models of care that would complement what was already in existence (Mitchell, Pinelli, Patterson, & Southwell, 1994; Mitchell-DiCenso, A., Pinelli et al., 1996; Simpson, 1997). The neonatal nurse practitioner (NNP) was introduced in Ontario in the late 1980s but the role had been implemented in neonatal intensive care units in the USA more than a decade earlier. The NNP role is the most well established ACNP role (Geier, 2000; Mitchell-DiCenso, A., Pinelli et al., 1996; Watts, R.J. et al., 1996). In the USA during the 1980s, there were reports of NPs educated in PCNP programs with acute care expertise being introduced into acute care environments to manage specialized acutely ill patients (Weinberg, R.M. et al., 1983). Early evidence of their effectiveness was likely the impetus for a broadened use of ACNPs in acute care hospitals and the development of ACNP fields of study. By the 1990s, descriptive and empirical accounts of ACNPs working with a variety of acutely and chronically ill populations in both Canada and the USA emerged (Geier, 2000; Sidani & Irvine, 1999; Simpson, 1997; Stetler, Effken, Frigon, Tiernan, & Zwingman-Bagley, 1998).

Introduction of ACNPs in Canada has not been without resistance. Physicians, in particular, can perceive the role as a threat to their own role and scope of practice or they may consider themselves at risk with respect to liability in relation to ACNP practice (Canadian Nurses Association, 2006). However, Mitchell and her colleagues (1996) evaluated the implementation of the NNP role in Ontario NICUs and their findings indicate interdisciplinary team member satisfaction and enhanced levels of professional satisfaction with the introduction of neonatal NPs. Staff nurses in particular reported a preference for working with NNPs over paediatric residents. The only professional group who were less satisfied in this study was respiratory therapists, likely because they experienced a perceived reduction in their scope of influence and practice.

While it is difficult to quantify the number of practising ACNPs in Canada, the role has become well established, albeit predominantly in large urban centres (Pong et al., 2006), positions continue to be advertised across North America and applications to educational programs are increasing (Struthers, 2007). There is no evidence that the dwindling interest that befell primary care NPs in Ontario during the 1970s and 1980s will occur in relation to ACNPs.

**Education of Acute Care Nurse Practitioners**

Educational preparation of ACNPs may contribute to differences in the practice of ACNPs, physicians and staff nurses. Education to prepare acute care nurse practitioners has been in place in the USA for more than thirty years, initially preparing neonatal NPs (Beal &
Quinn, 2002). Two decades later, as previously discussed, both Canadian and American health care leaders were faced with patient care challenges and contemplated how the complex needs of patients in acute care facilities could best be met. They concluded that graduate prepared advanced practice nurses were an appropriate solution (Shah et al., 1997; Simpson, 1997). In Canada, a conscious decision was made to establish fields of study embedded in existing graduate programs available for nurses (Mitchell-DiCenzo, A., Pinelli et al., 1996; Simpson, 1997). Commitment to graduate educated ACNPs is a distinguishing feature of the ACNP role in Canada.

In Canada, an early acute care NP-type role, the expanded role nurse (ERN), was introduced in London, Ontario in the late 1980s (Rubin, 1988a, 1988b). Education of ERNs was very similar to the education provided for the first PCNPs introduced in Colorado (Silver et al., 1967) in that it was offered collaboratively by medicine and nursing. To become an ERN, nurses enrolled in a graduate nursing program but completed additional course and clinical work with medical students before taking on a role that included functions traditionally associated with medical practice. Upon graduation, they practised in specialty areas that included orthopaedics, cardiology and cardiovascular surgery (Rubin, 1988a).

In 1993, 10 University of Toronto-affiliated teaching hospitals identified a need for ACNPs, in part because of anticipated reductions in physician trainee positions that would result in fewer medical resources available to provide patient care. Nursing leaders in these hospitals and at the University of Toronto seized the opportunity to expand nursing’s clinical scope and developed the first Canadian educational program preparing practising clinical nurse specialists to fulfill new responsibilities as ACNPs in large academic health science centres (Simpson, 1997). This not only allowed for the introduction of well established, credible advanced practice nurses with new capabilities in the management of client health/illness status but also prepared qualified nurse-preceptors for future graduate students who enrolled in the ACNP graduate field of study. There were 59 graduates of the initial post-master’s program.

In 1997, consistent with evolving educational recommendations, the post-master ACNP curriculum was revised and integrated as a field of study in the existing Master of Nursing degree program (McAllister, 2004; CASN, 2004). Beginning in the late 1990s, smaller programs preparing ACNPs were introduced at other universities across Canada including the University of Alberta (Worster et al., 2005), the University of Western Ontario, Dalhousie University (Halifax) and the University of Calgary. More recently, in 2002, the University of Toronto’s
MN-ACNP was offered using an on-line format, enhancing accessibility to this field of graduate study for students across Canada.

Education of ACNPs in Canada is consistent with the principles first proposed in 1990 by the National Organization of Nurse Practitioner Faculties (NONPF) (National Organization of Nurse Practitioner Faculties, 1995) and standards for clinical practice for ACNPs developed later (American Association of Critical Care Nurses & American Nurses Association, 1995; National Organization of Nurse Practitioner Faculties, 2004). Canadian educators of ACNPs were in favour of these standards, stating that nurse practitioner education and practice should prepare practitioners to address issues common to health care provision across Canada; accessibility, public participation, health promotion, appropriate use of technology and intersectoral collaboration (Canadian Association of Schools of Nursing, 2004).

In their quest to establish standards, principles and curriculum recommendations for nurse practitioner education, the NONPF Task Force adopted six domains of advanced nursing practice described by Brykczynski (1989) and recommended that NP curriculum focus on these domains:

- Management of client health/illness status,
- Nurse-client relationship,
- Teaching-coaching,
- Professional role,
- Managing and negotiating health care delivery systems, and

These domains are consistent with NONPF’s philosophical position that advanced nursing practice involves specialization in a field of nursing, expansion of knowledge and skills with the ability to advance the nursing profession, integrating a broad range of theoretical, evidence-based and practical knowledge that occurs as a result of graduate education.

It is of particular relevance to the current study that the nurse-client relationship has been identified as a core domain of practice for NPs. The nurse-patient relationship is viewed as central to the NP role and “typifies the personal, egalitarian, collaborative approach which enhances the effectiveness of care” (National Organization of Nurse Practitioner Faculties, 1995, p. 55). Interpersonal transactions are described as imperative to achieving therapeutic patient outcomes and facilitating patients’ involvement in the process of regaining or sustaining health (National Organization of Nurse Practitioner Faculties, 1995).
Acute care nurse practitioner education, focused on enhancing students’ understanding of the importance of interpersonal relationships and enhancing their abilities to establish and sustain effective relationships with patients, may very well prepare a practitioner who particularly values this domain of advanced nursing practice. It may also be that nurses who enter an ACNP graduate program already value this domain of practice and have well developed relational abilities. Achievement of competencies such as cultivating a relationship, which acknowledges clients’ strengths and assists clients in meeting their needs, and providing comfort and preservation of personhood (Brykczynski, 1989) may position ACNPs to emerge from their educational programs able to work effectively with patients who require their care.

Certainly undergraduate nursing programs preparing registered nurses place emphasis on the establishment of therapeutic relationships with patients, but given the breadth of knowledge and skill development required in basic nursing programs, it is inevitable that much of the practical knowledge and skill development in this area comes once they begin practising. It has been suggested that preparation of NPs should begin during undergraduate education, introducing students to the NP scope of practice, regulatory requirements and nature of the practice with particular emphasis on “practitioner relationships with patients” (Alpert, Fjone, & Candela, 2002). Nurses who choose to return to graduate school to become ACNPs are offered learning experiences intended to foster growth and development of relational knowledge and skills, which they may integrate into their care of acutely and chronically ill patients in a way that is unique in the acute health care system.

**Professional Socialization of Acute Care Nurse Practitioners**

Professional socialization may contribute to variation in the relationships ACNPs establish with patients when compared with staff nurses and physicians. Socialization is considered a process whereby individuals obtain knowledge, skills and the professional identity of a particular profession. It involves internalization of a profession’s values and norms such that their behaviour and self concept is changed (Hixon, 1996). Professional socialization of NPs begins with their educational program; learners are exposed to new knowledge, skills and values that subsequently guide them in their transition from staff nurse to nurse practitioner. Once NPs enter their clinical settings, both as learners and when employed, situational factors such as supervisor attitudes, NP deployment strategies and practice expectations continue the socialization process. If socialization influences present during NP education are unsupported in the clinical setting, an NP must make a decision; find a way to adhere to values promoted by
educators or move away from those values in order to work within the clinical setting’s infrastructure (Davidson & Lauver, 1984; Lurie, 1981).

Professional socialization influences how ACNPs enact their roles in acute health care settings. ACNP education programs emphasize the importance of ACNP-patient relationships, interpersonal communication strategies, partnering with patients and active listening to what patients say about their health issues, lives and goals. ACNP students are encouraged to ask about and listen to patients’ illness experiences and their subjective meanings. Socialization may be conceptualized as a continuum that moves from a phase of heightened anxiety as learners identify themselves as ‘novices again’ in terms of knowledge and skills, through a phase of role confusion when students may question their professional identity as nurses in this new role, and finally in an acknowledgment of the responsibilities and accountability they have in providing safe, effective patient-focused care as an NP (Roberts, Tabloski, & Bova, 1997). The end result is modification and expansion of professional values during the educational process (Weis & Schank, 2002).

Siccardi (1999) explored issues related to role transition from RN to NP in primary care. She found that the transition begins during formal education, i.e., graduate education, and continues for several years after graduation. A puzzle was used as a metaphor to represent the challenges inherent in putting the pieces of learning together and the changes involved in transforming themselves from registered nurses to nurse practitioners. As they developed their new identity as NPs, they found themselves holding onto their ‘nurse’ identity and claimed this as essential in the establishment of their new identity. Siccardi concluded that while NPs maintain their nursing identity during their transformation, they do so as they learn to utilize medical diagnostic reasoning processes.

ACNPs, once employed in clinical settings, often practise in a particular environment, usually working with a single specialty population in positions that are classified as advanced nursing practice. Advanced nursing practice roles offer practitioners increased leadership responsibilities, system access and a more autonomous status when compared with staff nurse colleagues. This is evident in position descriptions and documented in empirical studies (Geier, 2000). ACNPs begin their careers as staff nurses and usually attain a level of expertise prior to entering graduate school. Lurie’s (1981) early work surmises that better educated nurses are less bureaucratic or organizationally oriented, are more professional, are more psychosocially knowledgeable in their practice and are better able to deal with clinical uncertainty. Therefore, if the clinical setting affords ACNPs a degree of autonomy and support to enact the role and if
ACNPs have integrated the values imparted in the educational program, the nature of relationships established by ACNPs with patients may be qualitatively different from those between patients and other health professionals.

Finally, nurses who apply and are accepted to ACNP educational programs likely have a strong inclination towards life-long learning and professional advancement. They may also be striving for a particular type of role that enables them to be more autonomous while staying close to patients. An individual nurse who makes a decision to pursue a career as an ACNP may have pre-existing personal characteristics prior to entering an educational program which then result in a different attitude towards patients, relationships with them and nursing practice in general.

In summary, professional socialization is a complex process that is experienced as a transformation. Knowledge and values are conveyed during the educational process which act as pieces of the puzzle that must come together to continue the transition from nurse to nurse practitioner. While socialization during education is influential, the process continues when the NP becomes employed. When the employment setting’s values are congruent with those of the educational environment, NPs are able to maintain their nursing identity while taking on the additional patient care responsibilities required of their new role. This results in a new dimension to nursing practice as NPs offer services to patients that complement what currently exists in acute care settings.

Role Development of Acute Care Nurse Practitioners

The literature speaks to the nursing profession’s implicit contract with society to develop roles that meet the needs of the public (Ford, 1992; Keane & Richmond, 1993). Because PCNPs had been proven to be safe and cost effective, it seemed reasonable to expand the practice of NPs into specialized acute care settings. In fact, earlier evidence from primary care was likely the reason for early ACNP roles being introduced well before formal educational programs were established to prepare these practitioners (Keane & Richmond, 1993). Early studies of the use of non-physician care providers in acute care led many to conclude that it made more sense to encourage the use of non-physician care providers who would be available for an entire career to fill the gaps rather than resident physicians who only work in such areas for a three year training period (Watts, R.J. et al., 1996).

Complementary practice has been described in relation to physician and NP practice (Davidson & Lauver, 1984). Complementary practice is referred to as practice or role enhancement when conceptualizing doctor/nurse skill mix with its counterpart being substitution.
Enhancement is considered the extension of roles or skills of a particular role while substitution suggests that one is working across traditional professional divides or one worker is replaced with another (Buchan & Calman, 2004). In their descriptive study of American teaching hospitals, Riportella-Muller, Libby and Kindig (1995) distributed questionnaires to medical directors of all teaching hospitals and clinical departments to determine how they were using non-physician care providers (NPs and physician assistants). They were interested in teasing out the substitutive roles of non-physician providers (completion of one or more tasks by a person other than the person originally intended to do so) from those that were classified as enhancement (use of a person to go beyond what others do). They found that 60% of teaching hospital medical directors surveyed had experience with substitution in their departments and were satisfied with these non-physician practitioners. An interesting finding was that the majority of medical directors planned to increase their use of NPs and physician assistants in both substitutive and enhancement roles in the future. This suggests that the differences offered by NPs are of value in practice settings. Mundinger’s (2002) views are compatible when she suggests that focusing on the differences rather than the sameness of practice processes is essential if the NP role is to remain viable in the health care system. Balancing the use of substitution and enhancement practices may foster a ‘right provider, right patient at the right time’ approach, freeing up expert physicians to see patients with needs that required their clinical knowledge and expertise (Rafferty & Elborn, 2002). Exploring the differences inherent in ACNP practice may increase our understanding of how this role complements the practice of other health professionals.

ACNPs’ responsibilities vary somewhat with their employing organization, practice site and the patients for whom they provide care. However, when caring for a patient on any given day, an ACNP would complete a health history and an in-depth physical examination, order and interpret diagnostic investigations, determine a differential diagnosis, perform invasive procedures (dependent upon practice site), collaborate with patients and the interdisciplinary team to develop a plan including prescribing pharmacotherapeutics, evaluate the effectiveness of the plan at regular intervals and provide overall coordination of care (American Association of Critical Care Nurses & American Nurses Association, 1995; International Council of Nurses, 2002; Kleinpell & Hayden, 1999; Shah et al., 1997; Worster et al., 2005). ACNPs practice in ambulatory and in-patient settings such as internal medicine, cardiac care, surgical care, critical care, paediatrics, emergency departments, cardiovascular surgery and oncology (Piano et al.,
They are increasingly practising in other unique settings such as home care, long term care, sports medicine and tropical medicine (Worster et al., 2005).

**The Practice of Nurse Practitioners**

Sullivan (1982) commented that the “something special” about NP practice has a positive effect on patient adherence and reducing patient symptoms. She suggested that the process of care had not been effectively explored in research to date and, once explored, should be evaluated in terms of definitive clinical outcomes. Mundinger (2002) reinforces this point, suggesting that research focus on clarifying differences between care provided by physicians and NPs so that the differentiated services of NPs will survive. Donahue (1995) described the “added nursing” dimension as encompassing “holistic and humanistic care and incorporates the principles of health maintenance, health promotion, patient education, counseling, advocacy, collaboration and comprehensive client care” (p. 11-12). There are a number of studies that have attempted to describe NP practice patterns (See Appendix A for study details).

In their study of NP practice, Courtney and Rice (1997) tested a rating form designed to identify particular elements of NP practice with the intent to describe practice patterns in ambulatory settings. Instrument testing was the primary purpose of the study and the sample size (two NPs with 10 patient encounters each) was very small, limiting generalizability of the findings. Investigators found that NPs spent more than two thirds of their time in communication and interpersonal activities while addressing patients’ physical problems. While reliability of the instrument was established (r=0.86), the authors recommended that the ‘NP Rating Form’ not be used in its current form and be amended to capture more process of care aspects of the interactions that occur between NPs and patients such as the use of verbal and non-verbal communication to show empathy and build relationships, the use of collaboration and the management of the interaction to improve client self-esteem. From the reader’s perspective, it would have been beneficial to have more detail about the content of the instrument (i.e., items). While the authors deserve credit for testing an existing measure, the small number of NP – patient encounters evaluated limits the generalizability of practice descriptions to PCNP practice patterns in general.

Several researchers have investigated patterns of practice attempting to discover the “something special” that characterizes the PCNP care provided to clients. Allen (1993) used a sociolinguistic method to provide a textual account of the discursive practices of female PCNPs in consultation with female patients in an attempt to identify language behaviours or speech acts
that characterize the communication of NPs with patients, especially as they reveal relations of power. The findings of the study indicated that power, similar to that of physicians, is ascribed to NPs by patients by virtue of NPs’ health/illness knowledge and prescribing authority. NP power was evident in the use of professional jargon, denial of private space to patients and the use of language that was intended to control the office visit. It is of interest that there were also linguistic indications of the more positively interpreted empowerment of patients, which differed from the literature reviewed regarding physician communication. So, in keeping with what Courtney and Rice (1997) found, this study suggests NPs have interpersonal competence but that NPs do use the power of their position as expert to influence the behaviour of patients. This ethnographic study had a predetermined gender bias (female NPs interacting with female patients) making the findings less generalizable. While participant observation enhanced the rigour of the study, having an observer present during NP – patient consultations may have influenced the behaviours of the NPs.

Another approach used to address the “something special” of NP practice is discourse analysis, used to analyse conversation between PCNPs and patients. Johnson (1993) employed a combination of ethnography and discourse analysis to uncover processes and skills used by PCNPs in order to expand the understanding of their success in achieving patient care outcomes. The author used study findings to compare PCNPs to the literature on physician-patient interaction. She reported that PCNPs paid attention to perceived concerns of patients, used shared language, adopted a stance of co-partnership and used turn-taking in conversation with patients to establish connectedness with the patient’s talk. Johnson commented that her findings varied significantly from their literature reviewed regarding physician communication with patients, which was characterized as more disease focused rather than illness focused. While this study intended to contribute to our understanding of how NP processes might contribute to positive patient outcomes, this was not achieved. Similar to Allen’s (1993) study, the all female nature of the dyads studied limits generalizability. Finally, inclusion of physician-patient encounters in the study would offer a stronger method than using published literature when comparing NP practice with that of physicians.

While Johnson’s and Allen’s studies attempted to address relational aspects between NPs and patients, their findings have limited relevance for acute care. There are obvious differences in acute care environments, including the potentially acute nature of patients’ health issues, lack of patient choice of a care provider and the potential for increased duration and intensity of relationships between acutely ill patients and ACNPs. Additionally, no comparison group was
included in either study, which limits the reader’s ability to differentiate the practice of NPs from that of other professionals, such as physicians.

Two additional studies address practice patterns of NPs practising in primary care settings. Brykczynski’s (1989) initial work used an interpretive phenomenological approach to describe the knowledge embedded in the clinical practice of nurse practitioners. In this study, the author documented her approach to uncovering the clinical judgment of experienced PCNPs in great detail. She used a combination of interviews with NPs and participant observation of PCNP-patient encounters in a hospital ambulatory clinic environment. Emergent themes from this study that reflect the interpersonal dimension of NP practice include continuity of care, partnership, comprehensiveness, knowledge of the person, distinguishing between disease and illness and wholism. Findings from this study offer new information and overlap with Benner’s (1984) earlier work addressing nursing practice. While the list of competencies is not exhaustive, the findings contribute to our understanding of how NP practice differs from that of registered nurses. Interestingly, Brykczynski concludes that the PCNP practice described in her study is complementary in nature to that provided by physician specialists though she did not include a physician comparison group.

In a related study, Lewis and Brykczynski (1994) focused on the healing role of the NP engaged in primary care practice. They built on Brykczynski’s earlier work and framed their findings in the context of the healing domain of the National Organization of Nurse Practitioner Faculties curriculum guidelines. This interpretive phenomenological study uncovered themes that included ‘little things mean a lot’ and ‘healing begins with listening’, both stressing the importance of listening to patients and acting on what may seem like the smallest, insignificant issue. They also identified two additional competencies for the healing domain: using humour with sensitivity and risk taking. Each of these skills was integral in facilitating the healing process. While a very focused study, the findings contribute to the healing domain of NP practice. However, the primary care nature of the study setting makes it unclear if these competencies are generalizable to ACNP practice. This study was well designed but the reader must assume that enough participants were interviewed to achieve saturation because it is not discussed. In addition, there was no discussion of ethical considerations, e.g., informed consent processes. Both of these studies are valuable as they describe some of the potentially invisible elements of PCNP practice; however, it is impossible to know if these are unique to PCNP practice as no comparison groups were studied.
A final study exploring practice patterns of PCNPs used a different theoretical approach, applying principles of resource exchange to the NP-patient encounter (Donohue, 2003). The intent was to gain an understanding of patients’ expectations of NPs and compare those with what they received during NP-patient encounters. Patients were interviewed before and after their encounters with the NP and interactions between each dyad were taped and analysed. Patients reported receiving what they expected from the NP. Analysis of the interactions suggested that patients receive a combination of services, information, trust, self-disclosure, support, affirmation, time, acceptance and respect during interactions with NPs and that patients were satisfied with what they received. While Donohue intended to gain a better understanding of the relationships that occur between patients and NPs, the use of resource exchange as a theoretical approach imposed limitations. Only a portion of resource exchange addresses interpersonal elements. As well, this study included a small number of female NPs and female patients so generalizability is again limited. It is unclear if the researcher’s presence and involvement had any influence on patient or NP participants during this study. Pre-existing relationships (e.g., between NP and researcher) may negatively or positively affect participant involvement and influence how participants describe their interactions. While this study was a small pilot study (two NPs, eight patients) an important methodological strength was its focus on patients’ perceptions of provider-patient relationships, a perspective that is not regularly offered in empirical literature.

Since the introduction of the ACNP role several researchers have explored their practice patterns. Beal completed two studies, one aimed at describing roles and responsibilities of neonatal nurse practitioners (Beal et al., 1999) and the second describing a model of practice (Beal, 2000). Findings from the first study indicated that neonatal nurse practitioners engaged in comprehensive patient care including assessment, diagnosis and ongoing management of newborns, collaboration with other team members, ordering and performing procedures, prescribing therapeutics, providing parent support, educating nursing and medical students, participating in research and administration of patient care services. These responsibilities are in keeping with published standards of practice and role competencies (American Association of Critical Care Nurses & American Nurses Association, 1995; National Organization of Nurse Practitioner Faculties, 2004) and several direct care components are also evident in studies of PCNP practice patterns. This study involved a reasonable number of NPs (22 NPs employed in five neonatal ICUs) and the patients for whom they cared but was limited to a small region of the USA. As well, the NP role was well established in all five sites. Both of these factors
compromise the generalizability of findings to neonatal NP practice as well as to ACNP practice. Findings may represent regional practice patterns and the practice of established NPs may not be applicable to newly introduced roles in other acute care settings.

Beal’s (2000) second study was designed to describe a model of practice used by neonatal NPs in the same five neonatal intensive care units. This qualitative study used ethnographic methods and produced a description of neonatal NP practice that included a blending of medical and nursing approaches in patient management, a role of ‘combinations’ (medicine and nursing), a holistic perspective, role expansion, leadership activities and the maintenance of a caring focus. Beal concluded that the model is a unique feature of neonatal NP practice. It is, however, interesting to note how her descriptions support earlier work by Brykcynski (1989) such as using a holistic approach and offering comprehensive care. Beal’s model is also compatible with professional standards for ACNP roles. The model of care generated in this study does not appear to be as unique as initially thought.

Several studies attempted to describe and measure ACNP practice patterns using quantitative methods. Hoffman and colleagues (2003) used time-in-motion studies to develop an instrument to use in a work sampling study of a new ACNP and medical fellows and residents in an intensive care step-down unit. They found that the ACNP and physicians in training spend about 40% of their time in patient management activities. However, physicians spent more time in non-unit activities, e.g., attending education sessions, and the ACNP spent more time interacting with patients/families and collaborating with unit staff with the intention of coordinating care. A strength of this study’s design was the completion of time-in-motion sampling at two different points in time (6 months apart). While these findings suggest that coordination activities of ACNPs might be a unique feature of their practice, this study is not generalizable due to its small sample size (one NP, six medical trainees), use of a single study site and the potentially unique nature of an intensive care unit environment.

Another study, designed to measure practice patterns (Lambing, Adams, Fox, & Divine, 2004), used a descriptive, comparative design with a convenience sample of five NPs and six resident physicians and a random selection of 100 geriatric patients admitted to two different units; one managed by NPs and one by resident physicians. They found that NPs spent more time writing progress notes and planning care, consulted physical/occupational therapy and nutrition colleagues more frequently and discussed advanced directives more often with patient and families. They also cared for sicker and older patients. Resident physicians spent more time completing literature reviews and giving or attending in-services. They cared for slightly
younger and healthier patients. Another difference noted was the higher patient charges on the NP unit, which were attributed to increased professional fees associated with consultations requested. There were no differences detected in patient outcomes including readmission and mortality rates. While the authors concluded that ACNPs can provide effective care to geriatric in-patients, this study also illustrated differences in the practices of ACNPs and physicians in training. As discussed earlier, deploying care providers who focus their career in a particular specialty may indeed make more sense than having the sickest patients in our society cared for by those in training and who spend only short periods of time in each setting. Despite the conclusions of this study, it is important to note that ACNPs in the study had a mean of eight years experience making them experienced and perhaps not typical of all ACNPs. And though the investigators did review documentation on 100 random patient charts, the questionnaire that health professional participants completed about their practice relied on recall and so may not accurately reflect time involved in particular activities.

Rosenfeld, McEvoy and Glassman (2003) designed an instrument to assess practice patterns of ACNPs and then evaluated the instrument in two large urban hospitals. The intent was to develop an instrument that would measure practice patterns of ACNPs across settings. There were 61 ACNPs who completed the instrument across the two organizations (response rates of 65% and 51%). The authors found that ACNPs spent more than 50% of their time in direct patient care activities and approximately 33% of their time on indirect patient care. They spent very little time on activities related to administration, education, research or their own personal needs. The most common individual items reported were physical examinations, assessments, admitting patients and completing histories and physicals. However, what was evident was the blending of medicine and nursing inherent in how they spend their time, again reinforcing the premise that NPs practice differently than their physician colleagues. The authors concluded that the instrument was robust with reasonable reliability (subscale scores ranging $r = 0.53-0.86$) but it is unclear if the tool would be applicable in all specialty settings, e.g., paediatrics. In addition, there was no discussion of why the participation rate was so low leading the reader to wonder if the clinical utility or feasibility of the instrument is problematic.

In two Canadian studies, practice patterns of ACNPs were evaluated, initially alone and then in comparison with physician resident trainees. In the first study, 57 ACNPs practising in 11 hospitals in two large urban centres were evaluated using three different methods; activity diaries, questionnaires and semi-structured interviews with 10 of the ACNP participants (Sidani et al., 2000). Half of the ACNPs had previously practised as clinical nurse specialists, 88% had
formal education to prepare them for the ACNP role and all had master’s degrees. ACNPs reported being involved in independent decision-making including making referrals, ordering investigations and prescribing medications. They described the ACNP role as advanced nursing practice with a focus on the clinical practice domain (>80% of their time) that includes medical management, coordination of care, assessment and planning. When asked to describe their practice model, 37% reported a nursing focus, 12% reported a medical focus and 63% reported a blending of the two. These findings are consistent with published studies (Beal, 2000; Rosenfeld et al., 2003) and contribute to our understanding of ACNP practice patterns. The authors reported a good response rate (85%) and used multiple data sources to enhance the credibility of the research design. However, the questionnaires were developed by the research team and were not evaluated for reliability and validity. In addition, the activity diaries, while requiring participants to quantify their activities in minutes, were likely not completed concurrently with practice making them susceptible to recall bias and compromised accuracy. However, the study findings offer a Canadian context and reinforce recurrent themes of advanced nursing practice, a conscious blending of medicine and nursing and an emphasis on coordination of care in ACNP practice.

A second study investigated the practice of 31 ACNPs (82% response rate), 10 physician residents (42% response rate) and the care they provided to 544 patients (61% response rate) (Sidani et al., 2006). ACNPs were found to spend significantly more time in management tasks and informal coordination while physician residents spent significantly more time in formal coordination activities. ACNPs reported encouraging patient participation in care and providing patient education to a greater extent. Patients reported higher levels of care coordination, participation in care as well as more counseling and education when they received care from ACNPs. An interesting feature of this study is the discrepancy in ACNP and physician resident rates of participation. Many physician residents who chose not to participate did so because they believed the ACNP role was different from that of a resident and so believed the comparison to be invalid. This discrepancy in provider participation rates resulted in an even larger discrepancy in the numbers of patients cared for by each type of provider. However, statistical analysis was still possible and able to detect differences. The findings of this study are consistent with others, suggesting that ACNP practice is predominantly focused on patient management, both direct and indirect activities.

Studies seeking to provide descriptions of ACNP practice patterns have used both qualitative and quantitative approaches, often developing measures to ascertain what exactly
these practitioners do. Ultimately, it has been researchers’ intent to detect the ‘something special’ that ACNPs offer to the patient care enterprise, although most do not state this intent explicitly and are lacking comparison groups. Early studies of PCNP models of practice used predominantly qualitative methods and yielded a number of themes that describe NP roles and what NPs do. These themes are mirrored in more recent studies of ACNP practice. These studies, although contributing to our understanding of how ACNPs practice, have not illuminated any unique aspects of the interpersonal nature of ACNP-patient relationships and only two studies explored patients’ perspectives on NP practice.

Effectiveness of Nurse Practitioners

The emergence of new NP roles in acute care environments has resulted in significant professional discussion and debate about their safety and effectiveness in provision of health care to acutely and critically ill patients (Owens, 1999). The NP role has been studied since its introduction into primary health care settings in 1965. The majority of studies have addressed the evaluation of PCNPs in comparison with more traditional care provided by physicians. These studies in primary care have found that PCNPs provide equivalent care and achieve similar patient and system outcomes as their physician counterparts (Horrocks et al., 2002; Mundinger et al., 2000; Spitzer et al., 1974). In particular, PCNPs have been found to excel in communication and interpersonal care (Courtney & Rice, 1997; Horrocks et al., 2002; Johnson, 1993).

Relatively speaking there is a paucity of studies evaluating the impact of introducing ACNPs into acute care settings to provide comprehensive and quality care to acutely and critically ill patients. As with empirical literature addressing PCNP effectiveness, published studies of ACNP effectiveness have measured a number of different variables, most commonly length of stay, mortality rates and morbidity/complication rates (Sidani et al., 2006). Some of these studies include a comparison of care provided by ACNPs with that provided by physicians, usually medical trainees. Medical trainees are common comparators because they have typically provided care to patients in a variety of acute care settings. When changes in medical education directly influenced medical trainee programs and their numbers were reduced, ACNPs were introduced as an alternative care provider and evaluation of their safety and effectiveness required comparison of care provided by these two health professionals (Carzoli et al., 1994; Mitchell-DiCenzo, Pinelli et al., 1996; Pioro et al., 2001). The challenge comes when trying to compare published studies given the differences in research design and outcomes of interest.
However, trends related to ACNP effectiveness are in keeping with earlier PCNP effectiveness studies; results have indicated either no difference in care provided by ACNPs as compared with physicians or improvement in some aspects of care favouring the ACNP role (Sidani et al., 2006). Several studies, beginning with the first study published will be reviewed here (see Appendix A for study details).

An early study evaluated the introduction of an NP managed unit in a large rehabilitation hospital (Weinberg, et al., 1983). The care provided to patients in four stroke units was compared. Patients in three of the four units were managed by full time, board-certified internists and the fourth was managed by an NP, supervised by one of the internists. Twenty-five patients were randomly selected from each of the four units and evaluated. Variables included length of stay, lab costs/day, number of consultations and an index of illness score, a measure developed for this study with no established reliability/validity data (higher score indicates higher quality of care). The NP-managed patients had slightly shorter lengths of stay, lower lab costs/day, fewer consultations and higher index of illness scores. No statistically significant differences were found when comparing patients managed by the NP and those managed by each internist. In fact, no statistically significant variance across all four providers was detected, indicating that the NP provided a comparable standard of care to those of the internists. Of note was the similarity in findings for the NP-managed patients and patients managed on the patient care unit also managed by the NP’s internist supervisor, suggesting an influence on the NPs practice patterns. There was a small degree of variability on all measures across the four units but the differences did not appear to be clinically meaningful. One concern is the researchers’ use of numbers of consultations and testing costs as a proxy measure for quality; that is the number of tests and consultations prescribed by practitioners reflects good quality of care. While minimal variability across all four practitioners suggests that NP practice is comparable to internist practice, there is no guarantee that these findings are indicative of quality care. This was an important early study of an institution-based NP practice role, albeit in a rehabilitative and not an acute care setting.

Another study addressed the effectiveness of NP-directed care compared to medical house staff-directed care in the emergency department (Cooper, Lindsay, Kinn, & Swann, 2002). A convenience sample of 199 patients was randomly assigned at triage to receive care by either an NP or medical house staff. Outcomes included patient satisfaction (post-visit), patient responses to treatment (one month post visit), consultation time, waiting time, missed injuries and appropriateness of care. Patients reported being satisfied with the level of care provided by
both types of providers but felt more comfortable speaking to NPs and felt they received more injury-specific and injury/illness prevention information from NPs. NPs’ documentation was also found to be of higher quality. Only two injuries were missed and they were both in the NP group. There were no differences in patient outcomes a month after treatment. The authors concluded that NPs provide care for patients with minor injuries as well as medical house staff and with some enhanced patient satisfaction. While the research design of this trial is rigorous, there was no apparent attempt to blind those evaluating patient charts for appropriateness of care. As well, educational preparation of the NPs was not described which may affect generalizability of the findings to other settings.

A study focusing on the implementation of ACNPs with specific populations quantified the cost savings associated with introducing an NP to provide care to hospitalized patients with heart failure (Dahle, Smith, Ingersoll, & Wilson, 1998). A retrospective, pre/post chart review design involved review of all patients admitted with heart failure one year before and one year after introduction of an NP. Costs associated with room, laboratory testing, respiratory therapy, pharmacy, radiology, ECGs and NP salary were included in the analysis. Statistically significant cost reductions were demonstrated in total ancillary, lab, respiratory and ECG costs with the introduction of an NP to the service. Trends toward decreased length of stay, decreased room costs as well as decreases associated with radiology and pharmacy post-introduction of the NP were noted but did not achieve statistical significance. This analysis is the first to provide a cost analysis of NP care. A limitation of the study is the lack of randomization. As well, the study acknowledges that only one NP was involved and it is unclear if the study effects were related to the individual in the role or the NP role in general. The educational preparation of the NP is also not discussed.

The impact of ACNP care provision to medical inpatients as compared with traditional medical trainee care was evaluated by McMullen and his colleagues (2001). This study focused primarily on satisfaction ratings of referring physicians, hospital staff and patients. A convenience sample of patients was used and each patient was asked to complete a satisfaction survey one month after their discharge. Patients cared for by medical trainees were assessed as sicker in hospital and sicker one month after discharge. Patients who received care from ACNPs expressed higher levels of satisfaction with how ACNPs spoke about their case in their presence. Patients cared for by medical trainees were more satisfied with how test results were explained. Referring physicians and hospital staff were highly satisfied with the care ACNPs provided.
While there are interesting trends supportive of ACNP provision of care, details of the ACNP practice unit are lacking, methods are difficult to discern and the sample size is unclear.

There are three large randomized controlled trials evaluating the impact of ACNPs on a variety of key variables. The earliest of these evaluates care provided by neonatal NPs as compared with paediatric residents in the care of critically ill newborns (Mitchell-DiCenso, Guyatt, Marrin et al., 1996). The rigorous design included evaluation of a number of key variables (e.g., quality of patient care using indicator conditions, costs, complications, parent satisfaction) with researchers reporting equivalence in all outcome measures. Thus they concluded that NPs provide equivalent care to medical trainees in the neonatal setting. These findings support those of an earlier retrospective study of 244 patients cared for by NPs and physician assistants as compared with physician trainees in an neonatal intensive care unit (Carzoli et al., 1994). The strength of Mitchell-DiCenso’s and colleagues’ study is its rigorous design including prospective data collection, randomization of subjects and blinding of evaluators. A limitation, however, is the indicator condition tool developed which was based on medical expert opinion that may reflect local practice patterns so may not be applicable in other neonatal settings. Neonatal ICUs are also highly specialized critical care settings and may not be generalizable to other acute care areas. The sample size was also small which was related to the limited number of NPs practising in NICUs at that time. However, the findings offer a perspective on the practice of ACNPs with acutely and critically ill patients and the study itself offers an example for rigorous evaluation of other ACNP roles.

A second, larger randomized controlled trial was the first designed to describe the activities of practitioners as well as to evaluate outcomes of hospitalized patients cared for by ACNPs and/or physician assistants (PA) as compared with resident physicians (Rudy et al., 1998). Data on clinical activities of ACNPs, physician assistants and medical residents as well as associated patient outcomes were collected at four different time points over a 14 month period. When compared with the ACNP/physician assistant group, resident physicians worked longer days, cared for more patients, provided more hands on treatment, spent more time writing orders, consulting, doing procedures, talking with patients and spent more time off the unit. ACNPs and physician assistants were more likely to discuss patients with RNs and formally present patients on daily rounds. When data were controlled for length of shift, results were similar for the two groups (ACNPs/PAs versus residents) except that ACNPs and physician assistants were more likely to spend time speaking with the patients’ family members, reviewing charts and notes, performing hands-on assessment and performing research and administrative
duties. There were no significant differences in patient outcomes (i.e., length of stay, in-hospital mortality, occurrence of drug reaction, completeness of admission notes, readmission rates) between the two groups (ACNPs/PAs versus residents). Findings of this study suggest that the clinical tasks of ACNPs, physician assistants and medical residents are similar and that outcomes of care provided are not dependent upon who provides the care. Use of diary logs to collect data about practitioner practice patterns may lead readers to question the accuracy of estimates of time spent on particular tasks as these logs are not generally completed concurrently with clinical practice. As well, this study does not address the interpersonal competence dimension that has been previously demonstrated as unique to NP practice. Attention to this dimension in addition to those rigorously addressed in this study would be beneficial.

A final and more recent study randomized the care of patients admitted to general medical units in a large teaching hospital to teams of ACNPs and medical house staff (Pioro et al., 2001). No significant differences were found in outcomes at the time of discharge and six weeks after discharge including length of stay, charges, cost, consultations, complications, transfers to intensive care, 30 day mortality, patient assessments of care, SF-36 scores, symptom severity and changes in activities of daily living. One interesting finding was the reversal of randomization in 53% of patients randomized to be admitted to the ACNP unit and a variety of reasons were offered. However, the findings of patients whose randomization was reversed were analysed separately based on intention to treat and findings did not differ from those of the randomized cohorts. The authors did note that staff physician concerns regarding ACNP capabilities and their perceptions of limited flexibility of ACNPs in managing varying numbers of patients has the potential to impact on the applicability of these results in other settings. A strength of this study is the evaluation of care provided exclusively by ACNPs (without physician assistants), a model that is more typical in Canada where there are currently no physician assistants practising in acute care settings.

Review of empirical literature evaluating effectiveness of ACNPs offers encouraging trends and indications of effective and safe care provided to acutely and critically ill hospitalized patients by this relatively new health professional. Given the ongoing shortage of medical trainees and health professionals with expertise to provide comprehensive care to acutely and chronically ill patients, ACNPs fill a gap. However, at this time there is insufficient evidence to conclude that ACNPs are effective. While there are three published randomized controlled trials designed to detect statistical differences, their sample sizes were generally small and the outcomes they measured varied. Another significant issue that remains unresolved is the choice
of a comparator group. With the increase in the use of ACNPs in acute care settings, many of them teaching hospitals, the effectiveness of care provided by ACNPs has been compared with typical providers; medical trainees. This comparison may not be reasonable, as suggested by medical trainees who chose not to participate in Sidani’s and colleague’s study (2006). This point is particularly relevant when the ACNP have many years of experience in the role. Under these circumstances, comparing ACNP care with that of a medical trainee seems unfair and irrelevant. However, until models of care in teaching hospitals change, this comparator is likely to be used.

As with early studies of PCNPs, the most rigorous studies have emphasized traditional outcomes that address safety, effectiveness and equivalence with traditional models of care. While quantifying the impact of ACNP care on traditional patient outcomes is important in order to justify the continued existence and proliferation of ACNP roles, it is also essential that the ‘something different’ about the care provided to patients by ACNPs also be investigated. One such area is the interpersonal dimension of ACNP practice.

**Nurse Practitioner Relationships**

The final body of literature to be reviewed contributes to our understanding of ACNP practice, in particular their interpersonal relationships with patients. While the literature contains studies that address nurse-patient relationships, only three studies were identified that focus exclusively on NP-patient relationships; two explored dimensions of PCNP-patient interactions and relationships and one explored relationships of NPs practising in primary care and acute care settings. Given the primary focus of the current study, only studies of NP-patient relationships will be reviewed.

The most extensive study of PCNP-patient encounters was completed by Fisher (1995), a sociologist with a feminist theory perspective, who was interested in deconstructing social discourses, situated knowledge and gendered positions in evidence during encounters between health professionals and female patients. She observed a series of health professional-patient encounters and completed a detailed analysis of interactions. Two physicians and two NPs agreed to participate. Each was observed with two different female patients. Patients’ complaints were classified as either social psychological or medical in nature. Each consultation was observed and audio-taped by the researcher and detailed field notes were documented during and after each consultation. Fisher’s analysis was extensive and included findings relevant to PCNP-patient relationships in comparison with those between physicians and patients. Fisher
found that NP consultations were longer and could be characterized as supportive discourses. Although there was “asymmetry” (p. 173) noted in the NP-patient relationships, the degree of asymmetry was less than that observed in physician-patient relationships. Social-psychological as well as medical content was addressed in all NP-patient consultations. Both types of health professionals established themselves as medical experts (white coat, carrying medical file), but while physicians reinforce their dominance in the relationships, NPs tended to “undermine their professional status” (p. 175) in an attempt to minimize the difference between themselves and patients. NPs also acknowledged the patients’ expertise in relation to their own health, so when rival discourses (e.g., patients challenged NP views) are presented, NPs reformulate treatment options and approaches to achieve consensus. The central question the researcher sought to answer was “Do nurses do it better?” This may reflect a researcher bias that could be controlled for if analysis was completed by someone who was not present during the interactions and who worked from transcripts that had been cleaned of labels such as NP, doctor and patient. Ultimately, what Fisher concluded was that NPs do it differently. While not explicitly stated, the contribution of meaningful dialogue and effective interpersonal strategies to the therapeutic relationship can be underscored and is consistent with existing but limited empirical literature addressing NPs’ interpersonal abilities. Fisher offers detailed accounts and thick description of each case study included in this publication which is convincing and compelling. Its limitations are its inclusion of only female patients. As well, observing male physicians with female patients likely offers an even greater contrast because both NPs were female.

More recently, Covington (2005) completed a focused exploration of the “nature of presence” in therapeutic relationships that occur between PCNPs and patients. She grounded her phenomenological study on the phenomenon of caring and its related theories proposed by scholars like Watson, and Paterson and Zderad. The study investigated the experience of caring presence in the context of a therapeutic relationship from the perspective of NPs and chronically ill patients for whom they provided care. Covington suggested that in “caring presence” a person shares themselves through ways of “behaving, being and feeling” (p. 171). Three themes emerged that describe the experience. The first theme, mutual trust and sharing, was characterized by lowering and crossing of personal and professional boundaries, exhibiting open and honest communication, listening to one another and attentiveness. The second theme, transcendent connectedness, suggested a spiritual bonding in the relationship; NPs referred to this as “a calling” (p. 171). The third theme, a metaphysical experience, is closely related to transcended connectedness and is experienced as a strong energy source and “a place to share the
illness experience” (p. 171). Covington concluded that the experience of caring presence between NPs and patients with chronic illness is a “journey towards a mutual goal” (p. 172). It has been proposed that the nature of the relationship is responsible for encouraging patients to return for care, fostering patients’ positive health care decision-making. This study makes an important contribution to our understanding of NP-patient relationships, suggesting that a connection occurs that may be responsible for patients’ involvement in their own care and ultimately more positive outcomes. However, patient participants were asked to volunteer which may have resulted in only patients with positive views of NPs being included in the study. Readers will also find the description of methodological approaches vague, making replication and determination of credibility and truthfulness of the findings difficult.

Finally, Kleiman (2004) included NPs from primary (3 NPs), acute (2 NPs) and long-term care (1 NP) settings in her phenomenological study of NP experiences interacting with patients. A convenience group of NPs was approached to participate in the study and a snowball sampling strategy was used. All NP participants were female and had master’s degrees. Unstructured interviews yielded eight essential meanings; openness, connection, concern, respect, reciprocity, competence, time and professional identity and each meaning was further clarified by related qualities. Kleiman concluded that the structure of the relationship is characterized by “authentic attendance to health-related concerns, situated in an intersubjective relationship (connection)” (p. 268). The connection offers constancy over time and continues well beyond the face-to-face interactions, referred to as ‘presence in absence’. NPs, while feeling the limits of the time they have to spend addressing patients’ needs, described their interactions as unhurried, open and attentive. NPs emphasized their nursing identity, reflecting their relationship-orientation rather than one that is disease or cure-oriented. They reinforce their nursing perspective while engaging in medical activities, suggesting a blending of elements of the two kinds of practice, a finding that is consistent with previously examined empirical explorations of NP practice patterns (Beal, 2000; Sidani et al., 2000). This study, while including only a few NP participants, claims rich, thick description of the phenomenon, thus inferring the use of a trustworthy and credible research process. However, deficiencies may include lack of discussion of consent issues and the fact that participants were recruited from a single region of the USA resulting in a potentially region-specific understanding of NP experiences with patients. Finally, while this study contributes to our understanding of the nature of NP-patient relationships, patient perspectives are not addressed.
The findings of these NP-patient relationship studies, while exploring the interpersonal nature of NP role, provide only preliminary impressions of this aspect of NP practice. It is significant that no studies were identified that focus on interpersonal aspects of ACNP practice in acute care settings. No comparisons with other providers are documented and patient perspectives are not well represented. While the findings presented here may be applicable to ACNP-patient relationships, this fact has yet to be confirmed and requires focused exploration. In addition, it is important to investigate the perspectives of both ACNPs and patients with respect to this important phenomenon.

This chapter has examined and appraised literature that addresses the history of nurse practitioners, their education and socialization, practice patterns and role effectiveness, with attention paid to descriptions of unique aspects of nurse practitioner practice. ACNPs have been practising in Canada for close to two decades and while their roles have been described, their effectiveness is contested, is narrowly studied and has yet to be confirmed. While published studies to date conclude that care provided by ACNPs is equivalent to that of medical trainees, the majority used small convenience samples and had low power. While there are three published randomized control trials, they evaluated different models of care (neonatal NP, ACNP/PA, ACNP) using different outcomes. There is certainly not enough published evidence to be certain that ACNPs provide safe, effective care. It is, however, encouraging that some studies chose to include patient perspectives as an outcome measure. While all the studies reviewed provided support for the use of ACNP models of care, the ‘something different’ about NP practice has not been described. Interpersonal competence has emerged as a potentially unique feature of NP practice but has not been systematically investigated from both the NP and patient perspective. An exploration of ACNP-patient relationships may yield an understanding of the ‘something different’ offered by NPs in the care of acutely ill patients.
CHAPTER 3-PHILOSOPHICAL AND THEORETICAL PERSPECTIVES ON RELATIONSHIPS

Relationships are considered central to the practice of nursing and essential to effective provision of care (College of Nurses of Ontario, 2006; Ramos, 1992; Registered Nurses' Association of Ontario, 2006). Relationships are also considered paramount in the practice of medicine (College of Physicians and Surgeons of Ontario, 2006) although it is of interest that when ‘physician-patient relationship’ is used to search medical literature, the vast majority of citations address communication and interaction strategies, not the broader issue of relationships.

The term ‘relationship’ in nursing literature is often associated with adjectives that define the term such as therapeutic, helping, interpersonal and caring. A variety of definitions and descriptions have been proposed and the issue is further complicated when several terms are used interchangeably without establishing a clear meaning of what a ‘relationship’ actually is (Thomas Lawson, 1995). Terms such as ‘interaction’ and ‘encounter’ are used in some circumstances as processes that contribute to the overall ‘relationship’ and on other occasions as synonymous with the term ‘relationship’. Thomas Lawson (1995) describes the work of a number of nursing theorists, including Travelbee, Peplau and Orlando, who are considered interactionist theorists and use all of these terms in their theoretical perspectives on nursing practice.

Attempts to describe nurse-patient relationships have a long tradition in the nursing profession’s literature. In the context of nursing, a relationship is broadly defined as a purposeful and goal directed interaction or series of interactions that is intended to promote health, healing and improve the patient’s quality of life. The relationship is considered a process that is mutual, interpersonal, reflective and characterized by respect, empathy, trust, professional intimacy, power, genuineness and validation and requires careful, purposeful and active listening on the part of the nurse (College of Nurses of Ontario, 2006; Registered Nurses' Association of Ontario, 2006).

In an attempt to clarify important perspectives and define key characteristics and the essential nature of human relationships, the work of several philosophers and theorists are reviewed: Martin Buber, a philosopher, described “I-Thou” relationships as central to being human (1970b; 2004); Sidney Jourard, a psychologist, used Buber’s seminal work in his work on self-disclosure and applied it to health professional-patient relationships (1971b); Alastair Campbell, a theologian, discussed and compared relationships that clients have with a variety of health professionals (1984); and Josephine Paterson and Loretta Zderad, nurse researchers,
originated humanistic nursing theory as a foundation for understanding and practising the profession of nursing (1976). Their perspectives are reviewed in the context of health professional-patient relationships in acute care environments, acknowledging the philosophical lens used to view the central phenomenon explored in this study.

**Philosophical Perspectives on Relationships**

*Martin Buber*

Martin Buber (1970b; 2004), an Austro-German philosopher, has written extensively on theology and humanness but is best known for a unique philosophical stance on human relationships. He suggested that what makes man unique is his relationships with other human beings, specifically “man with man” (Buber, 2004 p. 240). Inherent in relationships between man and man is dialogue, which is considered central to human existence, requiring a person to be open and attentive to the experience of dialogue between him and the other, which may or may not involve actual verbal speech. In fact, Buber describes three types of dialogue; genuine, technical and monologue-as-dialogue. Genuine dialogue is communication that may be silent or spoken and requires each individual to truly be with another with the intention of entering into a mutual relationship. This form of dialogue is rare because of the attentiveness required on the part of both engaged in the dialogue. Technical dialogue is more purposeful in nature, serving to allow one to understand something but not requiring that there be a relationship. Finally, monologue that masquerades as dialogue is an interaction between persons but, in reality, is actually each individual speaking with himself, not the other; it is as if the other person does not need to be present (Buber, 2004). Buber clarifies that dialogue can be any form of communication; it can be in the form of words, impressions, behaviour, even a feeling that is transmitted from one to another that allows one to know the other as an individual. If it is genuine dialogue one can make a “connexion” (Buber, 2004 p. 23) with the other.

He contends that a meaningful dialogue can occur between oneself and ‘the other’, whether the other is another human being, an animal, or an object, such as a mountain or a work of art. A life of dialogue results in one being changed by the relationship with ‘the other’ and the resulting feelings do not leave him. So, in the case of a mountain, one would have to form an impression, perhaps being struck by the majesty and power of its natural state, and be changed forever because of the interaction with nature. In contrast, if one is living in monologue instead of dialogue, one is never aware that the other is not himself yet he may continue to communicate with the other, albeit in a far less intense and in-depth way. Being, as lived in dialogue, results in
reciprocity while being, lived in monologue, does not (Buber, 2004). Buber contends that it is a person’s genuine awareness and interest in the other and what happens between the two of them that allows one to engage in genuine dialogue. Dialogue allows one to perceive a common event from two sides (one’s own and the other’s) and understand what the event is in “a bodily way” (Buber, 1970b p. 24). However, one living in monologue wears his feelings like medals, displays his own power and is delighted with himself, living life looking in a mirror at himself. He does not see things from others’ perspectives. Others’ thoughts or feelings have little impact on him. That is not to say that any interactions that occur are not cordial or pleasant; they simply have no impact on one who is engaged in monologue.

Buber, while writing to address adversaries of his philosophy of dialogue, suggested that one cannot be forced to dialogue, but it does not require a special talent. “There are no gifted and ungifted here, only those who give themselves and those who withhold themselves” (Buber, 2004 p. 40). And one may not engage in dialogue today, but do so tomorrow. Clearly there are factors that contribute to people’s willingness to ‘give themselves’ in relations with ‘the other’.

This brings us to Buber’s discussion of the relationships human beings develop with one another. He describes relationships as being established one with ‘the other’ as either “I-Thou” or “I-It” in nature. An “I-Thou” relationship is characterized by openness, mutuality, reciprocity and presence. In contrast, an “I-It” relationship reflects a subject-object relationship where one interacts with another without recognizing the other as a unique individual. “It” does not necessarily mean an inanimate object but can be a person with certain distinct characteristics and qualities who is one-dimensional and who is not seen as a “Thou”. Buber (1970b) describes an “I-Thou” relationship as coming to know the immense ‘otherness’ of the other so that the other does not remain strange and unknown. This allows each individual in the dyad to attain the special designation of “Thou” to the other. Speaking “I” and “Thou” can only be done using one’s entire being, unlike speaking “I” and “It” which can never be done if one is using one’s entire being. The “It” which Buber (1970b) described has clearly defined boundaries in relation to the “I”. “Thou” has no such boundaries or borders; it stands in relation to the “I”. There is a sense that this relation is surprising, requiring intense attention in order for it to persist.

“I-It” relationships allow one to experience something and the experience is within oneself, but the other, who is the source of the experience, does not share that experience; the other allows itself to be experienced but is not changed. In fact, Buber (1970b) suggests that the “It” in “I-It” relationships is the source of experience as a human. Gaining experience, in Buber’s terms, infers a remoteness from the other that is not characteristic of the “I-Thou”
relation. “I-Thou” encounters do not yield experience, but essential change in both the “I” and “Thou”. While Buber does not propose that “I-Thou” and “I-It” relationships are oppositional, Kaufmann, in the prologue to his translation (Buber, 1970b), suggested that “I-Thou” relations are certainly celebrated by Buber. He suggested that “I-Thou” relationships are necessary to allow one’s life to have a degree of authenticity as a human being. It seems apparent that one must have “I-Thou” relationships to balance those that are necessarily “I-It”. It also seems impossible for one to have all “I-Thou” relationships as they require significant vigilance, attentiveness and energy with respect to ‘the other’. Kaufmann, in his prologue to the translation of Buber’s work (1970b), explains his interpretation of this reality.

Even as you treat me only as a means I do not always mind. A genuine “I-Thou” relationship can be quite exhausting, even when it is exhilarating, and I do not always want to give myself (p. 17).

Therefore, the intensity and meaningfulness of the “I-Thou” relationship could become overwhelming and unmanageable for an individual. In fact, Buber (1970b) suggests that human beings must persevere to manage or modulate attentiveness or else the world would constantly bombard them and they would lose ability to master it.

Buber (2004) conceptualizes the relationship between man and man as a turning to one another in order to communicate “in a sphere which is common to them but which reaches out beyond the sphere of each” (p. 241). This is what Buber refers to as the “between”, which he describes as a “primal category of human reality” (p. 241). This “between” is dynamic and changes as the “I” and “Thou” interact with one another. Its character emerges as unique between the two, a dimension that only the two can access. Buber (1970b) says this is because each “happens” to the other (p. 242). This element of the relationship between one and the other can be fleeting or it can last, but the capacity to experience the “between” is uniquely human and transcends each individual. It is far greater than the sum of its parts. Buber, interestingly, described what goes on “between” a human being and his “Thou” as a form of love, something that emerged in the work of both Jourard (1971b) and Campbell (1984), discussed later in this chapter. Buber (1970b) claimed that love is seen as a feeling, “a cosmic force” (p. 66) experienced between an “I” and “Thou” in relation. But, a “Thou” can change to an “It” if the relation changes and the “Thou” becomes describable by its qualities and a means to an end. So an “I-Thou” relationship may not last forever and can “run its course” (p. 68). Buber (1970b) is clear about this reality. “Every [Thou] in the world is doomed by its nature to become a thing or at least to enter into ‘thinghood’ again and again” (p. 69). Only an “It” can be put in order,
allowing it to be coordinated and organized, making the world more predictable and reliable. The relation between an “I” and his “Thou”, however, is not predictable and always appears new.

So, from Buber’s perspective, the important aspect of humanity to study and understand is not the individual and not the community but what occurs between man and man. Genuine interaction in the form of dialogue is central to the development of I-Thou relationships. There can be a “genuine relation only between genuine persons” (Buber, 2004 p. 239). Buber contends that relationships that occur between human beings are uniquely human and that “something takes place between one being and another the like of which can be found nowhere in nature” (p. 240). We live in a world where it is possible to create the past from experiences that evolve from “I-It” relationships. As a result of these objective relations, the world is reliable while still offering excitement, knowledge and stimulation. Buber (1970b) reminds us that “I-Thou” moments “appear as queer lyric-dramatic episodes” and are enticing but too many of them puts us at risk, pulling “us dangerously to extremes … shaking up our security” (p.84). He says that human beings cannot live without “It” but if we only live with that type of relationship we are not truly human.

Sidney Jourard

Jourard, a psychologist and psychotherapist, was significantly influenced by Buber’s work and used it to develop his perspectives on relationships between health professionals and clients, which he published as “The Transparent Self” (1971b). Jourard’s central premise is that human beings hide their true selves in order to protect themselves against criticism or rejection. This misrepresentation of oneself leads to misunderstandings and can ultimately result in illness. Jourard (1971b) purports that self-disclosure is important if one is to be authentically known by another and is “the empirical index of an “I-Thou” relationship, which … [is seen] as the index of man functioning at his highest and truly human level rather than at the level of a thing or an animal” (p. 6). Thus, it is not surprising that Jourard believed that an “I-Thou” relationship is necessary if a therapist is to help a client.

Jourard (1971b) extends Buber’s philosophy, specifying that mutual self-disclosure between a therapist and a client is essential. Self-disclosure is a two-way process. In order for one to choose to self-disclose, allowing one’s true self to emerge, one must feel that disclosure is welcomed by the other and will entail minimal risk to oneself. One will only self-disclose if one trusts the other. So, in helping relationships, Jourard claims that a therapist must be open to the client’s self-disclosure. If, however, the therapist uses standardized approaches, withholding
him/herself from clients, rather than developing an “I-Thou” relationship, clients can perceive this, which may result in feelings that the therapist has manipulated them. Clients can also feel that they have been treated in a way that is dishonest, inauthentic and not fully human.

In his research, Jourard (1971b) found that women self-disclose more than men and that women know more and tell more about others, playing an expressive role in society in comparison with men who play more of an instrumental role. In a study of nursing students, Jourard (1971a) found that those students who were more self-disclosing were more effective in developing close communicative relationships with patients than those who self-disclosed less. He suggested that there was a connection between one’s readiness to be open about one’s personal life and the ability to develop effective helping professional relationships. In other studies, he found that study participants disclosed more to their own family members, those of the same sex and those close to their own age. He also found correlations between what a person was prepared to disclose and what others disclosed to him, seemingly indicating reciprocity as a feature of self-disclosure. Jourard (1971b) used the term “partners in dialogue” (p. 17) to describe those who let each other know of their willingness to disclose. He suggests that such partnerships are necessary if one is to be truly effective in a therapeutic relationship.

Willingness to disclose one’s personal life leads to authenticity and honesty in the way one deals with others and the world in which we live. Jourard (1971b) suggested that if one is authentic, then an invitation to authenticity can be extended to others and, with the addition of technical know-how, it allows health professionals to reach out to those who are ill and in need of their help. He explained, however, that to be authentic does not mean sharing everything about oneself; it means that one and the other know each other honestly during the time they are together. Interestingly, while reciprocity seems to be an important feature in self-disclosure, Jourard explains there are times when it is not expected; for example, a patient who perceives he will derive benefit from unveiling his true self to a health professional will do so with no expectations of reciprocal disclosure.

In applying these perspectives to health professionals and patients, Jourard (1971b) bluntly stated that he believes professional training encourages those who graduate to don professional masks, to look and sound like a particular professional. “Patients are exposed, not to human beings who have expertise but, to “experts” who are dehumanized and dehumanizing” (p. 178). He goes on to suggest that such approaches are not healthy for patients or for health professionals and are examples of inauthenticity in action.
Jourard (1971b) specifically addressed nurses’ bedside manner but suggested that other professionals exhibit similar behaviour, such as physicians and teachers. He observed some nurses who used standardized, stereotypical modes of behaviour when interacting with patients in their care, which he perceived as inauthentic. This rigid interpersonal behaviour he refers to as “character armor” (p. 180) and it is used as a form of self-protection from possible hurt. Given that nurses work with the very ill and dying on a routine basis, use of character armor is a coping mechanism that protects them from the anxiety inherent in their work environment and hides their true selves from patients in their care. He claimed that this behaviour actively discourages patients from disclosing their true experiences of illness, an aspect of humanity that must be recognized by caregivers if a patient is to become healthy and experience personal growth. He named this the “phenomenal field” and suggested that attention to this field in patient care is as crucial as to that of the physiological field (e.g., vital signs assessment), which no self-respecting health professional would dare ignore.

Such rigid interpersonal behaviour may also prevent a patient from disclosing himself to the health professional and then the patient cannot be seen as unique. In turn, this type of behaviour results in health professional roles appearing as stereotypes. Neither the patient nor the nurse is being authentic which can lead to symptoms such as headaches and depression. In short, “failure or inability to know and be one’s real self can make one sick” (Jourard, 1971b p. 183-184).

Jourard (1971b) stated that interpersonal skill and competence allows the professional to produce valuable outcomes of one’s transactions with others and to engage in appropriate action to facilitate health. In a related discussion, Daniel (1998) describes the vulnerability of human beings and concurs that vulnerability is part of being an authentic human being. Authenticity is described as the ability to listen and hear the discourse of positive and negative desires of oneself, which, in turn, allows us to clearly hear the desires of others. Recognizing and engaging in mutual vulnerability enables us to share in the human condition.

Jourard (1971b) concluded his thinking on nurses’ relationships with patients with a discussion of nurses’ personalizing care. When a nurse displays interpersonal competence while caring for patients, it can be assumed that patients benefit from this skill. While receiving nursing care, a patient will feel the nurse ‘tunes in’ to him as an individual that he is heard and that he is cared about. The nurse uses the information about him to care for him as an individual. She realizes that every patient is unique and there isn’t just one way to provide care to patients. Jourard’s premise was that one could be this way because one cares about oneself, knows oneself
well and is open to experiences. The more an individual experiences, the less shocked he or she is when encountering something or someone different from him/herself. Jourard believed the quality of the relationship between nurse and patient plays a significant role in the patient’s recovery (1971b). He said “nursing is a special kind of love” (p. 207), words that echo an element of Buber’s philosophy and are elaborated upon further by Campbell (1984).

Alastair Campbell

Campbell (1984), a theologian with a philosophical bent, wrote about his views of health care relationships. He took a theological stance when discussing the professional care provided by physicians, nurses and social workers. He claimed that practitioner-patient relationships are characterized by personal service, concern and care that he suggested may actually be a form of love, a premise he borrows from Paul Halmos. His theological definition of love is very broad, not reflecting a romantic or sexual nature as is more traditionally the case. Love is considered by Campbell to be a commitment to another that reflects consistent, skilled and informed concern as well as respect for dignity and the rights of the individual. He describes the health professions as “disinterested lovers” because they are considered to be professions interested in the welfare of others, caring and helping those in need. They commit to providing skilled and informed concern that is characterized by tenderness.

Campbell (1984) also discussed whether health care professionals and patients have relationships that are like contracts or covenants. Contracts suggest equality between the parties and specified roles and responsibilities that are carried out by each. Alternatively, a covenant is characterized by interlocking obligations related to a common cause, which often begins with a display of spontaneous giving between the involved parties. Given the caring and tenderness that he claims characterizes this relationship, Campbell concludes that a covenant seems the appropriate conceptualization of the relationship as health care professionals profess a commitment to the people who come to them for help.

Campbell (1984) analyses the physician and nursing role separately but compares the relationships that each discipline has with patients who come to them for help. Physicians, historically, are seen as the most powerful of the caring professions. Their dominance is rooted in the science that is intended to ground their practice. Campbell claims this is a fallacy as there is more unknown about health and illness than there is known. However, the value that society places on preventing and curing illness has elevated their importance, cementing it in society. Campbell describes the relationship between physicians and patients as one focused on bodily
integrity and restoring the stranger who is isolated by illness from society back to the community. Their focus would seem to be on curing the patient’s illness. This seems to be a narrow view of physicians’ work with patients, even if only the Hippocratic oath is used as a reference point (Hippocratic, 2001).

Campbell suggested that nurses are less powerful than physicians in society and are relegated the physical tasks related to curing the patient of his illness. They are close to the human body of the patient while physicians distance themselves from it. While the relationship between nurses and patients can be rich in emotion and mutuality, there is a tension between “being with” patients, termed by Campbell (1984) as “skilled companionship” and “doing to” patients which he says focuses on managing bodily needs only (1984 p. 48, 50). It is considered easier for nurses to approach patients only when there is a task to be completed and nurses consider it easiest to do so with co-operative patients versus for those who are uncooperative. Campbell (1984) suggested that an exclusive ‘doing-to’ relationship with patients is potentially a “health-denying force” (p. 112). “Skilled companionship” is conceptualized as a relationship that is close, mutual and requires commitment and bodily presence but is not sexual in nature. The skill in this companionship is in sensing the needs of the patient and accommodating one to the other. Such companionship helps the patient move forward, according to Campbell (1984).

Campbell (1984) offers one final perspective, elaborating on health professionals “knowing what is best” (p. 87), reflecting an assumption that health professionals have the knowledge and expertise to help patients. Acknowledging that this is a relationship between helpers and those who require help, Campbell referenced Buber (1965), who claimed that an “I-Thou” relationship between those who help and those who require help is not possible because the “essential differences between helper and the helped” (p. 92). However, in order to help, a health professional must gain access to the “inner world” (p. 92), which the patient must grant. Sharing one’s inner world requires self-disclosure.

Josephine Paterson and Loretta Zderad

Paterson and Zderad, the originators of humanistic nursing (1976), draw on the work of a number of philosophers including Martin Buber. They evolved the theory of humanistic nursing using a phenomenological approach to understanding being and existence. Their theory describes nursing as “a response to the human situation” as it relates to the “health – illness quality of the human condition” (p. 11). The theory presents nursing as “a responsible searching, transactional relationship whose meaningfulness demands conceptualization founded on nurses’
existential awareness of self and of the other” (Paterson & Zderad, 1976 p. 3) in contrast to a nurse-patient relationship that is unidirectional and focused on the use of technical ability in the benevolent provision of care to patients in need.

Essential to the humanistic perspective is that nurses know themselves, and authentically present themselves to the world, a thread that is common in all the perspectives presented here. Once nurses understand their own existence, then and only then can they know another person and interact to develop a relationship that is characteristic of humanistic nursing. Paterson and Zderad (1976) articulated the framework of humanistic nursing as “incarnate men (patient and nurse) meeting (being and becoming) in a goal directed (nurturing well-being and more-being) intersubjective transaction (being with and doing with) occurring in time and space (measured and as lived by patient and nurse) in a world of men and things” (p. 19). So, from a humanistic nursing perspective, an authentic, intersubjective, transactional relationship between a patient and a nurse is fundamental for a nurse to be effective in nurturing and caring for a patient. This reflects an authentic commitment to the other to optimize human potential; their own potential and that of the patient. Paterson and Zderad (1976) suggest that nurses who enact humanistic nursing not only help other human beings but grow themselves as persons and derive nursing knowledge from their practice.

In their attention to the centrality of nurse-patient relationships, humanistic nursing integrates a number of elements that are compatible with Buber’s (1970b; 2004) work. Paterson and Zderad (1976) claimed that it is only through relations with others that one becomes oneself and fully actualized. This tenet is derived directly from Buber’s work and is acknowledged as such. Nursing is described in terms of dialogue, another central tenet of Buber’s existential philosophy. Nursing as a particular type of human dialogue is outlined in great detail in the theory, described as a specific kind of intersubjective relating between one and the other. Paterson and Zderad claimed that it is dialogue that allows one to see another human being as unique, and therefore be able to enter into relation with him. Humanistic nursing also incorporates the notion of “I-Thou” relationships and “the between” that occurs in those relationships, concepts illuminated earlier by Buber (1970b). Paterson and Zderad apply Buber’s philosophy to the context in which nurses establish relationships, stating that they experience “the between” while patients are experiencing peak life events, such as birth, death, winning and losing, under intimate circumstances. While each person becomes more when “the between” of an “I-Thou” relationship is established, Paterson and Zderad explain that in humanistic nursing practice, what happens in “the between” involves nurturing and conveys healing and growth in
the context of mutual presence. While “the between” is said to be nebulous and difficult to define, Paterson and Zderad concluded that it is the “basic relation in which and through which nursing can occur” (p. 24).

Having reviewed the perspectives of Buber (1970b; 2004), Jourard (1971b), Campbell (1984) and Paterson and Zderad (1976), it is clear that they think similarly about a number of significant relationship issues. Each discusses the importance of love, mutuality and disclosure to effective relationships. Buber focuses much attention on the importance of dialogue and “the between” that is evident when human beings develop “I-Thou” relationships as do Paterson and Zderad (1976). While Jourard and Campbell don’t use the language of dialogue, it is evident that authentic interaction between health professionals and patients is central to their perspectives, suggesting the importance they ascribe to dialogue when considering effective helping relationships.

Application of Philosophical Perspectives to Health Professional-Patient Relationships

Acute Care Nurse Practitioner-Patient Relationships

As the ACNP role is a recent addition to the health care system, none of the philosophical perspectives reviewed address ACNP-patient relationships. However, given that ACNPs are nurses, perspectives on nursing should be applicable. While ACNPs are nurses, their roles are considered advanced in nature so it is possible that the relationships they develop with patients are different from those of staff nurses. When considering Buber’s work, in the context of nursing it seems that nurses would be most effective if they attempted to foster “I-Thou” relationships with patients in order to effectively assist them with their health related needs. As Buber (1970b) suggests, this requires knowledge of oneself, attentiveness to the other in order to receive the message, hearing the true meaning in the dialogue, and sharing the experience with the patient. These relational elements are also deemed important by Jourard (1971b), Campbell (1984) and are in keeping with the tenets of humanistic nursing (Paterson & Zderad, 1976).

As ACNPs are direct care providers who are consistently involved with individual patients, striving for an “I-Thou” humanistic relationship characterized by authenticity, openness, attentiveness, mutuality and self-disclosure seems important. Daniel (1998) claims that nurses only becomes authentic when they engage in mutual relationships that are characterized by sharing power with rather than exerting power over the other. With education, motivation and skill development, nurses can become competent in developing this type of relationship; however ACNPs may be better positioned and academically prepared to do this
consistently. First of all, ACNPs receive additional education at the graduate level, which promotes the importance of health professional-patient relationships, including interpersonal communication strategies, partnering with patients and active listening to what patients say about their health issues and how they affect their lives. ACNPs are encouraged to ask about and listen to patients’ illness experiences and their meanings for them.

Secondly, ACNPs are employed in acute care environments, working with a specific patient population over time, in positions that are considered ‘advanced nursing practice’. Their position description outlines increased professional autonomy, leadership responsibilities, system access and an elevated status when compared with staff nurse counterparts. So, by virtue of their continuous involvement in a particular patient care environment, their additional education and their position in the organization, ACNPs may have opportunities to spend time to establish and maintain relationships in ways that vary from their staff nurse or medical colleagues. This can result in a different kind of relationship with different qualities and characteristics that may be valuable to both patients and ACNPs.

Thirdly, nurses who choose to pursue graduate education, such as an ACNP program, are likely to have a strong inclination towards life-long learning and professional advancement. They may also be striving for a particular type of role that allows them to remain directly involved with patients. This may result in different attitudes towards patient relationships and nursing practice in general and such nurses may be attracted to an educational program that prepares the type of practitioner that they wish to be.

Another perspective on ACNP-patient relationships that may be relevant emerges directly from Campbell’s work on “doing to” versus “being with” (1984), an element that is also evident in humanistic nursing theory (Paterson & Zderad, 1976). When considering the activities inherent in staff nurse and ACNP roles in patient care, the ACNP role may actually involve fewer activities that involve ‘doing to’ and more that entail ‘being with’ patients. By way of example, the care coordination aspect of the role requires that ACNPs complete a patient assessment that involves physical contact and ‘doing to’ but may also promote ‘being with’ the patient as ACNPs engage in dialogue with patients to collaboratively develop a plan that reflects mutually established goals. Dialogue is a feature of effective relationships (Buber, 1970b; Paterson & Zderad, 1976).

Finally, issues of mutuality and self disclosure are embedded in the philosophical perspectives of Buber (2004), Jourard (1971) and Paterson and Zderad (1976) and, while there is no ACNP research, there is empirical literature identifying mutuality as central to the
relationships between primary care NPs and patients (Brykcynski & Lewis, 1997; Kleiman, 2004). The nature of primary care NP-patient relationships is discussed in terms of the power of human connectedness. These authors suggest that sharing common meanings is necessary to foster hope for both NPs and patients. The approach by NPs to patients is described as personal, egalitarian, collaborative and leading to mutuality. NPs work with patients to enable them to see the possibilities rather than simply allowing them to constitute their own meanings. Partnership is identified as a strong tenet of NP use of healing relationships. These findings may have implications when considering ACNP-patient relationships in acute care environments.

Physician-Patient Relationships

Aside from some documented discussion about psychotherapy with Carl Rogers, Buber does not specifically address physician-patient relationships. However it is of interest that during the dialogue between Buber and Rogers, which was transcribed and later published, Buber challenged Roger’s premise that as a therapist, one can develop an “I-Thou” relationship with a patient (1965). Buber claimed that in any relationship where there is a helper and one who is requesting help there is a hierarchy. The two persons cannot be equal. While such a relationship can still result in change for both parties, it is the patient who is most changed. Authenticity and acceptance of one another is still important but Buber claims that while the helper, in this case the therapist, can see the situation from his side and that of the patient, the patient can only see his own side because of his need for help. Patients do not have the knowledge and skill to help, which is why they have sought help from the therapist.

Cohn (2001), a physician, applied Buber’s philosophical stance to the relationships that exists between physicians and patients. She tackles the feasibility of physicians developing and maintaining an “I-Thou” relationship with patients, recognizing that Buber describes a normative limit on relationships that have a specific purpose. It is implied that such a relationship is not a fully mutual partnership and so cannot be “I-Thou”. Cohn’s reasoning is in agreement with the Buber-Rogers dialogue (Buber, 1965). She explains that the reason that physician-patient relationships cannot achieve authentic “I-Thou” status is because physicians have knowledge and expertise and a patient can only experience and understand what it is like to be a patient and be treated by the physician whereas a physician can understand what it is like to treat as well as be treated. The inability of the patient to see the relationship from both sides results in limitations to mutuality and partnership. However, Cohn is clear when she proposes that physicians should strive for relationships with patients that consider them as persons not diseases
and acknowledge patients as having unique experiences. Buber and Rogers (1965) would refer to this as acceptance of patients for who they are. Embarking upon a relationship in this way shifts it from one that is “I-It” and toward one that is “I-Thou” in nature.

Jourard (1971b), while not discussing physician-patient relationships extensively, suggested that the behaviours observed in nurses’ practices can be seen in the practices of other health professionals. In keeping with the importance of pursuing “I-Thou” type relationships between helpers and those requesting help, it is likely that Jourard would propose that mutual self-disclosure, authentic presence and honesty in one’s relationship with a patient are paramount and essential if one is to be effective in addressing a patient’s needs.

Campbell (1984) expressed a clear opinion that physicians are considered the dominant health profession because of their closeness, yet physical distance, to human vulnerability. Human beings desire to be healthy and therefore cured if diseased, resulting in skills attributed to physicians being highly valued. Campbell describes the physician-patient relationship as one of societal-attributed power, influence and status. Their power and dominance in health care is based upon science, which, Campbell states, is actually unfounded, as medical science is flawed and not the panacea that it appears to be to the lay public. Campbell also suggested that there is a dual perception of the physician as god and brother. As a god, patients view the physician as the healer who knows all. As a brother, the physician is also a human being who requires that the patient join with him in the shared task of understanding and dealing with the illness. However, patients as well as doctors resist the ‘brotherhood’ view because it leaves both feeling vulnerable. When Campbell discusses medicine, he emphasizes the use of science to ensure bodily integrity, restoring the stranger to his community by healing his body and using science as prophecy, predicting what may cause ill health and attempting to change human behaviour to prevent disease. The contact that physicians have with patients is episodic. Campbell suggests that routine tasks of caring for those who are diseased have not been historically valued and are relegated to the other professions such as nursing.

The importance of the relationship between physicians and patients that is acknowledged as important by Buber (1970b; 2004) and Jourard (1971b) is also evident in other work (Stewart, et al., 1995). Stewart and her colleagues propose a patient-centred model of care for physician practice. This model discards traditional notions of a hierarchy of professional power and influence upon a passive patient, suggesting that a patient-centred approach is a way of improving relationships between care providers and patients which may result in increased patient satisfaction with care (Stewart, et al., 1995). The patient-centred model has been
proposed as an approach to use with patients to minimize or eliminate communication
difficulties by directing physicians to attend to patients’ concerns and expectations regarding
their visit. It directs physicians to focus on differentiating between disease (pathology) and
illness (the experience of disease) and establish common ground with patients and a sense of
mutuality. The work by Stewart and her colleagues, while focused specifically on physician-
patient relationships in family practice, is clearly compatible with the philosophical perspectives
previously discussed.

Nurse-Patient Relationships

Nurse-patient relationships are a central tenet of humanistic nursing (Paterson & Zderad,
1976). Campbell (1984) noted that nurses may engage in a relationship that is rich in mutuality
and physical closeness. Campbell suggests that the tension between ‘being with’ and ‘doing to’
patients can ultimately result in an offer of “skilled companionship” from nurses to patients. He
suggests that nurses should offer a relationship that balances tenderness with care of the body
while respecting the individual. The overall goal of the nurse-patient relationship is to foster
patient health, coping and well-being. In a related discussion, Daniel (1998) describes tension
between ‘power over’ and ‘power with’ as it relates to the relationship between nurses and
patients. ‘Power with’ relationships are said to preserve the integrity of power and the capacity
to accomplish a goal, thereby maintaining equality of authority and advantage between the two
parties, in this case, the nurse and patient. ‘Power over’ relationships result when a nurse ignores
his or her own vulnerability and commits acts that are dehumanizing resulting in a potentially
ineffective relationship with a patient. Nurses are authentic when they engage in mutual
relationships with patients that are characterized by ‘power with’ vs. ‘power over’. Similarly,
Campbell (1984) suggests that nurses may only choose to approach a patient if there is a task to
be done thereby ‘doing to’ the patient. This appears to be similar to Daniel’s perspective on
‘power over’ patients and could be interpreted as a dehumanizing activity.

Mutuality is an issue that is described as essential to an effective helping relationship and
is common across all philosophical perspectives presented. Helmich-Hensen’s (1997) concept
analysis of mutuality suggests that it is the midpoint or point of balance on a continuum that
spans from autonomy at one end to paternalism at the other. Mutuality is “a feeling of intimacy,
connection, an understanding of another” (p. 79) and “a dynamic process characterized by an
exchange between people related to a common goal or shared purpose” (p. 79). Helmich-Hensen
also suggests that there may be asymmetry in the ‘give and take’ of a mutual relationship but that
there is still a connection, a knowing exchange that makes mutuality possible. Outcomes of mutuality include an increased sense of situational control for both caregiver and patient, an increased ability of the patient to engage in self care, increased provider accountability, increased satisfaction with the relationship for both caregiver and patient, increased use of creative thinking in problem solving and decreased threat of legal action. In essence, mutuality is shown to balance power and respect and promote productive practitioner-patient communication.

Health professional-patient relationships have been considered from a variety of philosophical and theoretical perspectives. These views offer a lens with which to proceed with an exploration of these relationships in the naturalistic environment.
CHAPTER 4 - RESEARCH METHODS

This chapter is divided into three major sections. The first describes the methods used while conducting the study. Procedures used for gaining access, participant recruitment, data collection, analysis and strategies to ensure rigour are discussed. The second section offers a brief description of the data analysis process (i.e., audit trail) accomplished using a constant comparative method and applying techniques described by Strauss and Corbin (Strauss & Corbin, 1998). The purpose of this section is to illustrate how the data were analysed and offers a glimpse into my decision-making as data were coded, categories defined, central concepts identified and relationships among them clarified. The third section describes the ethical considerations for the study.

Part 1: Research Processes

The nature of the relationships that ACNPs have with patients is a clinical issue about which little is known. Qualitative inquiry is therefore the logical and appropriate choice when investigating a phenomenon about which little or nothing is known (Mayan, 2001; Strauss & Corbin, 1998). This form of inquiry allows the researcher to enter into the environment in which the phenomenon occurs and gather data on the experiences of the phenomenon from people in their daily lives. There is no attempt to control the environment or make any changes, just simply to understand and make sense of everyday life as it unfolds (Mayan, 2001). While there are many methods that qualify as qualitative inquiry (e.g., ethnography, phenomenology), grounded theory was chosen for this study. Grounded theory methods are discussed in detail in the following section.

Overview of Grounded Theory Method

Barney Glazer and Anselm Strauss were sociologists who worked from different but complementary sociological perspectives, developed the grounded theory method. They developed this methodology, which has its foundations in social science and symbolic interaction, to allow researchers to generate theory grounded in data that is systematically collected and simultaneously analysed (Field & Morse, 1985; Mayan, 2001; Strauss & Corbin, 1998). Strauss and Corbin, in their description of the methodological approach, clearly state that grounded theory is an inductive approach where “the researcher begins with an area of study and allows the theory to emerge from the data” (Strauss & Corbin, 1998). The embedded assumption
of the inductive nature of grounded theory is that there is no pre-existing conceptual framework to dictate data collection and analysis (Mayan, 2003).

Social interactions are central to patient-health care professional relationships and it is likely that how those interactions are interpreted influences relationship development. A symbolic interactionist views the world through the lens of interaction, believing that people “behave and interact based on how they interpret or give meaning to specific symbols in their lives” (Steubert-Speziale & Carpenter, 2003). In addition, symbolic interactionism suggests that people order their world using their interpretation of events in their lives (Morse, 1992). In a study of patient-health care professional relationships, the natural setting is filled with symbols and interactions that can be interpreted in a variety of ways by those exposed to them, such as clothing worn or the way language is used. Symbolic interactionism is consistent with my approach to answering my research questions. I was interested in gaining an understanding of the nature of relationships between ACNPs and patients and how they compare with the inherent nature of staff nurse-patient and physician-patient relationships. Development of relationships between people can be viewed as a social process. In addition, it seems likely that the response one receives from a person with whom one is interacting will influence how the relationship evolves between the two persons. It is assumed that the interpretations of the participants in the study will become clear as they discuss their relationships with others in the acute health care setting. These realities make the phenomenon of interest a good fit with grounded theory methods.

Grounded theory research explores basic social processes that occur within human interactions and is well suited when the researcher is seeking to understand the meaning or nature of experiences of people under specific circumstances. Specifically, it allows the researcher to move into the field to learn about those experiences from people themselves. (Cresswell, 1998; Mayan, 2001; Morse, 1992). Grounded theory is an important method for the study of phenomena relevant to nursing practice because it “explores the richness and diversity of the human experience” (Steubert-Speziale & Carpenter, 2003), thus contributing to the development of middle-range theories in nursing. Middle-range theories are “abstract renderings of specific social phenomena that were grounded in data” (Charmaz, 2006, p. 7). The advantage of middle-range theories is their narrow scope, limited number of concepts, relevance to the real world and that they can be empirically tested (Steubert-Speziale & Carpenter, 2003). Middle range theories may be contrasted with ‘grand theories’ that have no grounding in data (Charmaz, 2006) and are generally difficult to empirically test.
Another fundamental element of grounded theory is the use of a constant comparative approach to data collection and analysis. During data collection, the researcher actively engages in coding and analysis of the data concurrently in order to identify emerging themes and categories and then use them in subsequent data collection. This allows the researcher to investigate the legitimacy and relevance of emerging themes by comparing new data with the results of initial analysis (Morse & Richards, 2002; Steubert-Speziale & Carpenter, 2003). In fact, constant comparative analysis, the moving back and forth between data collection and analysis, is a strategy to ensure reliability and validity of the qualitative research process because the researcher is able to ensure data fit with the analysis on an ongoing basis (Mayan, 2003).

The paucity of empirical literature addressing NP-patient relationships, and my interest in understanding the relationships from NPs’ and patients’ perspectives, influenced my choice of method. Grounded theory allowed me to enter the acute care environment, the natural environment in which these relationships occur, and speak with ACNPs, physicians, staff nurses and patients, thereby giving them a voice as I attempted to develop an understanding of these basic social processes. While other methodological approaches might have been appropriate, the inherent social interaction evident in my research focus of interest fits well with the underlying philosophy of grounded theory. (Cresswell, 1998; Denzin & Lincoln, 2000; Steubert-Speziale & Carpenter, 2003; Thurmond, 2001). In addition, the constant comparative approach was advantageous as it encouraged me to seek and consider both corroborating and dissonant perspectives during theory development with the aim of generating codes, categories and concepts that would ultimately form a theory (Field & Morse, 1985; Steubert-Speziale & Carpenter, 2003; Strauss & Corbin, 1998). Finally, the grounded theory approach allowed me to focus on uncovering all there is to know about the relationships being explored from study participants, thus achieving saturation (Connelly & Yoder, 2000). The proposed middle-range theory, derived from data collected during this study, offers an explanation of the relationships that three different health professionals have with patients. Once explicated the sub-theories that comprise the global theory can be compared and contrasted in order to answer the research questions and highlight any unique contributions made by ACNPs in the acute health care setting.
Research Design

Selecting the Setting

A large, multi-site academic health sciences centre in metropolitan Toronto was chosen as the site for this study. This organization was deemed appropriate because it is a large organization that employs many ACNPs and was one of the original organizations to introduce the ACNP role in the 1990s. These characteristics ensured that there would be a large pool of potential participants with well-established roles within the organization. ACNPs from all three sites were approached first and invited to participate. However, only ACNPs from two of the three sites agreed to participate. This setting is an academic health sciences centre, affiliated with several colleges and universities. Though many ACNPs are employed in such settings, some are practising in smaller urban communities in community acute care hospitals without a teaching role. Therefore, the setting of this study may influence how the findings are interpreted.

Selecting the sample

Given my interest in understanding the relationships between patients and three different care providers from both patients’ and care providers’ perspectives, six quartets, each composed of an ACNP, physician, staff nurse and patient were recruited. I decided to establish participant quartets (Figure 1) in order to garner the perspectives of both the patient and the health care professional about the specific relationship in which they were involved. I anticipated initially analyzing the data in dyads within each quartet to allow for a comparison of specific relationships between each health care professional and an individual patient. Subsequent analyses could then be compared across quartets. However, during the early analysis, I realized that analyzing the data by participant group, i.e., ACNPs, physicians, staff nurses or patients, allowed me to implement theoretical sampling principles more effectively. Every participant described many different acute care relationships during their interviews yielding many more cases than just the specific relationship as outlined in each quartet. Therefore, it seemed logical to take advantage of the richness of description of each type of relationship rather than how the relationships compared within each quartet.

ACNPs were identified as the initial recruits because they were the primary focus of this inquiry. Initially, it was anticipated that participants would be drawn only from inpatient units. However, given the interest expressed by a number of ACNPs who cared for patients attending ambulatory clinics within the participating organization, I decided to also include them in the
study, ensuring that I noted any differences that emerged from their interviews. With the focus of the study being the relationship between each type of health professional and patients, it was decided that identifying the presence of those interactions was more important than the actual location where the relationship took place.

*Figure 1. Participant Quartet*

In order to recruit participants who were knowledgeable informants, i.e., willing and able to reflect upon and articulate their experiences with relationships (Morse, 1991b), certain eligibility criteria were established. Criteria for health care professionals were established that reflected the requirement for sufficient experience in their respective professional roles, allowing them to reflect on a variety of relationships with patients. Criteria for patients were established which ensured they had received care from an ACNP participating in the study.

ACNPs were eligible to participate if they met the following criteria:

- completed a graduate degree and an ACNP certificate program,
- practised for a minimum of two years in the ACNP role,
- agreeable to providing the names of patients with whom he or she had worked recently,
- cared for the identified patients a minimum of two days (or during at least two outpatient encounters).

Potential patient participants were identified once an ACNP consented to participate. ACNPs were asked to provide lists of patients for whom they provided care and a single patient was selected by the researcher. Patients were eligible to participate if they met the following criteria:

- received care in an acute care environment (inpatient or outpatient),
- received care from an ACNP, physician and staff nurse for a minimum of two days (or two outpatient encounters),
- able to speak/read English.
Once an ACNP and patient had consented to participate, a physician was identified who had provided care to the patient and had worked with the ACNP. Physicians were eligible to participate if they met the following criteria:

- practised with an ACNP in the acute care environment,
- identified as the ‘most responsible physician’ for patients receiving care from the ACNP,
- practised a minimum two years as a staff physician.

Finally, eligible staff nurses who cared for the patient participant were identified with the assistance of the ACNP and a nursing leader on the patient care unit. Staff nurse participants were eligible if they met the following criteria:

- minimum of one-two years in practice in the setting,
- practise in the same acute care environment with ACNP,
- responsible for provision of nursing care for patient participant for a minimum of two days.

Gaining Access, Participant Recruitment and Theoretical Sampling

Once an appropriate research site had been identified, I contacted the Director of Nursing for the organization. I forwarded her a summary of the proposed study and we met to discuss the feasibility of conducting the study within the organization. She enthusiastically endorsed the study and provided me with assistance in gaining access to staff nurses, ACNPs, physicians and patients in the organization. She contacted the chair of the Advanced Practice Nurse (APN) Council (of which ACNPs were members) and informed her of my intention to make contact with them.

Once ethical approval was obtained from nursing and the organization as a whole, I contacted the chair of the APN Council and arranged to attend a meeting to present the study and invite ACNP participation. The study was well received by all who attended the meeting though many members were unable to attend. This necessitated a second mechanism that could serve as an invitation to those who had not been present. A brief slide presentation explaining the study and inviting ACNPs to contact me if they were interested in participating was developed and emailed to the APN Council Chair who distributed it using her internal distribution list. This ensured that the names and email addresses of APNs remained confidential.

Several ACNPs expressed early interest in participating in the study. As outlined in the recruitment strategy (Figure 2), once an ACNP agreed to participate, together we identified eligible patients. After learning a bit about each patient, I considered who might provide me with a typical or atypical experience, allowing me to find corroborating and refuting evidence for
the developing theory. Once a patient was chosen, I asked a staff member not involved in the care of the patient, e.g., nurse manager, to contact the patient and ask if I might speak to him/her about the study. Every patient approached agreed to speak with me. I explained the purpose of the study in person or by phone and offered each an information sheet. I also described what I would be asking them during the interview. All but one patient participant were willing to talk about their relationships with me and agreed to participate. Since I reinforced with all participants that the contents of their interviews would not be shared with anyone else, including the health care professional participants with whom they had relationships, one patient declined to participate because she wanted her perspectives shared with them and theirs with her. Five patients consented immediately and one more signed the consent within 24 hours after discussing her participation with her family. Once a patient consented, the ACNP assisted me in identifying staff nurses and a physician who had cared for the patient on at least two occasions, as described earlier. When a quartet was finalized, data collection proceeded (Figure 2).

*Figure 2. Participant Recruitment Strategy*
Though participants were initially invited to participate using a purposeful approach, subsequent decisions about whom to approach were guided by principles of theoretical sampling. Theoretical sampling is described as a process of seeking opportunities to compare incidents, happenings or events simultaneously with data collection throughout the study. This approach to sampling allows the researcher to determine how categories evolving from the constant data analysis vary in their characteristics or dimensions. Theoretical sampling is important when studying new phenomena as it allows the analyst to investigate and evaluate the emerging theory (Strauss & Corbin, 1998). During the planning phases, I contemplated how I might operationalize these principles. Morse (2002) uses a fishing metaphor to explain the value of theoretical sampling. “Just as fishermen cast their lines into likely fishing holes, rather than randomly select places to fish, so qualitative researchers deliberately select participants for their studies” (p. 173-173). Although I identified several factors and characteristics a priori that in principle might influence relationships between patients and health care professionals (e.g., surgical vs. medical condition, chronic vs. acute health condition), I also contemplated who might be knowledgeable about relationships and be able to provide typical or atypical perspectives on emergent codes and categories that would contribute to the evolving theories.

As data collection proceeded, I used a constant comparative approach, reading interview transcripts with the intent of identifying codes, overarching themes and emerging categories that I could subsequently explore with participants. For example, the first patient I interviewed was a 45 year old woman who had been hospitalized for the previous month. An early theme reflected in our dialogue was that physicians have a special status and are ultimately in charge of managing her condition. I had a sense that she saw health professionals involved in her care in a hierarchy of influence and control. I wondered if younger or older patients would see their relationships with health professionals in the same way. I kept this hypothesis in mind during subsequent reviews of eligible patients and sought to invite patients who were older and younger in order to better understand this emerging category. In another example, the second ACNP I interviewed worked entirely with out-patients. She spoke about how she used time with patients to develop effective relationships, indicating that she only saw some of them monthly but was still able to make and maintain relationships. It struck me that the use of time might be perceived differently by ACNPs caring for in-patients because of their close proximity to patients. Therefore, it was important for me to speak with ACNPs who worked with in-patients and outpatients to understand the properties of ACNPs’ use of time. Thus my approaches to
recruiting study participants were generated from the results of concurrent data collection and analysis which are consistent with principles of theoretical sampling.

Researchers have no way to estimate the number of participants they will need to complete a grounded theory study because one cannot anticipate the quality of the data or number of cases that will be collected in each participant interview. Data of sufficient quantity and quality are required to achieve saturation. In this study, after completion of data collection with six quartets using simultaneous coding processes, no new significant concepts or information were emerging suggesting saturation of the concepts and categories. Glaser (1978) states that theoretical sampling ceases for any code once saturation is achieved. Theoretical saturation occurs when, as the researcher is coding and analyzing data, no new dimensions of a category emerge and the same dimensions or properties emerge time and time again. Strauss and Corbin (1998) concur, stating that saturation is accomplished “when no new information seems to emerge during coding, that is, when no new properties, dimensions, conditions, actions/interactions, or consequences are seen in the data” (p. 136). Saturation, however, is a controversial concept. Morse (1991b) suggests that if a researcher were to identify a secondary sample and conduct interviews with members of a secondary group, she might find that another perspective is introduced. Therefore Morse recommends that the researcher make the decision when a category is saturated and the study is complete. In this study, these data may only apply to patients and health care professionals in academic health science centres in large urban centres. The period when data were collected must also be considered because the environment may have certain characteristics that impact upon how relationships develop between patients and health care professionals.

During the research process, I fostered a sense of trust with all potential participants by discussing mechanisms built into the study design to protect their anonymity. I established my credibility by offering some details from my background including my ongoing practice as an ACNP as well as an educator and my genuine desire to understand their experiences and perceptions of patient-health care professional relationships in the acute health care setting.

Data Collection

Data were collected through a total of 23 semi-structured, formal, face-to-face interviews with 23 participants over seven months (6 ACNPs, 6 physicians, 5 staff nurses and 6 patients). A single interview with each participant was deemed appropriate (May, 1991) because of the nature of the questions and the potential difficulty of reaching some participants (e.g., patients)
on another occasion. Once informed consent had been obtained, interviews occurred at a time convenient for participants and at locations of their choice. All interviews with health professionals occurred in quiet and private locations in acute care settings. Half the patient interviews were conducted in patients’ homes, two occurred in their hospital rooms and one occurred in a private location in the hospital after an outpatient appointment. All interviews were audio-taped allowing me to listen to participants and encourage thick description (McCracken, 1988) and ranged from 25-90 minutes in length. All but one interview was accurately recorded. During one physician interview, there was an undetected equipment malfunction and I estimated that approximately five minutes of the interview were not recorded. The malfunction was addressed when noticed and the tape was reviewed immediately upon completion of the interview. Detailed field notes were recorded to supplement the transcript of the interview.

I, alone, collected the data. This facilitated uniformity in the approach during data collection and allowed me to take full advantage of theoretical sensitivity; that is the use of my previous knowledge, expertise and experiences from before and during the study to assist in effective data collection and subsequent analyses (Strauss & Corbin, 1998).

Given my interest in specific patient-health care professional relationships, it was important to ensure patients could accurately recall the health care professionals with whom they were involved. Potential for inaccuracy of patients’ recognition of health care providers is referenced in the literature (Lange, 2002; Zvara et al., 1996). Therefore, I decided to photograph each ACNP, physician and staff nurse participant using a digital camera. Mitchell-DiCenso and colleagues (Mitchell-DiCenso, Alba, Guyatt, Paes et al., 1996) used photographs as memory aids in a study describing the development of a measure of parent satisfaction. Researchers described showing photographs of care providers to study participants to ensure that they completed the study measure with an individual provider in mind. Interestingly, despite my pre-study concern that patients might not recall the health care professionals in their quartet, this did not become an issue. I did have the images of each professional available during interviews with patient participants but we did not rely on them for recall.

Before each interview, I collected biographical data from participants using a written questionnaire. I asked health care professionals to complete the questionnaire themselves and asked patient participants the questions and completed the forms myself (Appendices B, C, D, E).
Interviews are the mainstay data collection strategy in qualitative research (Kvale, 1996; May, 1991; Wimpenny & Gass, 2000). It is through the use of interviews that the qualitative researcher does not simply survey the terrain but actually digs deep into the phenomenon and actually mines it in depth (Kvale, 1996; McCracken, 1988). When interviewing, the researcher becomes an instrument of data collection (Wimpenny & Gass, 2000).

It is recommended that a grounded theorist use a flexible interview guide as it is necessary to be responsive to concepts that emerge during interviews and open to changing areas addressed in subsequent interviews to refine emerging theoretical concepts of the tentative theory (Charmaz, 1990; Wimpenny & Gass, 2000). I designed my initial guide and associated probes to encourage participants to reflect on their relationships and describe them in detail (Appendices F & G). I used my research questions to develop the interview guide, as suggested by Kvale (1996) (Table 1).

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Interview Questions/Probes</th>
</tr>
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| What are the characteristics of relationships between patients and health care professionals (ACNPs, staff nurses and attending physicians) from patients’ perspectives? | • Can you tell me what you think an ideal relationship with a nurse would be like?  
• What kinds of things have nurses done for you? What was that like for you?  
• Did you and [health care professional’s name] get to know each other? How did that happen?  
• How would you compare the relationship you had with [ACNP’s name] with the relationship you had with [staff nurse’s name]? |
| What are the characteristics of relationships between patients and health care professionals (ACNPS, staff nurses and attending physicians) from health care professionals perspectives? | • Tell me what makes for a good relationship with patients from your perspective  
• Tell me about a memorable relationship that you’ve had with a patient  
• Tell me about your relationship with [patient name]  
• Can you tell me about a relationship that wasn’t particularly good? |

As I identified common themes emerging from participant interviews, I listened carefully for those same themes in subsequent interviews and used new probes and strategies to actively encourage participants to offer detailed descriptions that might contribute to the depth of my understanding of that theme and uncover negative case elements. For example, when
interviewing an ACNP, she spoke about her use of humour in her relationships with patients. This interested me because it appeared to represent a strategy that was used regularly. I ensured that I listened for humour to emerge in subsequent interviews and introduced probes about its use with other participants, which allowed me to expand my understanding of its relevance to the phenomenon of ACNP-patient relationships.

At the start of each interview, I began with a briefing of how we would proceed. I offered an estimated interview length, reviewed the purpose of the interview, provided a reminder about the tape-recording in progress and ensured I’d answered any questions that participants had (Kvale, 1996). The interview guide for each type of participant always began with a very broad question that encouraged participants to immediately launch into a description of their experiences and a series of probes used to encourage participant elaboration (McCracken, 1988). Subsequent questions were designed to elicit in-depth descriptions of patient-health professional relationships and specific examples to illustrate their experiences (Kvale, 1996). In general, this format worked well. I did realize early in the process that asking patients about their recent acute illness experience served to increase their level of comfort with both the interview process and me. With health care professional participants, asking a broad question such as “tell me about what you think makes for a good relationship with a patient” allowed them to settle into the focus of the interview and work up to the deeper reflection that my questioning encouraged as the interview progressed.

Early interviews were broad and somewhat non-directive, allowing participants to talk about what they deemed important to tell me. This was necessary in order to expose salient features of participants’ relationship experiences in the acute care environment (May, 1991). Later interviews included questioning participants about issues that allowed for the exploration of emerging concepts relevant to the tentative theory (May, 1991; Wimpenny & Gass, 2000) such as the characteristics of their relationships, strategies they use in their relationships and what the results of such relationships are for the individuals involved. Through continued use of broad, open-ended questions, however, I allowed for the introduction of new ideas to my coding framework.

During interviews I made efforts to allow participants to set the pace and raise their issues, limiting my role in topic control (May, 1991). It was interesting that every patient participant, in some way, communicated to me that they were satisfied with the care they had received. To reassure patients, I reiterated my commitment to maintain their anonymity and told them that it was my intention to understand their perspectives so as to better understand the
relationships patients and health care professionals have, not to pass any judgment on the rights or wrongs of anyone’s actions. Health care professional participants appeared comfortable with the research process but I did reinforce with them my commitment to maintaining their anonymity.

When an interview appeared to be coming to an end and all questions in the guide had been addressed, I began a debriefing phase, acknowledging the participants’ contributions and inviting any additional comments (Kvale, 1996). I made every attempt to ensure that the discussion was complete before formally concluding the interview and stopping the audio-recording. No experiences relevant to the exploration were shared post-recording during the study, and field notes were documented as soon as possible, always within 24 hours of the interviews.

In my field notes, I documented my thoughts and observations about the interview setting, participant demeanor during the interview, initial perspectives on the main thrusts that emerged during the interview and a brief summary of the interaction. All hand-written notes were subsequently transcribed into a word processor for easy access during coding. Information recorded in field notes contributed to my thinking related to theoretical sampling processes and the overall process of data collection, e.g., effectiveness of interview strategies, appropriateness of interview questions and probes.

The process of interviewing generally went as planned. After the first few patient interviews, I became concerned that patients may be unable to articulate detailed perceptions of their relationships with different health care providers. After consulting with my supervisor, an experienced interviewer, and reviewing two transcripts and excerpts of interview audiotapes, we reviewed the interview guide and revised and reordered it to begin more broadly and then ease into questions that required more specificity. Interviews with health care professionals went well and the interview process I used with them required little revision. Questions that required patients to reflect upon and describe both a “positive patient relationship” and one “that didn’t go so well” were particularly effective in eliciting a broad range of relationships, their characteristics and the resultant consequences. I also adjusted the order of central questions to end on a positive note.

Data Management

All interviews were transcribed verbatim by a professional transcriptionist, which created some initial distance between the data and me (McCracken, 1988) and allowed me to use my
time to complete initial coding and contemplate emerging theoretical concepts. Turn-around
time for transcription was approximately seven to ten days. In order to ensure transcription
accuracy as well as to re-engage with the data, I reviewed each transcript for completeness and
accuracy by simultaneously listening to the original audio-recording while reading an electronic
version of the transcript, making revisions and adding occasional notes to reflect pauses or
changes in intonation to supplement the data available for analysis.

Transcripts were entered into a data management software program, N’vivo® (3rd
dition) which allowed on-screen coding, word finding, memo-recording and note-making.
Paper transcripts were easily printed from the program and were used early in the coding
process. Transcripts were initially read line by line and coded in N’vivo®. Transcripts with
initial coding included were printed and themes were identified for use in subsequent
interviewing. Paper transcripts were also used to allow for collapsing of codes that seemed
related. Once confirmed, these adjustments were made in N’vivo®.

Memos were written throughout the analysis process and were recorded electronically,
linking them to particular transcripts or sections. This way, memos remained embedded in the
context that inspired their development. During analysis, writing memos is an important tool,
which encourages the analyst to theorize about what is happening in the data and hypothesize
about codes and their relationships while still immersed in coding (Glaser, 1978). Memos were
written throughout the research process, outlining my thoughts about what each type of
relationship was about, what central concepts were emerging and how those were related to other
categories. They continued to be important as I developed my understanding of what was going
on in health professional-patient relationships. I used memos and theoretical notes as part of my
audit trail.

Interview tapes were retrieved from the transcriptionist once the transcripts were
completed and I requested that she delete electronic copies of them from her computer system.
Tapes, transcripts and demographic forms have remained securely stored, either under lock and
key (tapes/transcripts) or password protected (electronic). Digital photos were retained until all
patient interviews were completed and then they were destroyed or deleted.

A final element of data management relates to the use of quotations in this report. They
have been edited to ensure participant anonymity. Editing has been made explicit in the text
through the use of brackets and other symbols consistent with standard quotations (American-
Psychological-Association, 2001). Quotations from participant transcripts are identified in this
dissertation using a letter/number which correspond to participant type/specific participant and location in transcript (e.g., A6-222 = ACNP #6-line 222).

Analysing Data

Analysis began shortly after data collection began. It was my goal to keep in mind my central question, “what is the nature of the relationships that ACNPs, physicians and staff nurses have with patients?” I also knew that I wanted to understand those same relationships from the perspectives of patients. It was this interest that motivated me to design participant recruitment in such a way as to create quartets of participants. I anticipated interviewing each participant in each quartet sequentially and beginning the analysis across quartets, gaining detailed descriptions of each type of relationship (ACNP-patient, physician-patient and staff nurse-patient) within the context of the quartet. However, it became clear early on that I needed to be flexible in the timing of my interviews, particularly with patients and staff nurses. Restrictions on their time precluded me from completing complete quartets of interviews and analyzing them in sequence. Patients were coping with acute illnesses, often associated with significant effects on their lives, and I needed to be sensitive to their need to choose the timing of our interview. Interviews with staff nurses were also a challenge as their schedules were susceptible to change at short notice or their workloads on a given day forced us to reschedule. This resulted in my interviewing participants from a number of quartets rather than completing interviews within a single quartet before moving on to another. Given my interest in understanding the unique nature of each type of relationship, I decided that the type of relationship would be my analytic priority and I continued concurrent data collection and analysis, allowing me to form “a mutual interaction between what is known and what one needs to know” (Mayan, 2003) about each type of relationship, with no clear demarcation between data collection and analysis or between analysis and interpretation (Sandelowski, 1995).

During my analysis, I loaded the transcripts into the software program and read each transcript as it was completed. I began to take note of the characteristics of the relationships in acute care environments, as described by participants. I asked questions about patterns such as, what is happening in the relationship, when do these relationships occur, why do they seem to happen? I continued data collection, asking questions of participants to gather more detailed descriptions of the patterns that were emerging consistent with the principles of theoretical sampling. I returned to analysis of earlier transcripts, asked more questions and repeated this process iteratively. As categories were better understood, I was able to begin linking them
together, testing relationships between categories, drawing diagrams to illustrate relationships and going back to the data to confirm or refute them. At this stage the sub-theories addressing each type of relationship began to take shape. My goal was to derive a theory that was able to provide “the best comprehensive, coherent and simplest model for explaining diverse data in a useful, pragmatic way” (Mayan, 2003).

This analytic process was consistent with established procedures for grounded theory studies involving three levels of coding. The researcher begins with level one coding, identifying in-vivo or substantive coding, moves through to level two coding that takes level one codes to a more abstract level and finally, to the third level, identifying codes that are theoretical in nature and are the basis for the emerging theory (Wilson, H.S. & Hutchinson, 1996). Strauss and Corbin (1998) offer detailed guidelines for analysis at each of these levels, labeling them as open, axial and selective coding.

The first level, open coding, is described by Strauss and Corbin (1998) as “the process of breaking down, examining, comparing, conceptualizing and categorizing data” (p. 61). In essence, the data are pulled apart so that it can be put back together in new ways at a later stage (Backman & Kyngas, 1999; Mayan, 2003). To accomplish this, the transcripts were reviewed line by line. Themes and key ideas were identified and extracted from the text, word for word. I wrote memos describing my thinking and documenting descriptions of each code. Early codes tended to reflect what was happening in the relationships in the acute care setting. ACNPs spoke about what they do with patients (e.g., “finding out what patients want”, “communicating the plan” and “getting to know them”) and how they behave with patients (e.g., “being real” and “being comfortable with silence” and “face-to-face”). Other level one ACNP codes reflect their perspective on what is important in relationships with patients (e.g., “continuity”, “being there” and “trust”). I regularly used the words of participants to label level one codes. More than 130 codes were initially created but it quickly became clear that many could be grouped together to formulate initial categories.

As level one coding proceeded, the initial codes were compared and grouped into categories that could incorporate what the codes had in common. Categories are concepts that represent phenomena (Strauss & Corbin, 1998). I identified categories by reflecting upon the assigned meaning of each code, compared codes with one another and then considered if there was a category that could encompass a number of initial codes. For example, a category relevant to patient participant data called “time” was established to combine codes such as “taking the time”, “frequency of contact” and “wait times”.
Level two coding involved the identification of the relationships that were apparent among categories. Strauss and Corbin (1998) use the term axial coding to describe this phase of analysis because the researcher codes around an axis that is the category, trying to understand the properties and dimensions of each category. During this phase, the data are put back together in new ways to form more thorough explanations of the phenomena of interest. In this phase of analysis, a researcher might ask questions like “What is this?” and “What are the components of this social process?” (Cutcliffe, 2000). I asked questions of the data and the developing categories in an attempt to identify relationships between and among categories (e.g., what does this category have to do with this one? If this category/process is not present in ACNP-patient relationships, what would happen?). For example, in the case of the ACNP category “intent of the relationship”, I sought to understand why the relationship with a patient exists, how the relationship is played out and when it happens and when it does not. This allowed me to understand each element of the evolving theory in greater depth and how they related to one another. These categories were later elevated to a more abstract level as they were subsumed into level three codes, theoretical concepts.

During third level coding, known as selective coding, the researcher attempts to integrate all categories “to form a larger theoretical scheme” (Strauss & Corbin, 1998 p. 143). The researcher might ask “What is happening here? How do the substantive codes relate to each other as hypotheses?” (Cutcliffe, 2000). It is at this stage that the theory or model can take shape, becoming “a systematic structure which describes, explains and/or controls phenomena” (Backman & Kyngas, 1999 p. 147). The researcher develops a framework that “fits the data and that permits the researcher to cluster the data” (Sandelowski, 1995 p. 338). A theory can be either substantive or formal. In this particular study, a substantive theory was developed to explain the relationships that three health care professionals have with patients in an acute health care setting, a theory that that is “relevant to the people concerned and is readily modifiable” (Backman & Kyngas, 1999 p. 147). In addition, central categories relevant to each type of relationship were established. This phase of coding came as a result of reading and re-reading transcripts, memos and my journal and eventually putting categories on cards and visualizing how each category fit with others. For example, the central ACNP relationship category, ‘making a connection’ emerged to explain the essential nature of ACNPs’ intended relationships with patients and this category was able to account for the variation across all cases. It met the criteria for the choice of a central category established by Strauss and Corbin (1998).
Selective coding was aided by my theoretical sensitivity, which is described as the ability to give meaning and have insight into the events and happenings in the data as they relate to researcher experience, existing literature and theoretical knowledge (Strauss & Corbin, 1998). During the analysis, as I began thinking more abstractly about the categories emerging from the data, I considered literature I had previously reviewed that addressed nurse patient relationships, identifying findings similar to those of other researchers. Additionally, my own clinical experience as a nurse and a nurse practitioner was useful as I attempted to understand what I was uncovering and determine if my findings were logical. I became very aware of my own bias related to staff nurse practice. As I coded and analysed the staff nurse interviews, I became increasingly discouraged by the emerging themes that painted nurses as busy which influenced the levels of intensity of their relationships with patients. It was important for me to acknowledge these feelings and I discussed them with members of my committee and colleagues. I was able to gain alternative interpretations as a result of my consultations and actively sought to set aside my own bias and analyse ‘what was there’ in the staff nurse interview transcripts. Theoretical sensitivity was useful as I determined additional data to collect and as a method of checking the emerging theory for relevance.

The use of these processes of substantive and then theoretical coding allowed me to develop an integrated theory that fosters an understanding of the basic social process of relationship development (Cutcliffe, 2000) between three types of health care professionals and patients for whom they provide care.

Ensuring Rigour

The purpose of addressing rigour in any study is to clarify the strategies used to optimize truthfulness of the findings and minimize error throughout the research process (Brink, 1991). How one discusses rigour is controversial in relation to qualitative inquiry. In the past, qualitative researchers have been criticized in the scientific community for failing to “adhere to the cannons of reliability and validity” (Cresswell, 1998), but many writers believe that continuing to use positivist terminology in relation to qualitative inquiry muddies the water because the terms are only relevant to quantitative studies (Cresswell, 1998). A number of paradigms exist for addressing the veracity of qualitative findings, (e.g., (Lincoln & Guba, 1985)), however, I agree with authors who claim that our aim is the “minimization of error and the control over both accuracy and veracity of the research process” (Brink, 1991) which can be
accomplished using traditional concepts of reliability and validity in both quantitative and qualitative research (Mayan, 2003; Morse & Richards, 2002).

In qualitative research, the most important way to ensure that a study is rigorous is to continually focus on verification during the study. Mayan defines verification as “the process of checking, confirming, making sure, being certain” throughout the research process, allowing threats to reliability and validity to be addressed as they present themselves (Mayan, 2001). In a grounded theory study, the essence of rigour is captured in the use of very specific procedures and approaches. For example, the process of constant comparison, moving through coding, categorization and theorizing as data collection proceeds, increases the likelihood that the researcher is remaining focused on the data and the evolving theory (Brink, 1991). During the completion of this study I used a variety of strategies to minimize error and enhance rigour. The discussion of rigour will focus on aspects of reliability and validity as appropriate for qualitative inquiry.

Reliability

Reliability in a qualitative study addresses the question ‘can we rely on the findings to be true and accurate?’ (Brink, 1991; Koch, 1994). This is similar to the quantitative paradigm when reliability addresses issues of reproducibility. I used a number of strategies to ensure the findings would be accurate and dependable.

Prior to collecting data, I completed a small pilot study, interviewing ACNPs about the nature of their relationships with patients. During this study, I discovered that the questions I used were yielding superficial, instrumental types of information about their relationships instead of deeper, more affective perspectives. I was able to use this knowledge in the preparation of interview guides for this study. I also realized that my knowledge of the practice of ACNPs at times blocked me from clarifying ideas expressed by participants because I felt I understood what they were describing. This awareness reminded me of the importance of keeping my previous experience in abeyance and to “back into” the interview, attempting to have no preconceived notions (May, 1991). My use of interviews as a data collection method meant that I was the instrument (Kvale, 1996; Morse & Richards, 2002), so I optimized my effectiveness as an interviewer prior to beginning data collection by practising my interview strategies with members of my committee who have relevant expertise and by practising my interviews in front of a mirror.
Other strategies to ensure accuracy and truthfulness included completing all data collection myself, listening to interview tapes and reviewing written transcripts for accuracy, completing field notes within 24 hours of each interview and having photographs of health professionals available as memory aids for patient participants if required. I completed all coding and analysis and used journal entries and memo-writing to document my thoughts, hypotheses and theorizing.

In a quantitative study, another important reliability issue is inter-rater reliability. This is not relevant to qualitative inquiry because a researcher who has used judgment, with a particular theoretical lens, in making analytical and theoretical decisions does so based upon an understanding and experience of the process of conducting the research (Mayan, 2003). Since the researcher has a unique relationship with her data and has been immersed in the world and perspectives of the participants, it is difficult to imagine a researcher not engaged in the same study to arrive at the same conclusions (Cutcliffe & McKenna, 2004; Sandelowski, 1993), but exact reproducibility is an unrealistic outcome so inter-rater reliability is irrelevant. My coding of each transcript was based upon what I heard from participants, what I saw during the interviews, what I knew from the literature and what I had experienced as a nurse and nurse practitioner (Mayan, 2003). I did, however, review my coding strategy with my supervisor, who had read three interview transcripts and we concluded the strategy was sound. In addition, I discussed it with different members of my committee during the data collection and analyses phases, verifying the logic of my decisions. This provided opportunities to discuss the rationale for my analytic decisions and consider other possible interpretative approaches.

Internal Validity

For a qualitative study, the assessment of internal validity requires a researcher to ask “did we get the story straight?” (Brink, 1991; Mayan, 2003). To be internally valid the results of the research must be supported by the data and the reader must have complete confidence in the final conclusions (Mayan, 2001); in other words, are the results credible (Koch, 1994). Several strategies were used throughout the study process to ensure internal validity. Firstly, I used a semi-structured approach to interviews and asked specific questions of each participant. Using the constant comparative method, I added questions to the interviews based upon emerging codes, themes, categories and concepts. Secondly, as suggested by Brink (1991), I avoided inserting my opinions into questions used in interviews, opting to use open ended, ‘grand tour questions’, minimizing the risk that data came from me rather than the participants. Thirdly, I
kept a journal so as to reflect on my potential biases and any reactions I had to my interactions with participants and/or care providers in the clinical field during data collection (Koch, 1994). This encouraged me to be as reflective as possible, reducing the potential for my personal biases to impact upon the research process, ensuring that my conclusions came from the data.

Theoretical sensitivity must be considered in relation to internal validity as there is a risk that one can impose known concepts on the data rather than have the concepts emerge from the analysis. I was conscious of this possibility and so ensured that I saturated a concept with the data before looking at the literature to validate its emergence further. I made conscious efforts to place my earlier review of literature relevant to health care professional relationships with patients at the back of my mind and let the participants tell me what was important for them, allowing the concepts to emerge and the theory to be developed without the influence of pre-existing research.

Another threat to internal validity was any preconceived notion or philosophical perspective identified and researched during the research planning phase. As evident in earlier chapters, I prepared to study this phenomenon by investigating philosophical perspectives of helping relationships as well as any research relevant to the relationships ACNPs have with patients. There is no doubt that this exposure sensitized me and may have cultivated expectations of what I might find in this study, but I perceived this preparation as somewhat distant from the phenomenon being studied and, as such, having little impact during the research process. I did occasionally recognize the relevance of some of these earlier researched concepts, but made decisions to set them aside until I gained a full understanding of the phenomenon emerging from the data.

A final strategy that I used to enhance internal validity was discussion of my findings with knowledgeable colleagues. It is suggested that regular discussions of concepts, data analysis and the emerging theory with peers or colleagues who have qualitative research experience as well as those who have relevant clinical expertise can be invaluable and confirm that the story rings true (Cresswell, 1998; Mayan, 2001). At several points during the study I reviewed the study’s progress, my observations, reflections and tentative data interpretations with members of my committee. These meetings provided opportunities for committee members to act as peer reviewers in their roles of questioning, clarifying and asking difficult questions about my methods, meanings and interpretations (Long & Johnson, 2000; Mayan, 2001). During these meetings we discussed individual transcripts and the emerging coding framework I was using as I continued to interview participants about their relationships. In addition, one
committee member (DP) coded four of the 23 transcripts independently. Subsequent discussions confirmed that my coding framework and emerging categories were reasonable and were emerging from the data.

Member checking is another strategy that has been proposed as a method of establishing internal validity (Bloor, 1997; Brink, 1991; Mayan, 2001; Sandelowski, 1993). However, critics of this perspective suggest that member checking is not helpful in achieving its intent. Firstly, as the researcher progresses in her analysis and it becomes increasingly abstract and more generalizable, participants are less able to find their individual stories in the description (Mayan, 2001, 2003; Sandelowski, 1993). Secondly, the findings are a product of a mutual construction between the researcher and participants at a particular time and place, potentially fraught with methodological idiosyncrasies. When the researcher returns to corroborate the original findings, that context cannot be replicated and so participants may not deem the findings accurate. They may actually be different as a result of subsequent events or the study process itself (Bloor, 1997; Golaňšhani, 2003; Sandelowski, 1993). For these reasons, member checking was not included in the design of this study.

External Validity

In qualitative inquiry, the principle of external validity is realized in the transferability and generalizability of the findings in other contexts with other participants (Brink, 1991; Koch, 1994; Steubert-Speziale & Carpenter, 2003) and that the results truly reflect the phenomenon being studied (Brink, 1991; Morse, 1992). Grounded theorists have also referred to this element of validity as “the fit” of the study findings (Mayan, 2003) which evaluates “the extent to which a theory fits the empirical situations in the social area under study” (Lomborg & Kirkevold, 2003, p. 190). According to Mayan (2003), the intent of a grounded theory study is to build an interpretive or substantive theory in which features of a situation are linked to more abstract and general considerations. In the case of my study, the more abstract the theory became, the less it bears resemblance to specific scenarios presented to me by individual patient, ACNP, physician and staff nurse participants and the more generalizable it should be.

Attention to ‘finding the experts’ to recruit as participants was one way to ensure that the focus of the study remained on the phenomenon of interest (Brink, 1991). In this study, I established initial eligibility criteria so that I would find patient and health care professional participants who had relationships in the acute care setting. Subsequent recruitment decisions were made using principles of theoretical sampling, e.g., trying to understand if having an acute
problem versus a more long-term problem changes the patient’s perspective on their relationships with health care professionals.

The degree to which findings resonate with experts in the clinical world is one way to assess transferability. I have had opportunities to present preliminary findings from the ACNP-patient and physician-patient data analyses at national advanced nursing practice conferences (2005, 2007). I answered questions, which provided me with insights to support the emerging theory with evidence from the data. The responses from the predominantly nurse practitioner delegates at both sessions were overwhelmingly positive. They told me they could relate to the quotes from participants used to illustrate the theoretical concepts, indicating that the findings resonated with them, suggesting transferability. Discussions of the findings with a few physician colleagues also confirmed that key themes of the study make sense to them. During my informal discussions with nursing colleagues, I have received regular feedback that the findings are meaningful and important, again suggesting a fit with their experiences in acute care environments outside of the study site and contributing to confidence in the external validity of the findings.

**Part 2: The Research Decision Trail**

Qualitative researchers have a responsibility to assure the scientific community that the analysis and findings of their research are “systematic, objective and worthy” (Wolf, 2003). To achieve this end, qualitative researchers perform and describe the steps they have taken during data collection, analysis, interpretation and presentation of findings including decisions taken, meanings assigned and any influences perceived by the researcher (Long & Johnson, 2000; Wolf, 2003). The resultant documentation, called an audit trail, has its roots in the work of Lincoln and Guba (1985) who claimed that audit trails are an important technique in establishing confirmability of qualitative study findings. An audit trail allows the reviewer to examine three kinds of information; raw data, the products of data reduction and analysis, and data reconstruction and synthesis products (Long & Johnson, 2000).

Strauss and Corbin (1998) proposed that audit trails of grounded theory studies describe coding decisions that result in the emergence of categories, the emergence of theoretical categories and the identification of a central concept. The remainder of this chapter will address these issues.
Emergence of Categories

When I initiated participant recruitment, it was encouraging that the study was well received and of interest, especially to health care professionals. I had anticipated encountering challenges in gaining access to staff physicians and was not sure how they would perceive the study. I was concerned they might not see their participation worthy of the time commitment. However, this was not the case. I had no sense of what I would find as I started to interview participants. I did acknowledge that my thinking would likely be influenced by my practice as an ACNP, albeit in paediatrics, and my earlier review of literature about human relationships. Given that I was interviewing adult patients and health care professionals who provided them with care, I believe that I was able to bracket or set aside my own perspectives on relationships.

I interviewed three participants (one physician {M2}, one ACNP {A1} and one patient {P1}) and then began coding. Using N’vivo®, I reviewed the transcripts line by line and began using a consistent approach to question the data. Three questions used were; what are these data a study of? what category does this incident indicate?, and what is actually happening in the data? (Glaser, 1978). Each interview had several story lines but because I analysed interviews from three different types of participants, themes common across relationships were not yet apparent. However, themes did begin to emerge within each interview. To remain grounded in the data, during these early analytic sessions, I regularly used the words of participants to label the codes. For example during analysis of ACNP interviews, “taking time to hear the story’ was described as a strategy useful in developing relationships with patients and “connection” was used to describe some relationships, as presented in this early memo.

This ACNP has identified taking time to hear the story as important in engaging with the patient. She uses the word ‘connection’ which Buber uses (although it is spelled differently). And I’m starting to think that ‘positive therapeutic relationship’ and ‘connection’ might be addressing the same sorts of things (Memo, October 2003)

I continued to interview participants and reading transcripts until I had completed three interviews of each type and then postponed subsequent data collection so that I could focus on open coding. At this point, I started to see common themes emerging from interviews within each relationship type (e.g., patient interviews) and some themes from patient interviews that were similar to those emerging from health care professional interviews. For example, a code ‘nurses are busy’ emerged from staff nurse data but the same code was emerging from patient data. This led me to include questions about the time health care professionals spent with patients and to attempt to gain patient’s perspectives on the ‘busyness’ of nurses, physicians and
ACNPs. I continued to find differences in how each type of participant described their relationships. During this phase of open coding, a number of codes were well established with associated defining characteristics and some examples demonstrate the breadth of coding that occurred (Table 2).

**Table 2 Examples of Open Coding**

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions and Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being there</td>
<td>Being present, involved, invested, showing that the person you are with has all your attention</td>
</tr>
<tr>
<td>Continuity</td>
<td>Consistency of the person involved with the patient.</td>
</tr>
<tr>
<td></td>
<td>Is continuity more relevant to the approach, plan, communicating key information. Is this a feature of time or is it a discreet code?</td>
</tr>
<tr>
<td></td>
<td>Continuity is described by RNs as contributing to the development of the relationship with a patient</td>
</tr>
<tr>
<td>Focus on patients</td>
<td>‘Getting back to life’ is an in vivo code from an ACNP. Also reflected in the interviews with patients who speak about getting better, going home, feeling better, doing things in their lives. Usually reflects a focus on distancing themselves from acute health care</td>
</tr>
<tr>
<td>getting back to their</td>
<td></td>
</tr>
<tr>
<td>lives</td>
<td></td>
</tr>
<tr>
<td>Human piece</td>
<td>ACNPs see the other person as unique, with feelings, a family, a life that doesn’t involve illness. Recognition of the ‘human piece’ contributes to a sense of relationship ‘breakthrough’ and ‘connection’ with the patient. This code is also used in RN interviews and reflects the ‘personal touches’ the ‘human touch’ and how RNs feel like human beings themselves as well.</td>
</tr>
<tr>
<td>Keeping your</td>
<td>Strategically developed barriers to interpersonal involvement with patients. Some HCPs consider it a survival strategy in an intense clinical environment. Can be intermittently applied (e.g., ‘opting out’ of certain therapeutic responsibilities on ‘downer days’) or more consistently used. Seems to be related to disengagement.</td>
</tr>
<tr>
<td>distance</td>
<td></td>
</tr>
</tbody>
</table>

During the open coding phase, I met with my research supervisor to review my approach to coding and the framework that I was developing. We agreed that codes developed at that stage were realistic and could likely group into broader categories and I began this process (Table 3). In addition, we reviewed my interview strategies, questions and probes and made some adjustments to the interview guide, including probes related to emerging codes and categories and move towards saturation.

Though initial codes were collapsed into categories, I was still not clear about how the categories I was identifying might fit together to paint a picture of the nature of the relationships between each health care professional and patients. I seemed to be uncovering how relationships were established, how one recognized an established relationship when it existed and how the relationships felt to participants. I also recognized a common understanding of what patients were attempting to achieve through the relationships with health care professionals, of ‘getting
back to their lives’. At this stage in the analysis, there appeared to be a process at work, one that involved the development of these relationships.

Table 3. Early Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting to know them</td>
<td>A code that is evident in ACNP data predominantly and subsumes “the human piece”, knowing them in a different way, ‘knows my problems’ learning about the person, not simply the illness or disease being experienced by the patient. Getting to know them involves a degree of self-disclosure.</td>
</tr>
<tr>
<td>Bedside manner</td>
<td>This category encompasses codes that reflect how health care professionals behave with patients such as ‘being nice’, ‘friendliness’ and ‘being concise’. This phenomenon was evident in health professional and patient data.</td>
</tr>
<tr>
<td>Knowing the relationship is established</td>
<td>This category subsumes codes such as “breakthrough”, “perceived relaxation”, “comfortable with the other”, “keeping in touch”</td>
</tr>
<tr>
<td>Time</td>
<td>‘making time’, ‘taking the time’</td>
</tr>
<tr>
<td>Mutuality</td>
<td>‘private life’ and ‘sharing oneself’</td>
</tr>
</tbody>
</table>

I resumed data collection, delving more into how each participant saw relationships evolving in acute care settings and asking more questions about relationships that participants felt were good and those that were less so. I began to see the establishment of relationships as a process dependent upon a number of factors. I wondered if relationships developed in a stepwise fashion and how each individual impacted the relationship’s development. Each type of health care professional relationship is different. While ‘connection’ continued to figure prominently in relationships described by ACNPs, physicians seemed to be focused on the patient’s disease and nurses on the needs of the patient while in hospital. Patients, however, were focused on ‘moving on with life’ and they did not describe interpersonal involvement with health care professionals. I found this puzzling because patient and health care professional perspectives seemed discrepant. The following memo conveys my analytic thinking about the patient perspective at that stage.

In patient interviews, I am finding that patients are focused on what they need from the “experts”, e.g., information, answers to questions, pills on time, do the things they are expected to do. The needs they articulate are predominantly instrumental (physical in nature) and requiring skill of health professional vs. expressive (emotional in nature). However, there doesn’t seem to be a need to know health care professionals personally. They want their help, they want to be heard, they want their views considered but patients don’t speak about their relationships in ways that reflect intimacy or closeness though many say they “know X fairly well”. This perspective is different from that of ACNPs who feel they get to know patients well and use the knowledge of the individual person to provide care (Memo, December 2004).
At this stage, I was trying to understand what patients wanted in their relationships and their motivations in developing those relationships. Since I was simultaneously analyzing interviews with health care professionals, I began to wonder if their perspectives were at cross-purposes or whether patients were simply describing what they valued about health care professionals while they were acutely ill. I was frustrated with my early analysis of patient data and used the memo-writing process and a discussion with my supervisor to set these feelings aside and continue to interview patients, using probes to encourage them to differentiate the relationships they had with each health care provider and describe how the relationships felt to them.

I was soon able to refine the emerging categories into mid-analysis categories that reflected important elements of the relationships established between health professionals and patients from each perspective. For example, in the analysis of ACNP data, several categories appeared to reflect the actions taken by ACNPs to establish relationships with patients. My thinking about these mid-analysis categories is displayed in Table 4.

Table 4. Mid-Analysis Categories: ACNP Actions in Relationships with Patients

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making a Connection</td>
<td>Identified as an in vivo code in first ACNP interview. Encompasses early codes such as “developing rapport” and “establishing a therapeutic relationship”. Making a connection is an action taken by all ACNPs in relationship development with patients. It may be attempted but a connection does not always result.</td>
</tr>
<tr>
<td>Being Credible</td>
<td>Encompasses codes such that captured truthfulness, honest and a straightforward approach. ACNPs place importance on acting this way so as to be credible to patients. They are concerned that a lack of credibility interferes with relationship development.</td>
</tr>
<tr>
<td>Using Humour</td>
<td>Humour encompasses anything that ACNPs described related to “laughter” and “humour” and the impact this had on the relationship between patients and ACNPs. A lighthearted mood occurs as a result of humour. ACNPs describe using humour regularly but judiciously based on their assessment of the patient’s receptivity to it.</td>
</tr>
<tr>
<td>Making Time Count</td>
<td>This category encompasses codes such as “frequency of contact”, “spending time” “being accessible” and “important to see them”. Making time count was described as an important feature of relationship building and something that ACNPs do in the context of the relationship.</td>
</tr>
<tr>
<td>Finding things in Common</td>
<td>Finding things in common was maintained as a category because ACNPs described this action as an important thing to do with patients in order to build relationships. The commonalities they describe are not intimate but include things like common birth origins (e.g., same city), culture, pets and social activities (e.g., favourite television show).</td>
</tr>
</tbody>
</table>

I reviewed categories emerging from staff nurse and physician data and discovered that they, too, used actions to foster relationship development with patients. This new awareness inspired me to focus subsequent interviews on the processes of relationship development such as how relationships are established, when they develop, and how one recognizes when a
relationship is established. Interestingly, patients also described actions used by health care professionals in relating to them but rarely commented upon their own actions with respect to building relationships with health care professionals. Their stance was emerging as reactive rather than proactive.

**Emergence of Theoretical Categories**

As I continued to interview participants, the process of relationship development emerged. As I analysed new data and reviewed previously analysed transcripts, categories I identified as specific to each type of relationship started to group together into broader conceptual categories, specifically readiness conditions, relationship strategies, central relationship themes and the results of relationships being developed. While some overlap across each type of health care professional relationship was evident, I identified categories unique to each type of relationship. Meetings with committee members confirmed that the categories I identified were reasonable.

The second level of coding, termed axial coding, required me to gain an understanding of the dimensions of each category in each theory (ACNP-patient, physician-patient, staff RN-patient) as well as how the categories and their representative concepts related to one another. I asked questions of the data and identified the factors that contributed to the breadth of each category across a continuum. For example, the central focus of the physician-patient relationship, managing the disease, varied in intensity depending upon a physician’s “intent”, “rapport”, “time” and “humanness” with a patient. In contrast, analysis of ACNP-patient relationships suggested that the central focus of their relationships with patients, making a connection, varied in intensity depending upon their person/patient orientation, mutuality, interaction and their attention to boundaries between themselves and patients.

Though I continued to use N’vivo® to code and categorize the data, I supplemented this approach, using an index card system to sort out the relationships among concepts. This enhanced my ability to build theory. For example, while striving to understand the process of staff nurses’ relationship development, I developed a ‘picture’ of how each category fitted with others (Figure 3).
My goal during this phase of analysis was to understand the relationships among the categories I developed. This became obvious as the ‘process’ of relationship development and I was able to further group categories into phases of the relationship, namely “relational focus”, “readiness conditions”, “relational strategies” and “relational products”. These categories played essential roles in the relationships described by health professional participants and so were considered as concepts. During my final cluster of interviews, I was able to continue gathering data and testing the stability of the relationship processes as they were emerging. Analysis of the final interviews revealed that I was not hearing new ideas or adding any new concepts to the relationship sub-theories indicating saturation. The nature of each phase of relationship development was identified and subcategories associated with each were described.

By way of example, when continuing the analysis of ACNP interviews, the concept of “making a connection” was consistently evident. However, it had become clear that a connection was not always made between ACNP and patient. As I reflected on my analysis, a continuum took shape with a lack of connection at one pole, an ordinary connection in the middle and a strong sense of connection at the opposite pole. I continued to ask questions of the data (such as when does connection occur? when does it not occur? and what influences the connecting process?) in order to better understand the dimensions of what was emerging as an important concept in ACNP-patient relationships. At this stage, I met with my supervisor and committee members to discuss my findings. After much discussion, I realized that variation on several dimensions of ‘making a connection’ influenced the level of relational intensity that was ultimately developed (e.g., connected or not). I reviewed this in relation to the data and altered the model to include a typology rather than a series of continua in relation to connection.

“Managing the disease” remained important in physician-patient relationships, and unique dimensions influenced the relational intensity of those relationships. As staff nurses focused...
their relationships on “meeting patient needs”, relational intensity was also dependent on unique dimensions.

Another analytic strategy I used was to compare the perspectives of individual participants with the tentative theory. For example, I looked to see if the practice setting influenced the connectivity of ACNP-patient relationships and I examined the specific relationships described by each patient and ACNP to determine if their relationship had a “fit” with the tentative theory.

Identifying Central Concepts

When completing second and third level coding of physician and ACNP data, the concepts of “managing the disease” and “making a connection” respectively remained central. The central concept of staff nurse – patient relationships, “meeting patients’ needs” emerged more slowly as the process of relationship development was identified. Each of these concepts emerged as central with other, less vital concepts being related to them. The relationships among the central concept and sub-concepts in each type of relationship were meaningful and made sense. The dimensions of each were identified and described, thus accounting for variation in the social process.

For example, physicians consistently wove references to patients’ diseases into their descriptions of their relationships with patients, confirming “managing the disease” as the central focus. Readiness conditions were evident and influenced physicians’ inclination to “manage the disease” and they used strategies to establish the relationship. However, without the central focus, “managing the disease”, a relationship between physician and patient would not be necessary and would likely not occur. The same is also true for “making a connection” and “meeting patients’ needs” (ACNP and staff nurse relationship sub-theories respectively). Each of these central concepts is described in detail in the subsequent findings chapters.

Part 3: Ethical Considerations

Any research process has the potential to cause harm to study participants (May, 1991; Orb, Eisenhauer, & Wynaden, 2001); however, I did not anticipate any harm would come from participating in this study. Discussion of participants’ thoughts regarding their relationships in the acute care environment was not anticipated to cause any distress. However, a number of ethical issues were considered and addressed during the study process.
The first priority was to ensure that the privacy, anonymity and confidentiality of study participants were safeguarded. To ensure confidentiality and anonymity, each participant was interviewed in a private location. Participants were assigned study numbers and names were removed from transcripts. Identification numbers and transcripts have been secured in separate locations and will be destroyed no later than 5 years after study completion. Precautions have been taken to ensure that no identifying information was used in either this dissertation or will be used in future publications, e.g., use of pseudonyms, editing of quotations from transcripts to eliminate context-specific details while maintaining the intent of the statement (Kvale, 1996; Orb et al., 2001). Though identifiers have been used to link quotations to particular participants in this report, these will be removed in subsequent publications to ensure the anonymity of participants (Kvale).

A second priority, ensuring participants provide informed consent to participate, was accomplished using principles established for research involving human subjects (Kvale, 1996). Prior to commencing the study, approval was obtained from the hospital’s Nursing Research Review Committee and its Research Ethics Board. Information sheets, tailored specifically to health care professional and patient participants, were made available to potential participants when I approached them to participate in the study. Each health care professional and patient who agreed to participate signed a written consent to be interviewed and audio-taped with knowledge that study data may be used in future publications, taking measures to ensure their anonymity (Appendices H, I, J, K).

A final priority was protection of participant autonomy. Risks of coercion were mitigated by having a staff member not directly involved in patients’ care (e.g., a nurse manager) approach patients to enquire whether they were willing to speak with me about the study (Orb et al., 2001). ACNPs were introduced to the study at an APN meeting or through an electronically distributed slide presentation and they contacted the researcher to express their willingness to discuss the study. Once ACNPs identified eligible physicians and staff nurses, I approached them to determine their interest in participating. All potential participants were informed that they were free not to participate and a statement as such was included in the consent document. They were also reassured that if they initially agreed to participate and subsequently changed their minds, they could withdraw from the study at any time with no consequences. They were also free to not answer any question during the interview (Orb et al).
CHAPTER 5: FINDINGS (PART 1): MAKING A CONNECTION RELATIONSHIPS: ACNPS HAVE WITH PATIENTS

The purpose of this chapter is to describe ACNP participants and the nature of relationships that ACNPs have with patients in acute care environments so as to ultimately understand how these relationships are similar and/or different from relationships physicians and staff RNs have with patients. The central focus of ACNP-patient relationships, making a connection, will be discussed including the dimensions that influence relational intensity (patient/person orientation, mutuality, interaction, boundaries). The process of relationship development, including readiness conditions (authentic presence, intention to know the other, perceived patient openness), relational strategies (humour, time as a resource, establishing credibility, discovering commonalities) and relational products (making a difference, partnership, comfort with the other), is described (Figure 4). These findings contribute the ACNP-patient relationship sub-theory to the larger Acute Care Health Professional-Patient Relationship theory that describes how three different health professional-patient relationships compare in the acute care context. At the conclusion of the chapter, a descriptive analysis of patient perspectives on their relationships with ACNPs is presented and discussed in relation to the ACNP-patient relationship.

Pseudonyms have been used to ensure participant anonymity. Patient participants referred to ACNPs and nurses by their given names and to physicians using the title ‘doctor’ and their surnames. This reality is reflected in the choice of pseudonyms throughout this dissertation.

ACNP Participants

ACNP participants were all female, had an average age of 42.5 years of age and had been practising as nurses for a mean of 19 years. They had practised as ACNPs for a mean of four years, in the organization for a mean of three and half years and reported caring for an average of 10 patients per day. They reported spending almost 75% of their time in patient care related activities. Thirty-three percent of ACNP participants work with patients with surgical issues with the remainder working in either medical, outpatient or combined practices. All ACNPs cared for both hospitalized and ambulatory patients (Table 5).
Table 5. Characteristics of ACNP Participants

<table>
<thead>
<tr>
<th>Acute Care Nurse Practitioners (n=6)</th>
<th>Mean (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of participants (years)</td>
<td>42.5 (36-50)</td>
</tr>
<tr>
<td># Participants female (%)</td>
<td>6 (100)</td>
</tr>
<tr>
<td># Years in practice</td>
<td>19.4 (12-27)</td>
</tr>
<tr>
<td># Years as ACNP</td>
<td>4 (2-6)</td>
</tr>
<tr>
<td># Years at study hospital</td>
<td>3.6 (2-6)</td>
</tr>
<tr>
<td>Length of stay (LOS)(in days)</td>
<td>78.2 (5-180)</td>
</tr>
<tr>
<td># Patients responsible for daily</td>
<td>10.5 (5-15)</td>
</tr>
<tr>
<td>% Time in patient care-related activities</td>
<td>74.3 (66-80)</td>
</tr>
<tr>
<td># Working with surgical pts (%)</td>
<td>2 (33)</td>
</tr>
</tbody>
</table>

Making a Connection: Central Focus of ACNP – Patient Relationships

It became evident early in the study that ACNPs consider relationships with patients as central to their practice. The central phenomenon that emerges is *making a connection* with a patient. In fact, ACNP participants frequently use the term ‘connection’ to characterize their intended relationships with patients. Sandra describes what happens as a connection is made:

> We spend maybe 15 minutes with them … I do a brief history and physical examination. And they’re responding, sometimes there’s an internal connection between yourself and a patient, on a personal level, … you can understand what they’re experiencing or what they’re conveying to you and the rapport is built instantly. Or sometimes even in that 15 to 20 minutes, it’s not instantaneous, but it may take towards the middle or the latter half of that meeting to establish a connection with a patient. Sometimes it’s more of an intuitive thing than an actual concrete thing, that you can establish there is a connection. But again it’s an understanding, between the verbal and non-verbal communication and cues that are provided back and forth between myself and the patient, so it’s sort of mutual (A6-13).

Connection can be broken down into distinct elements that allow it to be clearly understood. These elements provide information about the nature, and specifically the characteristics, of connection. The nature of connected relationships is discussed including types of connections, why ACNPs make connections, how a connection is confirmed duration of connected relationships and its value to ACNPs. Dimensions that influence the degree of relational intensity (patient/person orientation, mutuality, interaction, boundaries) are also delineated.

The Nature of Connection

ACNPs describe connection as a way of relating, of being with another human being in a close and personal way. Kim speaks of this closeness:
We had a very close relationship. I knew she was asking me by the way she was looking at me because her eyes spoke so much. And I knew she was really wanting me to say… am I going to, am I going to come out, am I going to be alright through this one? (A2-140).

There is a real sense of positive energy that flows between an ACNP and patient who establish a connected relationship. During the interviews, ACNPs smile and speak more softly when they describe a connected relationship, as if they feel warm and encouraged just thinking about how those relationships are for them. Sandra describes how it feels for her: “There was such positive energy in the room. It was wonderful” (A6-45).

Making a connection involves time; it can occur during a single meeting or may develop during several interactions over time. ACNPs characterize connections that are established quickly as having ‘chemistry’ or ‘clicking’ and describe an almost immediate feeling of mutual comfort with the other person. Cara says that relationships that ‘click’ may be comparable to those developed in one’s personal life: “I think it’s the same thing with patients [as colleagues or friends]. There’s just a few that you know you will click with and some that you never click with” (A3-157).

Relationships resulting in an immediate connection are unusual. ACNPs indicate that most relationships take time to develop and require several interactions to become firmly established. Carol expresses her thoughts about establishing connections with patients:

Certainly it doesn’t always happen on the first meeting. Sometimes it does, and that may be just the chemistry between two human beings sitting, talking in that case. But, it doesn’t happen. And that may be, you know part of that is the way of communicating with a person but…different needs. It doesn’t happen with everyone, but I’ve been really fortunate that I’ve had that opportunity with a lot of people (A1-26).

Taking time to establish the connection is common. Cara reflects that most connections with patients take time for her to establish and she considers this a reflection of her personal style and way of being with people in both her professional and personal lives:

I’m not the type of person that makes friends with somebody really easily and right away and have that initial, you know, ‘I get along with you really well’. I have to suss people out, sort of get to know them, let them get to know me and then the relationship sort of develops over time, which is why I like [my practice setting] because … you do spend a lot of time with patients and [the relationship] develops over time (A3-29).

Jessie’s comments about her connection with a patient, Mike, reinforce that time is an important factor that influences the establishment of a connection:
I connected with Mike … Mike was a 64-year old transit worker and he had a prolonged length of stay. An absolute wonderful man, you know … he had a 45-day length of stay so he was here for a long time. He had a wonderful wife. He’d … take every day as it comes. … Come back in always smiling, always, you know, emailed me. He emailed me because I had been talking about getting my lawn ready so he emailed me a special recipe for my lawn so that I could get my lawn ready. So it was special and…when he [had the procedure]. … it was wonderful … it’s that connection, but we connected on a different level. We connected on a personal level (A5-198-202).

The language ACNPs use to describe relationships reflects their desire to develop a connection with each patient, but this does not always happen. Three levels of relational intensity are evident. The most typical ACNP-patient relationship is the *professionally connected* relationship. A comfortable interpersonal rapport, a sense of trust and honesty, some mutual self-disclosure of personal information and a moderate level of relational intensity characterize this type of relationship. ACNPs describe spending time with patients with whom they feel professionally connected, seeking to discover things they have in common. Jessie provides her perspective on this typical type of connected relationship: “A little bit more, it’s more business like [than a close personal connection]. It’s more professional. It’s less inquisitive” (A5-415).

Sandra provides an example of a professional connection with a patient that illustrates the degree of mutuality and self-disclosure that occurs:

I believe in being personally connected with a patient but not on a personal level. And what I mean by that I think you have to maintain a certain level of distance i.e., professional and appropriate behaviour. But you can still be personal, develop a personal rapport with a patient (A6-17).

ACNPs describe two types of atypical relationships; a less intense, more formal relationship, termed a *clinical* relationship and a more intense, strongly connected relationship that has emotional and personal characteristics, termed a *personally connected* relationship. Clinical relationships are described as unusual by all ACNPs. Given their intent to make a connection with every patient, a clinical relationship is disconcerting for ACNPs. They recognise that there are a number of factors related to themselves and patients that influence the evolution of clinical relationships. A cordial, formal and somewhat distant or disengaged manner and a low level of relational intensity are characteristic of this type of relationship. Wyn describes her behaviour towards patients with whom a good connection cannot be made, resulting in a clinical relationship: “I don’t always try … I don’t … if it doesn’t … click right
away or I know the patient’s only going to be here for a short time then it’s not a big problem” (A4-361). Jessie goes so far as to say that there may be no relationship at all when a connection is not made:

There is no relationship. It was strictly business-like. ‘Come in and we’ll take your blood pressure. I will review your medication, any issue? Yes? No? See you later. Do I want to know what you’re doing at home? If you want to tell me that’s fine’ (A5-166).

It is evident from their descriptions of clinical relationships that ACNPs see no room for mutual self-disclosure of personal information in clinical relationships. They focus on the business at hand and spend only the time that is necessary to address patients’ disease-oriented concerns. There is little or no social interaction and this type of relationship is always dissatisfying for ACNPs. Their recollections include details of what went wrong and what could have been done differently but they generally have no answers as to what would reconfigure the relationship. Their frustration is palpable.

The other atypical type of relationship is one that is described as close and strongly connected, a personally connected relationship. It is depicted as a personal bond with an emotional closeness that is more intense than the more typical professionally connected relationship established with patients. Jessie suggests that those with whom one strongly connects might be friends in another context, outside of health care:

You just connect on a different place and it’s a more personal place. They’re probably people that in ordinary life you would choose to be friends with. They’re people who share relatively similar thoughts and beliefs about life, about people (A5-483).

Jessie uses a metaphor to explain how she differentiates between personally connected and more typical professionally connected relationships:

Well, sometimes … you’re invited and you go and you’re a good dinner guest … And you use your manners and you’re pleasant and, you know, you would get invited back. But it’s not like you’re sitting down with an old friend and you’re actually [having a] conversation that is meaningful, that is, that you care about. … [it] is meaningful to you … [as] the dinner guest. [It’s a] little bit more formal, actually… And the atypical ones are when, you know, I can stop over to your house and have a cup of coffee. I don’t need to be invited. I can just go … I know you, just connect on a different place and it’s a more personal place (A5-451/483).

The pleasant dinner guest has a connection with his host. The rapport is pleasant and even warm. But there is a degree of formality to it. But when there is strong, personal connection between people, one can drop in anytime and always be welcome. It is personal, meaningful and comfortable in a deeper way.
Connectivity is important to understanding each of these types of ACNP-patient relationships. The three types of relationships described appear distinct with respect to levels of relational intensity and each can be described in terms of their characteristics, tone and level of comfort evident during interactions. While it is the focus of ACNPs to establish a connection with each and every patient, it is very clear that a connection is either established or is not. The four dimensions that influence relational intensity are discussed later in this section.

Intention to Connect

While establishing a connection is central to ACNPs’ descriptions of relationships with patients, it is not a foregone conclusion. There must be a willingness and inclination on the part of both individuals to forge the connection. This willingness to connect or not is covert and not discussed in explicit terms by the two individuals. It seems that it is like a process where each individual attempts to convey his or her desires and intentions for the relationship behaviourally as they orchestrate how they will interact over time.

A connection appears to occur only if both the ACNP and the patient are receptive to it. Patients may be seeking to secure such a relationship out of a need for someone to know them well and look out for them in a foreign and anxiety provoking environment. Wyn recalls a time she recognized such a need in a patient: “I just always felt that, you know, we had connected … quite well because she had, you know, she was a person who was dealing with … a life, a traumatic life situation and she needed a lot of support and information” (A4-65).

ACNPs describe going to meet a patient for the first time with the goal of making some sort of connection. Sandra describes her approach: “I always walk into the patient’s room very positive, thinking they’re going to give me the best that they have to offer and I am going to reciprocate. And I’d say 90% of the time it turns out that way” (A6-37). Wyn (A4) feels she is able to establish a connection with the majority of patients for whom she provides care:

Any patient who… I’m looking after for 3 or 4 days I would say… most times, I would have that kind of relationship [connected]. If not with them particularly, then with one of their family members, you know I would be able to connect with one of them (A4-97).

ACNPs are not always able to establish a connection because there are barriers. They describe the resulting relationships in more distant terms and openly express that they have not always given much thought to this type of relationship. Kim reflects on a situation with a patient for whom she is currently caring and the difficulties encountered in making a connection with him:
I don’t know very much about him. He doesn’t give much about family… I haven’t even explored so much of his family. I can’t really say. He’s just not a person that’s easy to get to know and he’s not as open (A2-109).

Even if an ACNP engages with a patient with intent to establish a connection, it may not happen. The patient may not be receptive to the actions the ACNP is using to establish a relationship, suggesting a lack of openness, and may actively resist any attempt she makes to engage with him, as illustrated in Jessie’s recollection:

So this guy was ambivalent about [treatment options]. He was never real with us. He was never genuine. He was incredibly anxious but he wouldn’t share anything. … If you even touched a cord he would look you straight in the eye and he would turn his head. He would purposely call us by the incorrect name (A5-122).

Cara recalls a patient who overtly rejected her attempts to establish a connection with him. During their first meeting, she approached him to introduce herself, her role and begin to establish a rapport:

He says ‘well don’t take this the wrong way but you’re just another cog in the wheel’ … So then I said okay if that’s the way you feel, fine. I said ‘but I guarantee you’ll come to appreciate me in the next couple of months’. So anyway … I just thought I’ll carry on, I’m not going to let it bug me. So I’d do what I had to do when I saw him (A3-181).

Conversely, the patient may be receptive and even attempt to connect, but the ACNP is not receptive at that time. This may be related to factors such as the readiness conditions described earlier, e.g., extent of ACNP’s authentic presence with the patient, or perhaps the ACNP’s assessment of the patient’s “fit” with her notion of how a patient should behave in the acute care environment. Wyn describes a patient with whom she did not connect, who, in her opinion, did not behave in a way that she deemed acceptable:

I probably looked after him for 3 weeks and afterwards he was admitted … at least 5 times over the next year kind of and you sort of start back at zero… I found that very difficult... I felt uncomfortable with him and he just made me uncomfortable… It was just I don’t know he just made me uncomfortable … he was inappropriate, you know, and … I would say that it was sort of a negative relationship in general (A4-378).

Cara also describes a patient whose behaviour was out of keeping with her expectations:

I had another patient who was like rough, rough, rough, … heavy into drugs and drinking… And this guy just put you off from day one and he was like ‘oh woah is me, why is this happening?, I’m so sorry for myself and it shouldn’t be happening to me’ and angry… And at first I thought … how am I going to stand this guy? (A3-193).

However, ACNPs do acknowledge that, though strictly clinical relationships do occur, they are unusual and ACNPs are able to tolerate the discomfort that they generate for them. To
do this, they resort to an impersonal style of communication that is primarily focused on the patient’s disease-related needs. Sandra explains her approach:

His behaviour was very erratic and not consistent and I think he was manipulating me to get the drugs, the narcotics and he played the same game with all the other team members. And I tried to establish a connection with him by saying, you know, you be upfront with me, I’ll be upfront with you. I want to try and help you. All the appropriate things or that I thought were appropriate things. Ultimately I don’t think any of us, myself included, developed a rapport with him. I think he was so socially challenged the only way he could connect with people was how it would meet his needs or [be] a gain for him (A6-221).

So, if one party, either the patient or the ACNP, lacks the inclination to engage in a connected relationship, it will likely not occur. ACNPs say that it is their intention to forge a connection but that their intention may change if they perceive that patients are not inclined to connect with them or if patients behave in a way that is counter to what is generally expected. Patients, too, influence the establishment of a connection. They may be interested in such a relationship or they may reject the ACNPs’ attempts outright. Intention to engage in a connected relationship is a mutual enterprise.

Evidence of a Connection

When a connection is successfully made, ACNPs observe changes in how the patient behaves or feels when they are together. Jessie says: “they all tell you in different ways that the relationship has changed” (A5-110). There might be an increase in eye contact and a brightening of the eyes (4-41; 5-58), physical relaxation (1-15), nodding of the head (6), an increase in smiling or laughter (1-21-22; 4-34-35), a sense that the patient is happy to see the ACNP (4-37), a slowing of speech (1-22) a sense of calm (1-30) or letting the ACNP see their vulnerability (A5-102).

ACNPs characterize each connected relationship as unique, reflecting the characteristics of themselves and patients as well as the needs, desires and goals of the patient. As a result, ACNPs are challenged to describe a standard sign that always indicates that a connection has been made. Jessie says: “Can I describe it [when connection happens]? No, because for each and every one of them, it’s different.” (A5-98). Kim recognizes the unique nature of each relationship reflecting the circumstances of the individual human being: “It’s just that connecting with a person and recognizing this … [is a] pretty unique situation. His situation is not the same as all other elderly men or all other patients. They’re all pretty much unique” (A2-321).
Relationship Longevity

There was not a great deal of discussion about the longevity of ACNP-patient relationships. When it was discussed, these relationships had a beginning and an end. The beginning comes with the person becoming a patient, requiring the services of the ACNP and her team. The end comes when those services are no longer required. Jessie describes the typical endpoint of her relationships with patients:

You know these families invite you into their families for whatever brief period of time. You are a guest. You are there at their invitation and [at some point] you have to leave. They know you have to leave. You leave after everything is done, be it good or bad, you still go … [so] I end it … I typically formally end it after they’ve had their [procedure] (A5-174/186).

ACNPs describe hearing from patients after the relationship has ended, often to give an update on how they are doing or, on occasion, to re-engage with them to gain assistance with a health issue. Kim describes an occasion when a patient’s wife contacted her when her husband was re-admitted to the emergency department:

There was … an elderly patient and he, too, had been with us not very long, maybe about a month. And his wife wanted him to go to a nursing home. He wanted to stayhome so…we maximized the resources [and he went home]. But about 3 weeks later he came into the emergency department. He’d only been in the emergency department 10 minutes and his wife called up and said ‘can you send Kim down, Peter is here. And I couldn’t go down immediately but I said ‘I will come down’. And I went down and saw him later in the emergency department (A2-325).

Though the relationship had ended three weeks earlier, this family wished to re-connect with Kim, likely because of their comfort with her as compared with the relative strangers they were meeting in the emergency department.

The closure that occurs in the ACNP-patient relationship reinforces that the relationship is one that ACNPs call ‘professional’ and occurs because of the patient presenting for care. In general, once patients move on with their lives and no longer requires the services of the ACNP, the relationship ends. This outcome does not appear to vary with degree of connectivity.

Value of Connection to ACNPs

ACNPs say that connection makes their jobs easier (A1), makes them feel good inside (A6), allows them to feel they are making a difference for patients (A4, A6), is valuable to them as people (A2) and that it creates a set of circumstances whereby they hear from patients once they have moved on to another setting, learning how they are doing once they’ve returned to their lives (A2, A4). Making connections with patients is important to them as health
professionals in the work they do with patients.

Dimensions of Connection

The intensity of an ACNP-patient relationship varies and is influenced by several dimensions; patient/person orientation, mutuality, involvement/interaction and attention to boundaries (Table 6). Three types of relationships are identified, ranging from a strictly clinical relationship, i.e., no connection with minimal relational intensity, to a professionally connected relationship, i.e., one that has moderate relational intensity, and finally a professionally connected relationship, i.e., high relational intensity. Dimensions were identified that reflect continua of characteristics of connection.

The four dimensions that influence relational intensity include; the degree to which the patient is seen as a person (patient/person orientation), the degree to which there is mutual sharing of information (mutuality), ACNPs style of interaction with patients (interaction) and ACNPs’ attention to boundaries (attention to boundaries). Variation across these dimensions determines if a relationship remains clinically focused or becomes professionally or personally connected.

Table 6. Dimensions of Making a Connection

<table>
<thead>
<tr>
<th>Clinical Relationship</th>
<th>Professional Connection</th>
<th>Personal Connection</th>
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<tbody>
<tr>
<td>Patient with disease</td>
<td>Patient/person Orientation</td>
<td>Person with disease first, then person</td>
</tr>
<tr>
<td>Limited or no self disclosure</td>
<td>Mutuality</td>
<td>More equality in mutual self-disclosure</td>
</tr>
<tr>
<td>ACNP-directed interactions, limited interaction, formal, aloof, distant</td>
<td>Interaction</td>
<td>Mutually initiated interactions, ACNP goes the extra mile, informal, familiar, negotiated partnership</td>
</tr>
<tr>
<td>Solid boundaries, minimal attention due to minimal relational intensity</td>
<td>Boundaries</td>
<td>Flexible boundaries re: personal information and emotions, vigilance re: boundaries</td>
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When considering how ACNP-patient relationships vary across each dimension it is important to note that if a relationship reflects non-connected characteristics on any dimension, it is likely that the relationship will not evolve to a connection at all and remain strictly clinical in
nature. Clinical relationships have discrete characteristics in relation to each dimension. In contrast, the characteristics of professionally and personally connected relationships vary across a continuum on each dimension. Personally connected relationships are categorized as having high relational intensity on most or all dimensions and professionally connected relationships are characterized as lower intensity across most or all dimensions. However, it is possible that there are some ACNP-patient relationships that might be somewhere in between or in transition from professional to personal levels of connectivity on some dimensions. A detailed discussion of each dimension of connection follows.

Patient/person Orientation

In their discussions of relationships with significant levels of connectivity, ACNPs consistently describe their view of patients as persons who are also patients experiencing disease. In their descriptions of connected relationships, it is clear that they are focused on learning as much about the person, such as likes and dislikes, what causes upset, what is encouraging, hopes and fears in addition to learning about symptoms and experience of the disease. Wyn describes this as a focus of her interaction with a patient during the initial interaction:

I talk to them about something that’s important to them. Ask about their family. Just try to show that I’m very interested in who they are as a person … making it very personal rather than … just trying to stick to the clinical stuff, to show that I … don’t recognise them just as a patient (A4-25).

ACNPs describe their emphasis on the person who is the patient, which often includes gaining a sense of who they were before the onset of illness. Sandra describes the importance of gaining and then using this knowledge in her work with patients:

I understand that you’re feeling horrible right now and I know this isn’t the way you’d like to be. And so I do a gentle reminder of what I remember they were like and how we will try and get them back to that point and even better (A6-73).

ACNPs recognise the importance of listening to the story from the patient’s perspective, no matter how much time that might take and integrating previous knowledge of the person into the here and now. Wyn describes it in this way: “I know things about them because I’ve had discussions with them … I’m interested in them as a person not just their medical piece” (A4-281). Wyn elaborates further, explaining that her way of thinking about patients extends far beyond their current health care experience to their home life:

Mrs. M, I would, you know, think of her as Tammy… I think of her when she’s at home and I think of her, you know, her son, he’s just going to university and then her husband and he’s busy and he works in construction … how does she do the other things that …
she needs to do to look after her family? ... I don’t really think about them ... as just being here [in the hospital] (A4-466).

In contrast, when there is a more limited, exclusively clinical relationship, the patient is described by the ACNP in terms of his status as a patient with physical, disease-related needs. There is no discussion of the person who is the patient. It would seem that, given the earlier description of the nature of connected relationships, ACNPs strive to establish at least a professional connection with each and every patient with whom they work but when that does not happen, they view the person exclusively as a patient. Wyn offers a detailed description of a patient with whom it was difficult to work, but the detail relates almost exclusively to his health condition:

He was a difficult patient because he was ... particularly needy ... Just from a time point of view, I didn’t have enough time to devote to him to make him happy ... He had ... ongoing care from a psychiatrist. He had a personality type disorder... and unfortunately he had a very serious heart attack. He was left with quite a damaged left ventricle. He was a young person, only 41 (A4-369/373).

In essence, if a patient is described predominantly in terms of his disease or health problems by the ACNP then the likelihood of a connection evolving is significantly diminished, even eliminated. The only way such a connection can evolve is if the patient, the ACNP or both change and become receptive to the development of a closer, more connected relationship. One ACNP talked about a connected relationship that was anything but connected initially. She found herself irritated by the patient’s communication style with her. With probing she was able to identify that she perhaps didn’t invest the time in getting to know the patient and her family as people, as is her usual practice:

But it was really not until Terri was admitted ... that I got to know her. It was when she came in ... there’s been that crystal connection with her as well, when she came in. But it didn’t happen right away. And...what was the difference? (Short pause) ... It was really getting to know the family and what this thing would mean to the family. So when they were in hospital, the whole family was there. And if I went in, I knew I was going to have to sit down for 45 minutes or an hour. It was going to be an investment of time (A1-131).

When considering the ACNP’s view of the patient, a stronger connection is evident when the patient is seen as a person first and a patient with a disease second. Relationships described by ACNPs as professionally connected seem to reflect almost an equal attention to both the human being and the patient by ACNPs. These relationships still reflect a connection but reflect a lower level of intensity characteristic of a professional connection.
In summary, ACNPs’ descriptions of professionally and personally connected relationships with patients reflect a dimension of patient/person orientation. In the most strongly connected relationships, emphasis on the person is more clearly evident. In professionally connected relationships, the acknowledgement of the person occurs but is balanced with detail about the patient as a person with a health issue. When ACNPs are asked about patients with whom they are unable to develop a rapport, i.e., clinical relationships, details of their disease and care predominate with little or no information about the person as a human being. These relationships are clearly uncomfortable and unsatisfying for the ACNP and they are thankful that they occur rarely in their practices.

**Mutuality**

The second dimension of making a connection is mutuality. Mutuality is defined as sharing between two or more people. Mutuality associated with connection is reflected in the feeling of comfort in the relationship that results in reciprocal sharing of things about oneself with the other. This sharing may come about spontaneously or may be encouraged by one or both parties. Mutual sharing of information about oneself by ACNPs and patients is described as bi-directional and reciprocal: “It’s nice to have a two-way … sharing of information” (A4-53). Jessie concurs: “It’s a two-way street … mutual respect” (A5-575/579). When asked how she knows when a connection is established, Cara describes herself as beginning to freely disclose personal information and suggests that the patient does the same: “You start disclosing a lot more personal information I find with them…then you would with other patients, … I think … that it’s sort of a reciprocal thing too. They probably disclose more information to you” (A3-133/137).

ACNPs attempt to describe how they identify the movement towards mutuality; it is something that ACNPs feel and they see changes in the relationships and the level of comfort with the other, but they consistently find this difficult to put into words. Recognizing the emergence of mutuality is one indication that a connection is occurring. ACNPs describe the mutual sharing of thoughts, feelings, cultural origins (A3, A6), emotions (A4, A5), hopes, stories (A5) and silence: “It’s almost palpable. It’s a tone in the voice; it’s a look in the eye. It’s a silence that it’s okay” (A1-71).

ACNPs convey that the closer they feel to the patient (i.e., a stronger connection), the more they disclose about themselves and self-disclosure only occurs when there is a connection. Patients usually initiate self-disclosure once they sense that the ACNP is responding to them,
indicating a readiness to connect. Jessie describes this readiness: “They’re not going to disclose information to you if they don’t feel you’re genuine, can’t trust you” (A5-21). Several ACNPs were able to describe situations when self-disclosure didn’t occur easily or quickly, indicating less of a connection between themselves and patients. Carol describes an early stage of a relationship that did eventually become connected: “I didn’t reveal as much of myself to them. Perhaps I didn’t invest the same amount of time or the same amount of, um, I didn’t invest the same amount of me in the time I spent with them” (A1-128).

When a patient confides personal information and they perceive a connection occurring, ACNPs begin to disclose personal information of their own. Cara describes such a situation: I’ve known this guy now for 6 months, twice a week [I] talk to him. You know he has hemorrhoids because he had a huge problem with rectal abscess. I mean … you get sort of in those intimate situations and it’s kind of hard, you know, and then they say ‘oh so what are you doing for the weekend?’ And … ‘do you ski?’ And I ski and bought these skis and blah, blah, blah (A3-149).

ACNPs, as part of their practice, ask patients personal questions in order to understand who the patient is as a person, living life. However, patients may encourage self-disclosure from the ACNP by asking minimally probing questions that are non-clinical in nature such as their city of origin, education or family composition. Kim provides an example: You often connect with people that have addresses outside of Toronto and oh you know how long have you lived in that area? Or did you grow up in that area. If I’m away for a weekend a patient [will] say, you know, ‘how was your weekend?’ ‘It was great, I was at the cottage.’ ‘Oh we have a cottage, where’s yours?’ … Just that kind of connectedness (A2-433).

In essence, mutual self-disclosure is a trademark of personal connection. One ACNP describes strongly connected relationships as those that ‘slip through’ reinforcing that this type of relationship with a patient is atypical. Such patients become important to ACNPs but their importance varies in intensity along a mutuality dimension. The more personal information is shared, the more personally connected the relationship becomes and the more important the patient becomes to the ACNP. Some mutual self-disclosure is characteristic of professionally connected relationships and clinical relationships do not include ACNP self-disclosure at all.

Interaction

Another dimension of connection is the kind of interaction that occurs between an ACNP and a patient. Interaction styles range from cool, guarded, formal and business-like in a clinical relationship through to a comfortable, uninhibited, informal style of interaction that characterizes a personally connected relationship. By way of example, Kim describes her feelings about
working with one patient, illustrating a clinically connected interaction style: “We haven’t made any connection and I, it’s just I’m trying to give him everything that he wants but I’m a little bit on my guard because [I know] I’d better have all the details for him” (A2-445). Cara, when asked how she works with a patient who has rebuffed her attempts to connect with him, recalls: “as a matter of fact I probably initially, after he said that, spent a little less time with him than I had to and you know, not gotten quite as personal with him” (A3-201).

Connected relationships have a comfortable feel to them. The rapport is well established and the communication style feels free, easy and unencumbered. Jessie contrasts the nature of a typical, more professionally connected, relationship with one that is more personally connected: “It’s a little bit more it’s more business like. It’s more professional. It’s less inquisitive unless there, unless you need to have some professional curiosity. Like unless you need to find out about conditions and stuff” (A5-415). Jessie continues as she describes the differences between a personal connection and those that are professionally connected relationships: “They’re more professional, less personal. You don’t engage in, I mean, you know their family but you don’t, you aren’t part of the family” (A5-443).

ACNPs recognise that a connected relationship may not always be feasible or realistic with a patient at a given time and their efforts to forge one may be for naught. Issues such as a patient’s severity of illness, level of consciousness or ability to communicate may influence the connecting process and thus the interaction. Wyn offers examples of when a connection with a patient may not be possible because a patient’s health status prevents or minimizes interaction:

Sometimes I find that if it’s a if there’s a language barrier or there’s something that’s… interfering with the patient’s level of consciousness or their … dependence on physical care, it’s different, … they’re not at [a] point to make that kind of relationship. Because sometimes they’re not as interactive and they can’t come along with their feelings” (A4-101).

Sandra implicates illness and disease factors when she describes patients who are unable to engage in a process of connecting: “I always walk into the patient’s room very positive, thinking they’re going to give me the best that they have to offer and sometimes it doesn’t [happen] depending on what illness spectrum the patient’s at” (A6-37).

The attention paid to the interactions with patients by ACNPs contributes to the establishment of a connection and they must have the emotional energy to invest in the other person at that time. If the ACNP has other pressing issues occupying her mind, then the interaction may be more impersonal. Carol describes how her frame of mind affects the type of interaction:
Probably a good part of the time it’s the mind-set that I’m in when I start the discussion, or when I phone that person, or when I walk into that meeting to meet them. If I have to, say, if I have a list of the things I need to be doing, I may not be 100% there (A1-28).

There are times when ACNPs recognise that they are not prepared to interact with patients in a comfortable manner. Cara describes using strategies to address such situations: “Some days… I’ll say ‘you know what, I just can’t deal with today … I’m having a downer day. I can’t deal with that, can you?’” (A3-113).

Personally connected relationships are described as interactions that reflect ‘going the extra mile’. ACNPs provide several examples of what might be considered ‘going the extra mile’. Jessie describes her desire to be the one to provide information to a particular patient with whom she is close so that she is there to ‘pick up the pieces’ if required: “You just you don’t want to cause them pain but you want to make sure that they… you want to be the one that tells them … so … that they’re not hearing second or third information” (A5-234). Kim describes arranging special services for a patient to contribute to her sense of wellbeing: “I had a really close relationship with her and I would go in and see her in the morning … I made arrangements for her to get her hair cut when she needs [it,] you know, that kind of a thing” (A2-49).

Personal connection breeds a style of interaction that is comfortable and informal. The more connected the relationship, the more conversational and informal the interactions become. In addition, opportunities for interaction are more spontaneous, requiring less planning. Clinical relationships are uncomfortable and more business-like. Professional connections have more in common with personally connected relationships in terms of comfort but professional connections are differentiated by their more business-like and less personal interactions.

**Boundaries**

A final dimension of connection is the attention paid to boundaries by ACNPs. Boundaries emerge as a differentiating issue when discussing ACNP-patient relationships. In the health care context, a boundary is a line that should not be crossed in a therapeutic relationship between a health professional, in this case an ACNP, and a patient. The boundary represents the difference between relationships that are personal and those that are maintained as professional with a focus on helping. Awareness of boundaries is not described as impeding the development of connection but emerges as an important consideration for ACNPs in order to prevent movement from what ACNPs term a professionally intense relationship to a personal, friendship-type relationship. ACNPs recognise that, though they may develop close, connected relationships with patients, these relationships are not personal friendships. However, as
described earlier, Jessie says that those highly intense, connected relationships might well be friendships if developed under different circumstances, within a social context. ACNPs are on guard, ensuring that professional boundaries are in place.

As with the other three dimensions, there is a clear demarcation between clinical relationships and connected relationships. Once a connection is apparent, a continuum appears to exist in terms of attention to boundaries that differentiates professionally connected from personally connected relationships. There is no apparent need for ACNPs to consider boundary issues with patients with whom there is no connection. In fact, they describe an imposed distance between themselves and the patient that is intentional on their parts. The formal, distant interactions, the lack of mutual self-disclosure and the view of the patient exclusively as a patient with a disease all contribute to ACNPs minimizing information sharing about themselves and establishing strong boundaries in clinical relationships. ACNPs suggest that there are pieces of themselves that they do not make available to patients in clinical relationships. There seems no apparent risk that boundaries will be breeched.

Despite the intention of ACNPs to establish connections, when they recall their connected relationships, the discussion of boundaries does emerge. Moreover, as the strength of the connection increases, ACNPs seem to attend to boundaries in an attempt to monitor and mediate the potential for over-involvement with patients. None of the ACNPs believes she has ever crossed the line and become over-involved, but ACNPs have developed a few very close, personal connections. As Cara says: “some slip through” (A3) indicating that close emotional connections do develop between ACNPs and patients even if one is guarding against it.

The predominant purpose of boundaries is to prevent over-involvement, yet allow what Sandra refers to as a personal connection to develop within a professional relationship:

I’m always very careful. I believe in being personally connected with a patient but not on a personal level. And what I mean by that I think you have to maintain a certain level of distance i.e., professional and appropriate behaviour (A6-17).

Kim describes a scenario that illustrates her awareness of the boundaries inherent in her connected relationships with patients as differentiated from those with friends: “It’s a professional relationship, so you just can’t go in and sit down and say oh I’m having a rotten day. You know you can’t do that, which you would with a friend?” (A2-397).

Boundaries are also used by ACNPs to protect themselves from intense emotional reactions and their impact. Cara refers to her use of barriers, which she sees as instrumental in allowing her to continue her long-term work with patients:
You develop good relationships with a lot of patients but I think I also put up barriers somewhat because you wouldn’t survive in this job if you didn’t. … I learned that early on and, you know, I think I do … put up barriers because you just couldn’t do that every day and not fall apart, I don’t think (A3-105).

Boundaries are used when an ACNP carries out her work with patients. Given competing priorities, ACNPs establish acceptable methods of communication with patients and use boundaries to enforce appropriate access to them as a resource. Jessie’s comments illustrate the use of boundaries early in a relationship when connection was evolving.

If they’re calling about things that aren’t important then we review, you know, when you call me, I’m a very busy person … I can’t be calling you to, you know, to chat about nothing in particular. If there’s a concern, you know, by all means let’s address that concern (A5-535).

In this example, Jessie clearly has no trouble establishing boundaries early. However, in personally connected relationships, ACNPs describe increased vigilance with respect to boundaries.

The risk of blurring or crossing boundaries in highly connected relationships leads to some discomfort for ACNPs. In fact, it seems that the stronger the connection, the more uncomfortable ACNPs become about boundaries, resulting in a heightened awareness of boundaries as an issue. Cara’s perspective makes this clear. “I think you do have to kind of recognise maybe when things are getting a bit too far and pull back a little bit” (A3-161).

While boundaries serve a purpose in the relationship, comfort with those boundaries may change during the relationship. As Sandra illustrates in a general description of rapport development, she has a firm idea of where the boundary should be between herself and the patient but can become uncomfortable as the relationship proceeds:

You can still be personal, develop a personal rapport with a patient. I do tend to have some discomfort if the patient wants to connect on a level that exceeds the professional boundary, i.e., wanting to know about my personal life and those kinds of issues. I don’t think that’s appropriate. However if they’re telling me a story about their life and they ask me do you understand what I’m saying or can you connect with what I’m saying, I may convey to them yes in fact I do because I have personally undergone something (A6-17).

Attention to boundaries emerges as an important dimension contributing to the understanding of connection that is affected by ACNPs’ views of the patient as a person, the mutuality that occurs between them and the overall interaction that occurs between ACNPs and patients. In a clinical relationship the boundaries are firmly established, limiting what the patient is able to access from the ACNP as a person. However, those relationships that evolve into a professional connection include boundaries that are more dynamic and fluid but this does not
usually present a problem. Personally connected relationships are characterized by a heightened awareness of boundaries because of the potential risks of over-involvement and ACNPs’ intention to prevent this from occurring. It is perhaps attention to boundaries that is most important in preventing a relationship from being transformed into one of over-involvement, which would be seen as unprofessional and associated with diminished therapeutic effectiveness.

In summary, ACNPs’ reflections on relationships yield four dimensions that influence ACNPs making a connection with patients; patient/person orientation, degree of mutuality, interaction style and attention to boundaries in their relationships. All emerge as important dimensions when trying to understand the nature of the relationships established between ACNPs and patients. From ACNPs’ descriptions, there appears to be a clear division between relationships that are strictly clinical and those that are connected, but there is a less clear delineation between professionally and personally connected relationships with respect to each dimension.

**Readiness Conditions for Making a Connection**

Before an ACNP-patient connection can be made, readiness conditions must be fulfilled. Readiness conditions are the circumstances that must exist within and for the ACNP if she is to move forward with making a connection. Analyses of ACNPs’ descriptions of their relationships yielded three readiness conditions that enhance the potential for a successful connection; being authentically present with patients, having an intention to know the patient and perceiving a patient’s openness for a connected relationship. An ACNP must perceive that each of these readiness conditions is successfully met before a connection can occur. ACNPs explain that they intend to develop a connection with every patient but this does not always occur and it is often these readiness conditions that have an impact on how the relationship will evolve. A description of each readiness condition and the circumstances under which each is met or not met are discussed.

**Authentic Presence**

Having an interest in patients as human beings and behaving in a way that is genuine and sincere towards the other characterize being authentically present with patients. ACNPs express a need to be a person, behaving in an open and honest way so as to encourage a similar response from the patient. When an ACNP is authentically present the patient is able to see who the ACNP is as a person, not just as a professional. Carol gives an example of this perspective in the
context of talking to patients. “No matter how many years you’re in the business, no matter how skilled you become, if you’re remaining human, I don’t think you ever feel completely at ease with giving someone really bad news” (A1-116). Jessie also describes her expectations in relationship building of herself and of the patient. “It’s being real and having the patient being real… Honesty, open, honest and genuine and on both sides … that makes a good relationship (A5-5).

ACNPs consistently describe their desire to work with people; enjoying them, learning from them and helping them. This genuine interest in people contributes to the authenticity with which they approach relationship development with patients. Kim and Wyn respectively articulate this joy in working with people:

I think it’s the way I approach people … in general and patients, I’m very friendly and I’m generally smiling and I enjoy my work and I enjoy meeting people (A2-29);

And it’s more the people … the people connection that … I enjoy because the rest of it is just paperwork (A4-349).

It is unusual for ACNPs to intentionally present inauthentically to patients but there are situations when this might happen, albeit rarely. ACNPs report times when they are distracted by other responsibilities or competing priorities which does not allow them to focus exclusively on the patient and making a connection with him. If this situation persists, a clinical relationship will develop. However, if the ACNP realizes what has happened, she can adjust, refocus and present authentically to the patient with the intent of making a connection.

In summary, a humanistic and genuine presence with patients is integral to ACNPs’ approach to establishing relationships with patients. They recognise its importance and relevance to this central process in their work.

Intention to Know the Patient

A second readiness condition is ACNPs’ intention to know patients. It emerges as a distinct condition that has an impact on ACNPs’ readiness to move forward with making a connection. ACNPs describe their desire to get beyond the diseases and understand who patients are as individuals. They try to learn about how the disease is affecting patients’ lives, what their lives were like before the disease, what is important to them and what they are trying to return to; in short, who they are in the world? Carol attempts to explain the importance of going beyond the disease and the illness, giving two examples from her practice:
It’s way beyond, ‘I have a problem with pain, I need medication’. That’s just one piece. … It sounds so simplistic, but … it’s the human piece. And it’s more than just, ‘I know your name’. It’s more than that (A1-43/49);

And arranging for her to come in, there were several mountains that needed to be moved, just to get her to the point to come in. There were problems with home-care people, difficulties with home-care people … setting up with visiting nurses whether she was going to be able to have this [medication], prepare her and the family. … It was really getting to know the family and what this thing would mean to the family. … But then it was talking with her mother and father, and hearing about her kids, and a cousin coming in from New York City (A1-131/143).

Sandra describes the importance she places on knowing a patient well and how she uses the knowledge to make a connection with and help the patient move on with his life: “If there’s a certain trait that I know the patient has when they’re feeling well, but they’re not exhibiting right now, I bring it back into that clinic meeting to remind them: ‘I know what you’re like’” (A6-73).

As with authentic presence, it would be unusual for ACNPs to not have the intent to know a patient. However, when ACNPs encounter a patient who does behave in a way they believe to be inappropriate, this can influence an ACNP’s interest in getting to know the patient better. This is a rare occurrence and if the situation persists and this condition is not met, a clinical relationship is likely to evolve.

ACNPs’ recollections indicate that they believe that getting to know the person, the human being, is essential if they are to establish a relationship that allows them to help patients through acute illness.

*Patient Openness*

The final readiness condition required when making a connection is an ACNP’s perception of a patient’s openness or desire for a connected relationship. ACNPs describe their early interactions with patients and how they attempt to get a sense of patients’ desires, needs and wants with respect to their relationships with health care professionals. ACNPs recognise when patients are open and may need or want to connect. As Jessie says: “[He] made me know him” (A5-290).

ACNPs note behaviours that indicate to them patients’ desire to connect, such as open and honest sharing of personal information and taking an interest in the ACNP as a person. Cara recalls a patient’s mother whom she perceived wanted a connected relationship with her and with others on the team:
She was very open and honest with us too and she would tell us exactly how she was feeling and, you know, if she saw you in the hallway, like she would seek us out in the hallway and come and talk to us when she was visiting her daughter. And ... I would say ... 'how are you doing' and 'how are you coping ... do you need to talk to somebody? Do you want to go for a coffee?' (A3-261).

Patients also indicate to ACNPs when they are not interested in the closeness and intimacy that characterize a connected relationship. These behaviours are similar to those allowing ACNPs to recognise a lack of connection with a patient. Cara describes a patient who was comfortable having interactions with her that involved limited socialization:

I don’t think he would ever tell me that he was really down and didn’t want to continue treatment. Although he would tell her [his wife] and she would call me and tell me and then I would talk to the team ... I just think he’s not that kind of a person, that just kind of opens up to people really easily ... I mean I think he feels comfortable coming downstairs and you know telling us about his vacation (A3-365/377).

ACNPs are comfortable reading the cues of patients in their care and identifying their need or desire for a connected relationship. They are also generally comfortable with patients no matter what their relationship needs appear to be. They do not force a connection with those who do not wish one, but given ACNPs’ inclination to connect, they remain open to a connected relationship.

Readiness to connect, from the ACNP perspective, involves three readiness conditions; being authentically present with patients, engaging in relationships with patients with the intent to know them as persons beyond the disease and finally, the perception by ACNPs that patients wish to develop connected relationships with them. If any one of these conditions is not met a connection may not be made. Given that the central theme of ACNPs’ relationships with patients is to make connections, these readiness conditions set the stage for the use of strategies to make a connection.

**Relational Strategies Used by ACNPs in Making a Connection**

Making a connection requires ACNPs to use strategies to enhance the closeness of their relationship with a patient. These relational strategies are intentional actions used by ACNPs as they strive to make a connection. They are used both to influence fulfillment of readiness conditions as well as moving forward in relationship establishment. Continued use of particular strategies is dependent on ACNPs’ perceptions of their effectiveness in making connections with patients. If an ACNP recognizes that a connection is being established, connecting strategies are used to further solidify the relationship. If no connection is made, use of these strategies appears
to diminish or cease entirely. Four connecting strategies emerge as important for ACNPs; humour, time as a resource, demonstrating one’s credibility and discovering commonalities with patients.

**Humour**

Humour is used by ACNPs to establish good relationships with patients. From their descriptions, humour is behaviour or words that evoke a lighthearted mood and even laughter. Several types of humour are described by ACNPs including: “plays on words and puns” (A1-192); “self-deprecating humour” (A1-191); “black humour” (A5-222); and “gentle humour” (A6-69). Humour serves a number of purposes and is used as a basic strategy to communicate, connect and cope with day-to-day practice. Jessie explains:

> I do use humour quite often. I use it as a communication tool. I use it as a coping mechanism too. I use it for me. I use it for my patients. If they’re [annoying] me … I’ll say to them ‘you know what don’t [annoy] me … because I will disconnect you [from the machine] and I’m the only one in this world who can do that’ (A5-214).

Jessie recounts the reaction of patients to her approach: “Usually they laugh because they know I would never do that” (A5-218).

ACNPs describe using humour often but they acknowledge that there is a time and a place for its use. ACNPs feel confident in their ability to judge when it is appropriate to use humour. Jessie uses humour often and is aware that her use of ‘black humour’ happens once she knows a patient well:

> I tend to judge beforehand whether or not it’s an appropriate ... And I generally, if people start to see my humour and especially my black humour because I have a huge black humour side, I usually know them fairly well (A5-222).

Sandra describes her intention to use humour everyday with every patient but she takes care when using it. “Joking is very sensitive and you have to be very careful. But I use joking every single day almost with every single patient” (A6-73). Humour, however, is not always received in the way it is intended, as Carol describes: “Initially [with one patient], I had a couple of attempts at humour that blew up in my face! … I remember once I tried some low, little thing and they looked at me as if I had two heads. I laughed at myself, well … that didn’t work, did it?” (A1-198).

Humour is used to help patients feel better about their situations. Sandra describes her approach as she attempts to lift the spirit of the patient: “I use gentle humour when things are
dire because sometimes when families and patients are stuck in imminent death you need to uplift the spirit” (A6-69).

Humour is used to alter the dynamics between the ACNP and patient. Kim describes a situation where she uses humour in an attempt to reframe a negative situation into one that was more positive. She believes she was effective doing so:

There’s one [patient] that’s known to be so, so grumpy and… I just go in, in the mornings and he has a list of complaints. And so two days ago I started saying ‘okay I’m hearing, you want every one of them and I can’t do anything about this and this but I can always listen’. And then I said ‘is there a good story you can tell me tomorrow so I could start my day out well?’ And he goes ‘oh you want to hear a good story?’ So he came up with a good story and a funny story. So now it’s I guess it’s use of appropriate humour as well so he says ‘do you want the complaints this morning or the good story?’ ‘No you’ve got to give me the good story first’. So you spend a little more time but it’s hard for them being in a hospital so if you can make light of a situation and connect with them in that way I think it’s very important (A2-37).

Power differentials that are a result of health professional expertise may influence interactions between health professionals and patients, but attempting to ‘level the playing field’ is something that ACNPs consider when building these relationships. This allows the ACNP to work with the patient more effectively. Carol describes how humour helps to achieve this purpose: “It puts us on equal ground … It breaks down artificial… boundaries…. [and] the work part, the assessment part is easier if you’re on equal ground” (A1-201/203).

Humour is also used to maintain a connection with a patient. Jessie describes her use of humour throughout her relationship with a specific patient: “We … both [ACNP and patient] have senses of humour …he’s got a very dark sense of humour so he’s constantly trying to see if he can … push my buttons” (A5-318/322).

Humour is a tool that is effectively and commonly used by ACNPs in establishing and sustaining connected relationships with patients. Humour is used to reframe a negative situation, altering the dynamics between ACNP and patient and helping patients to feel better. ACNPs believe that humour is welcomed and well accepted by patients.

Time as a Resource

ACNPs view time as a resource and its use is an important connecting strategy that is conceptualized in a variety of ways; making time for and spending time with patients, being there for them, investing time in patients and allowing patients time to process their situation. Making time for patients is central in ACNPs’ descriptions of their practice. They consider the interface with patients fundamental to their role. Time is seen as an essential commodity that
ACNPs can offer in a way that is qualitatively and quantitatively different in its nature and composition compared to other health care professionals.

ACNPs care for, on average, ten patients each day. They describe seeing each patient every day, completing an individualized assessment of each patient’s needs and determining the time required to address those needs. Time is mentioned frequently, indicating its importance. In particular, it is the time spent alone with a patient that ACNPs believe to be most significant. As a relationship develops, ACNPs describe spending more time and interacting more frequently with patients. Wyn describes her thinking when deciding how to allocate time to spend with a patient who is to receive ‘bad news’:

Make sure that you have time, like it’s not something that you want to deliver, bad news and then not be available … to follow up … that you’re going to say [tell the bad news] at 5:00 p.m. and you have to leave (A4-153).

Kim describes when a patient required more of her time in order to meet his complex needs:

Because he is at risk for never going back to his home at some point so maybe there’s a difference if there’s more vulnerable or more needs for a patient I’ll recognise that and spend more time and effort on those kinds of things (A2-281).

ACNPs recognise that spending time with patients contributes to the development of a relationship and to its maintenance. Spending time to listen and offering patients time to tell their stories allows ACNPs to gain valuable information that rushing patients may not yield. Jessie recounts a telephone encounter with a patient who paged her but did not immediately offer the problem when she returned his call. She needed to wait patiently until he was ready to tell her his real concern:

And it [the pager] was going off so I went and I looked and it was [a patient]. And I called him. [He said] ‘Oh, hi I already talked to [the doctor] because [he] was on call’. And I said ‘oh, okay, and you know just kind of waited thinking well what was that about? … so waiting and waiting and waiting and you know just kind of cajoling him along and letting him talk (A5-74/78).

Wyn expresses a similar perspective, feeling comfortable just sitting with a patient if she senses that she might be needed: “I don’t mind just sitting with people if …they want to just sit or just listening to them talk. I think I like to give people time to think about things and, you know, being available to them” (A4-221).

ACNPs consider themselves fortunate to be able to spend time with patients and they consider time a gift they are able to give a patient. Carol articulates this perspective:

That particular couple … taking my time to listen to their stories. That sounds so simple. And I think for patients, that I do that. But if you need to take an hour and twenty minutes, as an ACNP I have the luxury… I have the time to do that” (A1-78).
ACNPs see the investment of time they make as beneficial to relationships that are built between themselves and patients. Carol says that it is important to use: “time to listen” (A1-80). She recognises the importance of the investment of time in the patient and his or her family: “But I know for this particular couple it was the investment of time and listening and letting them sound off when they’re so angry. It takes time.” (A1-78).

ACNPs value the time they spend with patients and it allows them to gain a sense of how the relationship is developing and serves as the impetus for seeing patients more regularly, indicative of an increased relational intensity. The time they give is not always spent addressing health or disease related concerns. Sometimes it is more social, fitting with the perspective that, in another context, such a relationship might be between friends. Kim describes such a situation:

I would go in and see her in the morning. And we’d talk all about the things that could happen in the day. Then I’d go around and see her at dinnertime and we talked about jewelry. We both liked shoes. We talked about going shopping … I’d sit on her bed and just talk with her at the end of the day and I might be there for a half an hour (A2-49/61).

Being there for patients is considered essential for ACNPs in their practice. Being consistently involved with patients and providing continuity allows ACNPs to make the plan happen, offer information and provide overall coordination of care. Cara discusses continuity and its importance in relationships with patients: “I think continuity of care is a huge issue and I think the way we work downstairs [in the clinic], we provide that” (A3-633).

Wyn comments on the consistency she offers patients and how spending time regularly with them allows her to know them in a different way:

So they find a consistent person from the time they’re admitted or they’re on this ward, I’m the consistent person who’s coming in every day … I know things about them because I’ve had discussions with them. Because I would say that a lot of people don’t spend as much time with patients talking about things with them as the nurse practitioners do or that I personally do (A4-281).

Wyn goes on to say that she knows patients in a different way and feels she spends different amounts of time in different ways with patients, all contributing to unique relationships developed between them and herself.

Wyn comments that she is available for patients and this allows her to know patients in a different way and differentiates her approach from those of her physician specialist colleagues: “The [physician specialists] that [go on medical rounds] with us certainly are only there, just in and out kind of thing” (A4-281).

Finally, giving patients time to contemplate, consider and decide about options in a fast-paced health care system is an important way ACNPs use their time. Wyn describes the
importance of reading a patient’s cues, giving the patient time to collect her thoughts and tell her story:

And then you know when she was telling me about her strokes and things like that she got a bit tearful and I know it was difficult for her to, to talk about all these things and you know just sort of gave her time and let her tell that you know at her own pace and that sort of thing (A4-269).

Sandra acknowledges the patient’s need for time to consider information provided to him, and that rushing him did not suit his style nor was it in his best interests:

And it was almost, not bargaining per say, but it was it was putting the cards on the table, letting him think for 24 hours. I knew by what he was saying he didn’t want to give up and he didn’t want to die. He just didn’t want the situation to be the way it was (A6-109).

Using time as a resource emerges as a strategy used by ACNPs to establish connectivity. Making time in their relationships with patients is seen as important because it conveys an investment in them, facilitates patients’ access to ACNPs and communicates to patients that they are valued.

Achieving Credibility

Credibility as a health care professional is viewed as essential to gain patients’ trust. ACNPs believe that they must establish credibility by behaving in a trustworthy, honest and straightforward manner and living up to promises they make to patients. Establishing credibility is an explicit and essential strategy described by ACNPs.

Central to achieving credibility is honesty. ACNPs discuss their intention to be totally honest in their interactions with patients. Cara recalls one young patient with whom she believed she had a good relationship because of her honest approach: “There was another young girl who was, like, 17 and she didn’t do well from day one … I think I had a fairly good relationship with her. I was always really honest with her” (A3-545).

One approach to being honest is to know one’s limitations as an ACNP and acknowledge these. Kim describes her approach when a patient asks a question to which she cannot respond:

I think it’s a good thing to say ‘I don’t know, I don’t know, I can’t supply that information because I don’t have enough knowledge about that’. … ‘I can ask my physician colleague and he will come around and talk to you’. … I think generally speaking it’s [saying ‘I don’t know’] most often positive because you just don’t leave it hanging … I’ve never been uncomfortable saying that. … I don’t recall being challenged on that … And I think it’s a very honest thing to say (A2-479/487).

Cara adds her perspective about establishing credibility, suggesting that conveying self-confidence can influence the confidence that a patient has in her:
Having a sense of confidence that you know your stuff and you know your area and that … I’m confident that I know what I’m talking about when I answer questions (A3-25/29).

ACNPs describe providing information in a straightforward approach as another way of demonstrating that they are credible. ACNPs try to anticipate what the patient might need to know. They do this so that patients will have all the information they need. Jessie describes her straightforward approach: “This is what the next 24 hours is going to look like … you want to make sure that you’re giving factual, accurate information, that you’re allowing them to explore their thoughts and feelings and ask questions” (A5-282).

Cara validates the impact of her honest, straightforward approach when she describes the reaction of a patient when she provided significant information about her prognosis: “She was very brave, you know, and said ‘okay I needed to know that. I need to make some plans and, you know, I appreciate your honesty’” (A3-81).

Earning one’s credibility as a care provider is seen by ACNPs as an essential strategy that aids in making connections with patients. Honesty and a straightforward approach are useful in establishing credibility as a care provider, leading to stronger relationships with patients.

Discovering Commonalities

Finding things one has in common with another person occurs when one is establishing a relationship. In fact, friendships often develop between individuals who have something in common. ACNPs regularly describe uncovering things they have in common with patients. ACNPs seem to look for such similarities and point them out to patients as they talk with them. These commonalities often appear early in their interactions and become readily apparent to the dyad. Kim acknowledges the relevance of commonalities between herself and patients: “I think it makes a personal connection and I think it’s just being human, just talking about things that people have in common and connecting in that way on some commonalities” (A2-441).

ACNPs provide many examples of the types of commonalities they discover with patients. These common threads are noted to have significance for both ACNPs and patients. Cara recalls a relationship she had with the mother of a young patient: “It was the hardest, watching her poor mother go through that, I guess because you can sort of empathize. I have a daughter as well so, you know, I think oh my … to be in that situation” (A3-77). Discovering commonalities seems to inspire a sense of empathy for ACNPs and Cara’s recollection substantiates this. It allows ACNPs to better understand what patients are experiencing in their lives. Kim recounts a personally connected relationship she had with a patient and the
commonalities they discovered: “So she talked a lot about her sisters and I had sisters so there was a real personal element to it and that was nice” (A2-49).

Discovering these commonalities also leads to mutual self-disclosure of more personal information. The discovery itself is a first step in self-disclosure because the individuals then acknowledge that there are aspects of their lives that they share. Jessie describes a personally connected relationship that she has with a patient and how they interact with one another. The personal nature of the discussion and the regularity of the contact with the patient differentiates this relationship from those with whom she is less connected:

I think we relate more on a personal level. We relate as parents of young children. We relate as we relate professionally. We both like to use the computer and communicate by email so you know he’ll send me websites or check this out or do this so we do a lot of that. I always answer him, but by email (A5-314).

The relational strategy of discovering commonalities is a tool ACNPs use regularly, although its effectiveness as a strategy may be variable. Acknowledged commonalities between an ACNP and a patient are characteristic of a connected relationship, but are not apparent in relationships characterized as strictly clinical. ACNPs do not discuss why this is the case but it may be related to readiness conditions such as a patient’s lack of interest in connecting or a particular view of the patient held by an ACNP that influences her intention to make a connection.

These four relational strategies; humour, time as a resource, achieving credibility and discovering commonalities; are used by ACNPs to make connection with a patient. These strategies may be used to influence the achievement of readiness conditions as well as proceeding with making a connection. The effectiveness of these strategies as ACNPs strive to make a connection is modulated by the dimensions that influence the degree of relational intensity achieved.

**Relational Products of Making a Connection**

The impact of making a connection is described by ACNPs and they specify that these relational products occur to varying degrees depending on the degree of relational intensity achieved between ACNPs and patients. The products of connected relationships are the result of ACNPs making a connection with patients. Their presence can be used as indicators of a connection being made. When a connection is not made, as in a strictly clinical relationship, relational products are not discussed. However, in connected relationships, both professional
and personal, three products emerge; partnerships with patients, a sense of comfort with patients and making a difference to them.

**Partnership**

One product of a connected relationship is partnership, which evolves as a result of working closely with the patient. ACNPs recognize the important role that patients play in their own health. ACNPs’ descriptions of relationships suggest that they see patients as having some expertise in their own care and in their lives. The process of making the connection allows ACNPs to learn much about the patient as a human being. This knowledge assists ACNPs to understand patients’ goals and to negotiate partnerships that suit them both in order to achieve those goals. For example, Kim describes her work with an older patient whose family members were concerned about him returning home despite his desire to do so:

> I talked to him and I asked permission if we’d be able to do all those things [homecare services] and he thought it was a great idea. So he was hopeful and he did go back to his home but he liked the idea of being independent but was quite open to having additional resources (A2-253).

Kim listened to the patient’s wishes and negotiates with him to establish plans to assist him at home while simultaneously addressing family members’ safety concerns. If partnership was not a desired outcome for this ACNP, it might have been easier to simply conform to the family’s wishes and place the patient’s name on a list for a nursing home. Instead, she partners with the patient to consider options that will meet his goals, address his family’s concerns, as well as address the issues that she knows will be relevant post-discharge for ongoing monitoring and care. Cara also considers partnership as a product of a connected relationship: “We can choose to go on with treatment” (A3-229), using the inclusive ‘we’ to reflect their work together, patient and ACNP.

In order for patients to be active partners, they require information about their options. ACNPs, having established their credibility, are able to provide information that patients need and then ensure that they have the time to make an informed decision whenever possible. Carol explains the complexity of the process for one patient with whom she made a connection:

> So there were a lot of things and [there was] fear. And having to get her to really think about her choices … I could make suggestions, give her the options that there seem to be right now. But it was difficult……clearly all she wanted was to get rid of the stress of pain. It was essential for her to realize [where] certain choices might move her (A1- 165-167).

Carol has a heightened awareness of the important role she plays in helping patients consider options but clearly understand the role patients have in the process.
As a product of a connected relationship, partnership is mutually beneficial and offers an approach that allows for patients and ACNPs to meet their mutually established goals. ACNPs express satisfaction with this product and how it contributes to their overall satisfaction with their professional work as Sandra suggests: “It’s all about them, you know … [there is a] partnership that we have with patients … I love it!” (A6-458/456).

**Comfort with the Other**

Another product of establishing connected relationships is the development of a mutual feeling of comfort between ACNPs and patients. This comfort is a result of making a connection, which plays a role in maintaining the relationship over time. Comfort with the other likely influences the eventual achievement of partnerships as well as a sense of making a difference for patients.

Comfort with the other is characterized by a good rapport that allows easy flow of conversation and a feeling of being at ease with one another. Sandra comments on the strong connection she developed with a patient and the comfort she believes they both had in their relationship: “There’s a comfort in the strength of connection that we have because I feel I’ve gone through this process with him of encouragement, emotional encouragement so he keeps trying and he doesn’t give up” (A6-442).

Comfort affects how one feels when presenting oneself to another. When one is truly comfortable with another person, one can be oneself rather than playing a role or taking care to behave in a way that one believes is acceptable, in a prescribed context. In contrast, a lack of comfort with the patient characterizes clinical relationships. Kim (A2) and Wyn (A4) both provide examples of when they did not feel comfortable being themselves in relationships that could be classified as clinical relationships:

He doesn’t give you, he doesn’t give me much of a sense that I can actually, can be too. I guess I just don’t feel as comfortable being more myself with him (A2-365);

It’s not the way I usually am with people so I found that very difficult and … I felt uncomfortable with him and he just made me uncomfortable from a, I don’t even know what it was, but … it was unsettling (A4-378).

Both ACNPs identify their discomfort with a particular patient and clearly feel they could not be themselves. They also communicate that the relationship lacks connectivity.

How comfortable one is with another affects the degree to which information is shared between two persons. When ACNPs discuss comfort in reference to sharing of information, it is usually the patient’s sharing of information they describe. Sometimes the information is
voluntarily shared and on other occasions sharing is in response to an ACNP’s question. Interestingly, two ACNPs discussed the intimate information that they are able to obtain in connected relationships, specifically regarding patients’ sexual activity. Cara recalls a patient who talked very openly to her on one occasion, conveying the comfort one with the other:

And, you know, and then telling me about he and his wife separating and how they’re back together. And, you know, then saying to me ‘oh I had sex on the weekend’ and I said ‘okay’. Like but I mean that doesn’t happen with every patient, you know (A3-141).

Similarly, when Jessie asked a patient with whom she had a personally connected relationship about his return to a sexual relationship with his wife, he answered her question with minimal embarrassment. She recalls that discussion and responded enthusiastically: “Now if I wasn’t comfortable with him?” (A5-363). She was trying to demonstrate that neither one of them could have engaged in that discussion if there wasn’t comfort with the other. Jessie reinforces her perspective and the mutual nature of the level of comfort by suggesting: “Being genuine so that they know that they’re comfortable sharing their feelings with me, I’m comfortable sharing my feelings with them” (A5-13).

A final aspect of comfort with the other important to ACNPs is that which comes with silence. When a connection is established, ACNPs describe being comfortable with the silence that may occur when they are with patients, such as when a patient has received bad news. ACNPs believe that giving bad news or being part of that process and working with patients who receive such news is fundamental to their role as a care provider in acute care settings. They find they spend extended periods of time with patients on such occasions and when the relationship is connected, the silence that can occur is not problematic. Kim offers her perspective and seems to find the silence comfortable: “I’m quite comfortable with nothing, just sitting, if there’s nothing more to say I can sit for a minute and if the patient has nothing more to say, there’s comfort in silence” (A2-209).

Comfort with the other is an outcome that ACNPs strive to achieve as they make a connection and the signs of its presence are not only felt by ACNPs, but they suggest that the signs or cues of its presence are observable and recognizable. Comfort with the other is a confirmatory sign that a connection has been made and contributes to the maintenance of the connected relationship.

Making a Difference

Making a difference in patients’ lives also emerges as a product of a connected ACNP-patient relationship. Some ACNPs actually use the words ‘make a difference’ seeing it as
valuable and contributing to professional satisfaction. They seek to make a unique contribution to patients’ lives and are pleased when it happens. ACNPs see themselves helping patients move forward, achieving mutually set goals and moving on with their lives. The contributions they make towards patient goal achievement are seen as making a difference to the patient. This product may also provide validation that ACNPs contribute to patient care in a way that is complementary to what already exists in the health care system. Kim describes when she thinks she makes a difference for patients in her care: “I look for the difference that I can make in them and giving them at least a little bit of joy or comfort or something in their day” (A2-113).

Jessie describes the role she plays with the team, working with patients who may have significant illness with little chance of recovery but who, with her help, are able to rally. It is easy to hear the importance that making a difference has for Jessie:

Having somebody with incredible odds going in, that they’re going to have a bad outcome and … to see them that much closer to having a good outcome. It’s like, you know what? That’s why we do this. You have a little glimmer of hope (A5-286).

Carol describes working closely with patients in hopes of making a contribution to their wellbeing: “Your goal is to help them move through a difficult stage, whether it’s anger or physical symptoms, but it’s um, (short pause) helping them move through.” (A1-84).

Jessie, recalling a patient with whom she had a strictly clinical relationship, describes her role in helping patients move forward, hoping to make a difference, and the frustration she clearly feels when this does not happen:

It was hard because you want to help people but when you get… responses like that you really feel like you’re doing nothing and that you are increasing the burden on them. I mean your job is caring. You’re to relieve burden. You are to help people. You are to move them forward. You know you’re there, you’re a nurse (A5-150).

Jessie’s experience illustrates that making a difference is perceived as virtually impossible in a minimally intense clinical relationship.

There are three products of connected relationships between ACNPs and patients. Firstly, a partnership approach evolves allowing ACNPs and patients to work together to achieve mutually established goals. Secondly, ACNPs describe a level of comfort with patients when there is a connection. That comfort allows them to accomplish things together. Finally, ACNPs have a sense that they make a difference to patients when they are able to make a connection with them. That difference makes their work worthwhile. These products of connection also serve to confirm that a connection has occurred. There is no evidence of similar products when clinical relationships are established.
Patients’ Perspectives on their Relationships with ACNPs

The six patient participants in this study shared their perspectives on relationships they have with specific care providers as well as other providers with whom they are interacting currently or have interacted with in the past. They were heterogeneous in terms of the biographical characteristics. Thirty-three percent were female and their mean age was 51 years (range 29-71 years). Their current or most recent hospitalization averaged 35 days and they reported approximately seven admissions to hospital. Half of patient participants had been hospitalized within six months of the interview. Seventeen percent of patient participants required surgery during this or their most recent admission (Table 7).

Table 7. Characteristics of Patient Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Mean Age (Range)</th>
<th>Mean LOS in days (Range)</th>
<th># Hospital Admissions (Range)</th>
<th>Time since last admission (years)</th>
<th># Female (%)</th>
<th># Surgical (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients (n=6)</td>
<td>51.4 (29-71)</td>
<td>35 (0-150)</td>
<td>6.8 (1-25)</td>
<td>.5 (0.1-0.66)</td>
<td>2 (33)</td>
<td>1 (17)</td>
</tr>
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The main goal for patients with acute illness is moving on with their lives. No matter what condition necessitated their involvement with the acute care health care system, moving on with their lives is their priority. Moving on with their lives did not mean the same thing for all patients but did reflect a sense of being better than they were before as a result of their exposure to the acute care health professionals. For one patient it might mean getting back to the suburbs, living with his family and playing with his children. For another, diagnosed with a terminal condition, it can mean enjoying the life that remains. What is common to all patient participants is that they see health care professionals as contributing to the achievement of this goal.

It is clear from the analysis of patient participant interviews that they perceive their relationships with physicians, nurses and ACNPs as distinct from each other. What follows in this chapter is a summary of the key themes that emerged from discussions with patients about their relationships with ACNPs. The main theme that is central to their relationships with ACNPs is that ACNPs make things happen. Sub-themes that contribute to making things happen include ACNPs’ use of time, their position in the hierarchy within a team, their focus on the treatment plan, knowing the patient well and being present with the patient. Each of these themes is discussed in detail.
Central Theme: ACNPs Making Things Happen

Central to patients when considering their relationships with ACNPs is that ACNPs make things happen for them. None of the patient participants in this study has ever encountered an ACNP before so this type of health professional was new to them. As patients become familiar with this different health professional’s involvement in their care they become knowledgeable about the role they play in their daily care. ACNPs are commonly described as leaders of the team, being in charge and running the unit. Mr. Parker differentiates the ACNP from the staff nurse: “[The nurse] is just a nurse on the [unit] whereas Cara…runs the unit more so” (P3-505). ACNPs are identified as the first point of contact if patients have problems related to care provided and patients also express confidence in ACNPs’ abilities to help them.

Patients explain that in order to make things happen, ACNPs see patients each day, allowing them to become familiar with patients’ needs and thoughts about treatment plans. Though patients may see a staff nurse more frequently during the day, patients notice that ACNPs stay for longer periods of time. Several patients comment on the efficiency with which ACNPs complete their work, such as paperwork, reading and writing reports and arranging diagnostic investigations. They also notice that ACNPs have more autonomy than staff nurses in decision-making and in accomplishing what is needed to meet patient needs.

ACNPs work as members of a health care team that also includes physicians and staff nurses. Patients report seeing physicians least often but see the ACNP as a direct link or bridge to physicians. Patients perceive ACNPs as working closely with physicians, consulting with them about overall treatment plans and then following through with the plan with the patient on a day-to-day basis. Mr. Parker describes how he sees Cara: “She [Cara] takes the place of Dr. Luke. I think most of the time … I deal with Cara a lot and she goes to Dr. Luke and gets things signed and stuff” (P3-341). Once the plan is established, ACNPs are able to explain the plan and what it means for patients in ways that patients understand. Patients note that ACNPs are present, available and accessible to them should they wish to discuss anything.

Patients report that they engage in small talk with ACNPs at times but that much of their communication is related to their condition and the plan to get them well so they can move on with their lives. In addition, it is apparent that there is an association between the degree of relational intensity identified by the ACNP with specific patients and those patients’ impressions of mutual self-disclosure that occurs between themselves and ACNPs (discussed later in this chapter - ‘Patient and ACNP Perspectives on Their Relationships: How Do They Compare’).
Sub-Themes: Time, Hierarchy, Team, Plan, Knowing the Patient, and Being Present

Six sub-themes emerge which patients think contribute to ACNPs’ abilities to make things happen on their behalf. Each sub-theme is summarized.

Time

Patients report that, despite knowing ACNPs have many patients for whom they provide care, they seem to have time for them. Interestingly, in direct contrast with staff RNs, ACNPs are not regularly described as busy when patients describe their relationships with them. Patients indicate that they perceive ACNPs spending more time more frequently with them compared to other professionals. Mr. Lang substantiates this impression: “I see her [ACNP] more than, say, the physicians” (P6-501). Mr. Parker who is being seen in an ambulatory setting, quantifies the contact he has with the ACNP and the physician: “He [physician] comes [to clinic] less than Cara, you know … I see Cara all the time. I see him [the physician] maybe every month or every 3 weeks” (P3-385).

Patients have a sense that the time ACNPs spend with them asking questions allows ACNPs to get to know patients and understand their needs, answer patient questions and clarify any misconceptions about the plan. Some patients even comment that ACNPs return to check in with them later in the day, ensuring that they have a good understanding of the plan and to answer any new questions. It is also clear that those patients who have long standing relationships with particular ACNPs feel their level of comfort is enhanced as a direct result of the amount of time they have spent together. Mr. Parker comments on the impact of the longevity of his relationship with Cara, the ACNP: “She knows me pretty well, you know, so when [I] say [a] long time it’s not like, you know, a couple of times” (P3-405). Mr. Parker has known Cara for 4 years and he has a sense that she knows him well as a result of the duration and frequency of their contact.

Hierarchy

Patients consistently describe health professionals in terms of a hierarchy. They note that ACNPs are positioned higher in the hierarchy than their staff nurse colleagues but not quite as high as physicians. Patients know that ACNPs are nurses but they are seen as having more autonomy and latitude with respect to making things happen in patient care. Mr. Kean confirms this perspective: “I think they have more freedom of action to make decisions and it’s a good way” (P2-580). Patients perceive a hierarchy, placing staff RNs on the low end, followed by
ACNPs, with physicians at the top. Mr. Kean describes how he sees ACNPs fitting into the organization hierarchy in relation to nursing:

I don’t know who else had to check out what she [ACNP] did. I’m sure there’s checks and balances that go on in the practice even if you’re a, even if you are a nurse practitioner, which is a leg up I think over normal nursing (P2-576).

Mrs. Roma also differentiates between ACNPs and staff RNs, commenting on how she relates to the ACNP with respect to sharing personal information: “I knew she [ACNP] was a little bit higher so you don’t, I don’t ask too many questions” (P4-1012).

Patients’ comments reflect a traditional view of the hierarchy and the resultant patient-physician relationships; that is, patients and physicians speak exclusively about the patient’s diagnosis and what the physician can do to address the problem. Patients speak extensively to ACNPs about similar issues and see ACNPs and physicians as similar in their ability to help them move on with their lives. But patients view physicians as deserving a more formal, respectful approach. When Mrs. Tudor attempted to differentiate the relationship she had with the physician who cared for her from the one she had with Carol, the ACNP, she said: “You respect him, his position as doctor, at that level of your profession” (P1-234). So, while on one hand patients view physicians as ultimately in-charge of their care, they also see the ACNP as influential on a day-to-day basis with staff nurses carrying out the plans established by physicians and ACNPs.

Team

Patients consistently comment that ACNPs are part of a larger health professional team. Mr. Lang describes how he sees the team operating: “They’ll [the team] always come in the room, 3 or 4 or 5 of them, and we’ll discuss what the issue [is]” (P6-237). Some patients even identify the ACNP as a leader of the team, in charge and actively involved with the team in developing a plan of care. Mr. Lang comments on Sandra’s (ACNP) role on the team: “She was always part of the team… she was a leader. You could see those qualities” (P6-477/485). Mr. Kean also commented on the leadership role of the ACNP providing him with care: “It’s a special unit … where nurse practitioners are pretty well running the show but the doctors are in there on regular rounds” (P2-348).

Inherent in the team concept that patients describe is a sense that ACNPs function as links, like bridges, between patients and physicians. Given that patients see ACNPs more frequently than physicians and patients know that physicians are essential in establishing their
plan of care, that linkage is seen as vital. For example, when Mr. Parker was asked how he’d arrange to see the physician if he needed to, he explained: “I’d tell Cara and she’d tell him and he’d come over” (P3-529), indicating his view of Cara as an effective bridge between himself and the physician.

The Plan

Diagnostic and treatment plans are central in all discussions with patient participants. An effective plan is seen as pivotal to attaining their goal of moving on with their lives. There are three elements that affect the plan and, ultimately, making things happen. First of all, patients notice that ACNPs try to anticipate their needs. Patients give examples of ACNPs answering questions while including information that goes beyond their specific questions, providing anticipatory guidance. For example, when Mrs. Tudor was preparing to go home, the ACNP, Cara, talked to her about her fear of never walking again: “I’m really worried if I can walk again because of the pain. And she answered me, and then she said: ‘Okay a physiotherapist would help you do all these things’” (P1-195). Cara hears Mrs. Tudor’s expressed concerns and anticipates what else she might need to know to be prepared for her imminent discharge. Mr. Kean also expresses a sense that Kim, the ACNP who works with him, anticipates what he might need to know about his condition: “Well Kim was pretty good about making sure I knew where I stood on that [the need for a test]” (P2-830).

Secondly, patients are confident that ACNPs work closely with physicians to establish diagnostic and treatment plans for them. This also relates to their perceived hierarchy in terms of decision-making and their role as a member of the team. Mrs. Tudor describes her perspective on the lines of decision-making regarding the plan for her care: “She handled it right because you know, I know she’s always getting in touch with Dr. W… they will talk and see what will happen, what they’re going to do. But I know she’s doing it the right way” (P1-220).

Finally, once the plan is established, patients note that ACNPs describe it to them, translating it into language that they can understand and ensuring that it makes sense to them. Mr. Kean provides an example: “I was just curious … about the … surgery and I think Kay explained [what they would do]” (P2-874). Mr. Lang expresses his appreciation for how the ACNP, Sandra, interacts with him with respect to clarifying the plan and making it happen: “She might even drop back throughout the day, you know, ‘did you understand everything that was said? … So I appreciate things like that” (P6-229/233).

These three elements; anticipating patient needs, working with physicians to establish the
plan, and explaining the plan; culminate in putting the plan into action. Given their regular presence in the unit, their elevated status as a nurse and latitude in decision-making and their relationship with physicians, patients see ACNPs making the plan happen: “Well I just watch her operate and I understood that being a nurse practitioner she had, she had more latitude to make decisions about things, to call things up, call for an x-ray, call for something, call for things. They could initiate things” (P2-584).

Patients observe that ACNPs are able to anticipate what patients need, work with physician colleagues to establish a plan and then work with others, such as staff RNs, to ensure the plan is implemented. ACNPs also ensure patients understand the plan and how it applies to them.

Knowing Me

Patients describe their sense that ACNPs know them well so they are the most appropriate health professionals to adjust therapeutic plans in order to address individual needs. They do not make similar comments about staff RNs or physicians. This may be a result of the familiarity patients establish with ACNPs. Mrs. Roma describes her perception of Wyn as she made things happen on her behalf: “Yeah like what Wyn was doing, she knew exactly what was going on. So … it was easier to … answer the questions” (P4-996). Mr. Parker concurs. “She knows me pretty well” (P3-405).

The advantage of ACNPs knowing patients’ needs so well is that patients don’t have to repeatedly communicate details to them. Patients value ACNPs’ comprehensive understanding of their issues and are confident in their knowledge. Mr. Kean recounts how he relates to the ACNP as compared with a physician who came to complete a surgical assessment with him: “Well of course she wouldn’t, she [ACNP] didn’t ask the kind of questions he did. She had it all before anyway” (P2-694). In this case the patient acknowledges that the ACNP is well aware of all his issues and so does not need to continue to ask the same questions. Mrs. Roma comments on how well Wyn, the nurse practitioner who works with her, knows her issues: “She was really good… she exactly knew what my problems were. She knew exactly” (P4-920). Part of understanding a patient’s issues relates to knowing their attitudes about their illness. Mr. Trip describes how the ACNP made an effort to understand him: “Just understanding and, you know, it sort of seems like she … has … the same attitude that I have” (P5-689).

Patients recognise that ACNPs gain an understanding and knowledge of their problems, no matter how complex they might be. They can differentiate those who know them well from
those who know them less well and they appreciate those who make an effort to acquire an understanding of their unique issues.

Being There

A final theme that emerges from discussions with patients is that they see ACNPs as being there for them in a variety of ways. Patients not only commented on how they spend time with them as discussed earlier, but also the importance of ACNPs being accessible and straightforward and the impact that has on their feelings of comfort with and confidence in ACNPs. They describe ACNPs as spending time on a consistent basis, which results in patients feeling that they have access to the ACNP. This allows patients to feel comfortable with ACNPs and confident that their issues are being addressed competently. Patients’ perceptions of ACNP accessibility seem to vary in relation to the degree of relational intensity established between them. For example, Mr. Trip, whose relationship with Jessie (ACNP) would be classified as personally connected, says he can talk to her about anything and feels that her approach allows him to feel comfortable:

I can talk to her about, you know, certain things or ask her certain things and she’ll give me, you know, just not straight forward answers but she sort of does it in a way that makes it sort of like, comforting? (P5-1239).

Mrs. Tudor, whose relationship with Carol (ACNP) is also personally connected, says that it is easier to talk to Carol than others but she isn’t entirely certain why this is the case:

[It]’s just the way, you know that sometimes there’s a person that once you see her, just by looking at her face, it’s like you always, [pause] I don’t know how to explain it. But just the way, by looking at her, I think I can always relate [to] her (P1-228).

In contrast, in a relationship characterized as a more professionally connected, Mrs. Roma comments that she would only enter into discussions of a more personal nature with the ACNP if she senses openness to this on the ACNP’s part. Mrs. Roma describes how she interacts with Wyn, the ACNP: “unless she opened up too, so … you kind of, you get into [personal discussions]… but if she doesn’t ask those [personal] questions then you kind of just … answer her questions and that’s it” (P4-1064).

How ACNPs interact with patients also contributes to their sense of ACNPs being there for them. Most patients comment that ACNPs communicate in a clear and straightforward manner with them but they also report that there are times when they engage in small talk with ACNPs. Small talk is a form of discourse that is not related to the patient’s condition but more about their worlds, e.g., television shows, sporting events, movies, family. Mrs. Tudor recalls
her conversations with the ACNP caring for her: “She used to come and we’d talk, you know … Stuff like, … family. Normal conversations” (P1-191/195). This seems to have the effect of humanizing the interaction, potentially enhancing the degree of relational intensity and patients’ sense of comfort with the ACNP. It is interesting to note that patients engage in small talk most often with staff RNs, occasionally with ACNPs, but almost never with physicians. This is likely due to the traditional view of the patient-physician relationship that dictates how communication should occur and what the focus of that communication should be, namely the patient’s disease and health condition. For example, Mrs. Tudor describes a typical conversation with the physician with whom she had quite a personal engagement: “[We’d talk about] my situation…what will happen …what’s the symptoms … I have to watch out [for] when I come home” (P1-105).

Being there for patients contributes to a sense of confidence in ACNPs. Several patients mention that they feel they can contact the ACNP between visits and they are confident in the abilities of the ACNP to follow through with them. Mr. Lang says: “Oh yes I believe every word, every word she tells me … I’ve got a lot of respect for her” (P6-225/229). Mr. Kean also expresses confidence in the ACNP working with him: “I felt very confident with her because she’s very, very, very competent … in the way she’d go about things” (P2-702). It became clear that ACNPs met the expectations that patients had for them.

In summary, interviews with patient participants yield data that contribute to our understanding of relationships between patients and ACNPs. Patients who experience acute illness have a single goal; to move on with their lives. When considering their relationships with ACNPs, it is clear patients see them as making things happen on their behalf. ACNPs are seen as having an elevated nursing status in the health care team hierarchy, which enhances their abilities to make things happen. Patients perceive them as making things happen by working with and perhaps even leading a team of health care professionals, focusing on the plan for patients’ care, spending time with patients to know and understand their unique needs, using approaches that inspire confidence and being there for patients as they move through their illness experience. Having summarized patients’ perspectives on their relationships with ACNPs, the next step is to examine how patient perspectives compare with ACNP perspectives on their relationships.

**Patient and ACNP Perspectives on their Relationships: How Do They Compare?**

When the analyses of patient and ACNP data are compared, patient themes provide significant support for the ACNP-patient relationship sub-theory. What is most striking when
reviewing the similarities between what patients say and what ACNPs say about their relationships is that the central theme for ACNPs is interpersonal in nature (making a connection) while the central theme for patients is instrumental in nature (making things happen). ACNPs are focused on the relationship predominantly as an end in itself, allowing them to feel good about what they do and effectively achieve mutually established goals with patients. A patient views the relationship with an ACNP as a means to an end; contributing to achieving their goal, moving on with their lives. It would appear, however, that despite the differences, patients and ACNPs are not entirely at cross-purposes and the process and outcome can still be positive, as it was for participants in this study. Each patient theme is examined as it relates to the ACNP-patient relationship theory.

The central theme from patients’ descriptions of their relationships with ACNPs, making things happen, is not explicitly discussed by ACNPs but several patient sub-themes that contribute to the phenomenon of making things happen for patients are reflected in ACNPs’ views of making a connection and how that evolves between them. Patient themes that are significant in relation to the ACNP-patient relationship theory include being there, time, knowing the other, and some aspects of being part of a team. It is also noteworthy that the strength of the relationship and the degree of comfort patients seem to feel in their relationships with ACNPs are comparable to how ACNPs describe relationships with patients (i.e., clinical, professionally connected, personally connected). There is no evidence of a clinical relationship existing between any of the ACNP and patient participants in this study.

From the ACNP perspective, authentic presence is identified as a readiness condition that must be met prior to making a connection with a patient. While ACNPs reflected a deep understanding of their role in being present with patients and how they can achieve that state, patients may be responding to their authentic presence when they describe the impact of ACNPs being there for them. An ACNP who is there for a patient inspires a sense of comfort, confidence and creates moments when patients feel free to discuss almost anything. So, patients notice ACNPs being present with them suggesting that ACNPs achieve and maintain their readiness condition and can proceed with establishing a degree of connectivity.

A second readiness condition, ACNPs’ intention to know patients, is also reflected in themes emerging from discussions with patients. Patients acknowledge that ACNPs know them and their unique issues well and this is satisfying for them. They told of others who did not know them well and how they were then required to describe their issues, providing information repetitively. Patients did not, however, describe ACNPs learning about them as people. Their
comments seemed to address only ACNP knowledge of their health issues. Given that patients acknowledge ACNPs’ ability to gain an understanding of their unique issues and that all ACNP-patient relationships in this study achieved some degree of connectivity, we can see that this readiness condition for making a connection is also relevant in ACNP-patient relationships.

A third patient theme compatible with the ACNP-patient relationship sub-theory is the concept of time. ACNPs view time as a resource and use it as a strategy when attempting to make a connection. Time is conceptualized in a variety of ways by ACNPs; making time for patients, investing time in patients, allowing patients time to process information and being there for patients. Patients’ descriptions of time are less well differentiated but time is clearly important to them in their relationships with ACNPs. As well, being there, which is associated with ACNPs’ use of time as a resource, fits with patients’ views that ACNPs being there for them influences their comfort and confidence in ACNPs. Both ACNPs and patients recognize that time spent together contributes to the development of their relationships. Patients do not perceive that ACNPs spend extended periods of time with them but they do describe ACNPs spending more time than other health care professionals. It is also clear that patients know who ACNPs are and that cannot be said about all others involved in their care. Patients also acknowledge that knowing ACNPs over a prolonged period of time enhances their level of comfort and positively influences the relationship. Time is a fundamental element in ACNP-patient relationships from both perspectives.

Patients’ emphasis on the plan and its prominence in their descriptions of their relationships with ACNPs also arises in discussions with ACNPs. The plan is not explicitly addressed in the ACNP-patient relationship sub-theory, rather it is part of what ACNPs do as a result of establishing a relationship with patients. So, for example, when the plan is discussed by ACNPs, it is one of the things they address when they spend time with patients and their discussions allow them a vehicle to establish their credibility. Given patients’ focus on moving on with their lives and the emphasis they place on ACNPs making things happen, the plan understandably features prominently for patients. This theme can be interpreted as supportive of the ACNP-patient relationship sub-theory.

The team perspective raised by patients is also reflected in the ACNP-patient relationship sub-theory. ACNPs describe their role as an interface between patient and team in relation to how they implement their relational strategy, establishing credibility. ACNPs discuss being a member of a team and referring patients to others on the team to address issues and questions that might be beyond their scope of practice. So, though team does not figure prominently in this
sub-theory and was not discussed explicitly by ACNPs, the patient’s sense of the ACNP being part of a larger health care team is accurate.

The only theme that is not evident in this portion of the theory is patients’ perceptions of ACNPs having elevated status in the acute care hierarchy. Hierarchy is not addressed at all by ACNPs, likely because it is implicit in their position. ACNP participants in this study have practised in the role an average of 4 years, the ACNP role is well entrenched in the organization and it is viewed as a nursing leadership role. However, patients see ACNPs as nurses, but more highly positioned than their staff RN colleagues. Patients are correct in their assessment that ACNPs have additional decision-making ability and authority and, on an organizational chart, ACNPs would indeed be positioned on a level above staff RNs.

Overall, when emergent themes from patient interview data are compared with those in the ACNP-patient relationship sub-theory, they are complementary but not identical. Patients do not focus upon interpersonal dimensions of the relationship as ACNPs do, but patients’ descriptions and their examples provide evidence that a degree of relational intensity is established which is mirrored in the explicit descriptions by ACNPs. While patients do not explicitly discuss a need or desire for a ‘connected relationship’ with an ACNP, patients discuss ACNPs spending time, getting to know them well and ultimately tailoring the plan to their individual needs. These behaviours are seen by patients as contributing to making things happen on their behalf and lend support to the ACNP-patient relationship sub-theory.

**ACNP-Patient Relationships Summarized**

In discussions with ACNP participants it is clear that making a connection with patients is the central phenomenon and is fundamental to their work with patients in acute care environments. Though patients do not identify this as a central tenet of their relationships with ACNPs, their descriptions reflect a degree of relational intensity. A typical relationship is one that has been labeled professionally connected. Rarer are the higher intensity personally connected relationships and the un-connected, clinical relationships.

Four dimensions characterize the nature of the connection that is established between ACNPs and patients; patient/person orientation, mutuality, interaction and boundaries. The connection phenomenon is complex and involves elements of time and context. Making a connection is influenced by readiness conditions and then strategies used to establish the connection. Once a connection occurs, ACNPs describe experiencing a sense of partnership, comfort with the patient and making a difference in their lives, all of which are products of the
connection and contribute to professional satisfaction experienced by ACNPs in their role as well as contributing to successful achievement of the patients’ goal of moving on with their lives.

Patients comment on the time ACNPs spend with them, being there for them and getting to know them well. They appreciate ACNPs’ focus on the diagnostic and treatment plan, which patients see as vital if they are to move on with their lives. Patients recognize that ACNPs are nurses but see them as more influential, with more power and autonomy when compared with staff nurses, as a result of their position in the hospital hierarchy. Patients value the role ACNPs play on the health care team and their own relationships with ACNPs. The analysis of patients’ perspectives provides support for the ACNP-patient relationship sub-theory of the overall ACHPPR theory that has been developed (Figure 4).

*Figure 4. ACNP-Patient Relationship Sub-theory*
CHAPTER 6 – FINDINGS (PART 2): MANAGING THE DISEASE: RELATIONSHIPS PHYSICIANS HAVE WITH PATIENTS

The purpose of this chapter is to describe physician participants and the nature of relationships that physicians have with patients in acute care environments so as to ultimately understand how these relationships are similar and/or different from relationships ACNPs and staff RNs have with patients. The central focus of physician-patient relationships, managing the disease, will be discussed including the dimensions that influence relational intensity (intent, rapport, time, humanness, team). The process of relationship development including readiness conditions (assume patients’ trust, something can always be done, confidence in own expertise), relational strategies (humour, listening, informing, imposing boundaries) and relational products (seeing patients move on with life, patient appreciation) are described (Figure 5). These findings contribute the physician-patient relationship sub-theory to the larger Acute Care Health Professional-Patient Relationship Theory that describes how three different health professional-patient relationships compare in the acute care context. At the conclusion of the chapter, a descriptive analysis of patient perspectives on their relationships with physicians is presented and discussed in relation to the physician-patient relationship sub-theory.

**Physician Participants**

Physician participants were 50% female and on average 48 years of age. They had practised as physicians for approximately 21 years, almost nine of those in the current organization. They reported being responsible for approximately 18 patients each day and spend 72% of their time in patient care related activities. Thirty-three percent of these participants were involved with a population who required surgical intervention (Table 8).

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<th>Table 8. Characteristics of Physician Participants</th>
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<tbody>
<tr>
<td>Age of participants (years)</td>
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<tr>
<td># Years in practice</td>
</tr>
<tr>
<td># Years at study hospital</td>
</tr>
<tr>
<td>Length of stay (in days)</td>
</tr>
<tr>
<td># Patients responsible for daily</td>
</tr>
<tr>
<td>% Time in patient care-related activities</td>
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<tr>
<td># Participants female (%)</td>
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<tr>
<td># Working with surgical patients (%)</td>
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Managing the Disease: Central Focus of the Physician-Patient Relationship

When physicians were asked “what makes for a good relationship with a patient?”, physicians’ first responses generally related to issues of listening (M1, M2, M4, M6), accessibility (M2, M3), honesty (M1, M3), communication and information giving (M1, M3, M4, M5, M6) and trust (M2, M4, M6). However, the core theme of managing the disease emerges early in the interviews. Physicians consistently report that a patient’s health issue is the reason for meeting. They explain that anything that develops between them is directly related to the patient’s disease and the physician’s desire and goal is to diagnose, treat and manage the disease. The relationship between a physician and a patient is viewed by physicians as a vehicle or means to achieve the purpose of managing the patient’s disease. In response to questions about specific patients, physicians launch into detailed descriptions of the patient’s disease, its severity and acuity, how they treat the patient and the effectiveness of that treatment. For example, Dr. Levis responds to the first interview question this way:

What makes a good relationship with anybody is communication … [and] a partnership between the patient and the health care provider but I think in [my area of practice] that partnership is sort of under the microscope. And the reason is because of the acuity of the disease, of the high risk of dying associated with the disease. The incredible impact patient compliance has on outcome so I typically say to patients, “you have to do your part”, which is, you know, taking your meds, … watching for the signs. And I have to make sure I’ve got you on evidence-based medicine. If you do what you’re supposed to do and I don’t have you on evidence-based medicine, then you’re not going to do well. And if I have you on evidence-based medicine and you eat Kentucky fried chicken, you’re not going to do well … the partnership is the single most important thing and then both sides of that partnership, much like a marriage, have to know what their responsibilities are and you have to have an understanding of what their commitment is to living up to their part of that responsibility. And we need good communication so that you can know when things are changing (M5-9).

Dr. Levis’s description, though she mentions partnership, reflects a ‘physician as expert’ perspective and a desire to do what is right for patients and her expectation is that patients comply with her plan. Despite mentioning the importance of communication, she consistently weaves the disease into her discourse, demonstrating the centrality of disease in the relationship between herself and a patient.

The majority of physician participants work with hospitalized as well as ambulatory patients, so it is not surprising that acuity and severity of disease influence physician-patient relationships. Physicians view patient acuity as having a significant impact on how they relate to patients. The more severe patients’ symptoms and disease, the more physicians sense that patients implicitly trust them and the more relational intensity that can develop between
physicians and patients. This relational intensity is perceived to be positively correlated with acuity, possibly because acuity also significantly influences the amount of time that a physician is required to spend caring for the patient and how urgently interventions must occur. For example, if a patient is at high risk for imminent death, physicians note that the relationship develops quickly. The physician feels a sense of urgency to explain the dire nature of the situation to the patient and family, what can be done and what the patient can expect. Dr. Carter describes her perspective on acuity:

I think relationships are so different. … sometimes you formulate a relationship with somebody in the emergency room if something is acutely happening. And because of the nature of it, it because they feel that you’ve been with them during a really acute presentation they always are grateful to you for that (M4-183).

If patients are acutely ill enough to be hospitalized, they may have a heightened sense of their own mortality. Once they are improving and moving towards discharge home, the change in acuity influences the relationship, often resulting in a perceived reduction in relational intensity secondary to diminished need and decreased frequency and duration of contact between physician and patient. Physicians usually initiate these changes in frequency and duration, but patients may respond by lobbying for additional contact with the physician, as they perceive an ongoing need. Dr. Henry describes how he views communication with patients/families on a busy in-patient unit:

Some families are more … demanding than others of your time. And here it can be difficult because I’m on the floor all day and they know I’m on the floor all day. And you’ll get situations where they want to talk to you 3 or 4 times a day… And you have to set some limits and that can be and you have to set them really nicely. But I think I’m fairly approachable as a person and that in a sense makes it tougher because they feel they can come and talk to me any time, right? (M1-249-253).

Physician participants are clear that the relationships they have with patients are not friendships and there is limited or no mutual sharing of information about themselves with patients. Dr. Reese comments on the unique nature of his relationships with patients: “I’m not their friend. I don’t think that’s really part of the relationship but I’m someone who’s a little bit distanced from that sort of thing but who is empathetic, I would hope” (M6-9).

Dr. Reese specifically states that an encounter with a patient: “is not a mutual event” (M6-21) and he later discusses his avoidance of sharing personal information about himself with patients:

I tend not to speak about myself, or my particular private life. They don’t know very much about me that way so that I don’t expect that most of the patients that I deal with on
that level can tell you very much about my background or, you know, my family (M6-377).

Dr. Levis finds that patients learn things about her life away from medicine but she isn’t the one who discloses this information to them:

I heard from so and so that such and such and I’m going oh [my], so I can walk into clinic and see somebody that I’ve seen 3 times and they’ll say so I hear you [do such and such]? Well I never told anybody (M5-281).

It is evident that patients who find out something about a physician’s life may share that information with one another but physicians don’t communicate those details to patients themselves.

However, most physician participants do speak about things they have in common with some patients such as movies, books, traveling or an interest in politics. Physicians view the discovery and sharing of such commonalities as acceptable with patients. It allows patients to see that physicians are human beings. Dr. Levis confides: “I think [them knowing things about me] is great! I’m human!” (M5-289).

It is clear from their discussions about relationships that physicians see their relationships with patients as necessary for them to do their jobs and the type of relationship they develop is conceptualized as one based upon clinical need; that is, physicians ask questions and learn things about patients, their symptoms and how their lives are affected so they can determine the severity of the disease and then proceed with diagnosing, treating and evaluating treatment effectiveness; in other words, managing the disease. Learning about patients is unidirectional and is not personal. Though the relationship may be pleasant, even enjoyable, it is focused entirely on managing the disease. From discussions with physician participants, it is evident that they don’t believe that patients expect anything different from them. They believe patients come to see them to have them manage their diseases.

Relationships that physicians develop in order to manage patients’ diseases do vary in intensity. Their descriptions of typical relationships suggest a degree of comfort with patients and an easy rapport. While physicians engage in discussions with patients about their lives, their intention is to learn as much about the severity of the disease rather than learn about the person that is the patient. Physicians do recognize the humanity of their patients but they choose to maintain a professional distance from them so as to be effective in managing the disease. Physicians acknowledge that they are part of a team and engage with patients in that context. This type of relationship is *professional* in nature.
Most physicians also describe two types of atypical relationships: a less engaged, more formal and less comfortable relationship termed a clinical relationship, and a more intense relationship with more social characteristics that can be labeled as more personal. Each type of relationship varies on a number of dimensions that are discussed in the context of the nature of managing the disease. The dimensions of physician-patient relationships are patient/person orientation of the relationship, rapport, time and team (Table 9).

Table 9. Dimensions of Managing the Disease

<table>
<thead>
<tr>
<th>Clinical Relationship</th>
<th>Professional Relationship</th>
<th>Personal Relationship</th>
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</thead>
<tbody>
<tr>
<td><strong>Patient/Person Orientation</strong></td>
<td>Gathers personal information to understand the patient’s disease, Sees diseased patient who is a person.</td>
<td>Gathers personal information to understand the patient’s disease, discovers some commonalities. Sees a diseased person.</td>
</tr>
<tr>
<td><strong>Rapport</strong></td>
<td>Comfortable, meets physician’s expectations</td>
<td>Enjoyment, physician and patient share social types of personal information</td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td>Time spent positively correlated with patient acuity</td>
<td>An increase in time spent not correlated with patient acuity</td>
</tr>
<tr>
<td><strong>Team</strong></td>
<td>Engages with patient as part of team</td>
<td>Engages with patient in addition to time spent as part of team</td>
</tr>
<tr>
<td>Limited personal information known about patient. Sees diseased patient with disease.</td>
<td>Distant, formal, frustrating for physician</td>
<td>Minimal time spent, not clearly positively correlated with patient acuity</td>
</tr>
<tr>
<td>Limited contact with patient by all members of team</td>
<td></td>
<td>Limited personal information known about patient. Sees diseased patient with disease.</td>
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Dimensions of Physicians Managing the Disease

A number of dimensions emerge as contributing to the essential nature of ‘managing the disease’. These dimensions become evident when one asks physicians about relationships with patients, when they are established and when they are not, where they happen, why they happen and the purpose of the relationship they develop with patients. Some of these dimensions are similar to those that characterize the ACNP-patient relationship but there are differences as well.

Relationships that occur between physicians and patients have a distinct nature. The four dimensions are patient/person orientation, rapport, time and team. Each is discussed in the following section.

Patient/Person Orientation

When a physician meets a patient for the first time, the intention is to learn about the patient’s problem and associated symptoms so that the physician can proceed with managing the
disease. They focus on the patient with a problem. It is also important that physicians determine how urgently the patient’s problem requires attention. Physicians assume that the majority of patients inherently trust them and recognize their competence to help them with their problems. Physicians use the first meeting to establish a baseline understanding of patients’ physical status with respect to the reason they are seeking assistance. They assume that patients have problems that require attention and they may be anxious about what physicians will discover. Dr. Reese describes this perspective on initial encounters with patients in general:

Most people… find it just a little disconcerting because… one of the things that physicians do is understanding bodies of physiology and having some techniques or at least some information and … you can see things about people that they can’t see themselves about their wellness or illness. That’s disturbing a little bit just in general terms so I think when a patient comes to see a physician, or to see me, there’s always a little bit of anxiety in the background. What will I say … what will I see? Will I see something that they don’t see … could they be … really ill and they don’t know it (M6-25).

Information that physicians glean about a patient’s life beyond the acute care environment provides contextual information, which contributes to the physician’s understanding of the severity of the patient’s symptoms and ultimately of the disease. Ongoing discussions about the patient’s life (e.g., activities of daily living) enhance the physician’s ability to evaluate the accuracy of the diagnosis and effectiveness of treatment strategies, not only for the individual patient, but also for other patients with similar problems, currently being treated and those who will be in the future. Collection of information supports the intention of understanding the patient’s disease. Dr. Levis explains how she uses information about patients’ lives in her practice:

If you’ve had a seven-year history of [this disease] you’ve already made lifestyle adjustments, you may have already gone permanent part-time, you may have already made accommodations at your work. Some patients don’t even realize how many accommodations they have made, their life just changed over 7 years so they, you know, they don’t pick up their kids any more. They don’t pick them up off the ground when they’re crying. They just realized or learned that they can’t do that. … They don’t walk the dog any more. The dog gets put out in the backyard. So these changes happen in a gradual way without them realizing it but they’ve already accommodated (M5-29).

Many physicians collect information about patients’ families, children, pets, where they live or what they do in their day-to-day lives. They use this information to understand how disease affects their functioning as an indication of disease severity. Dr. Luke suggests that gaining an understanding of how a patient lives life provides a key to gaining an accurate picture of how the disease is being managed: “In trying to decide about the treatment course that an individual
could benefit from, then knowing what their performance status was, what they were doing just before they got to you [with the disease] is important” (M3-81).

Physicians’ focus when engaging with a patient is to collect information that allows them to determine the cause of the symptoms (diagnose), reduce or eliminate the symptoms (treat), and evaluate the patient’s response (follow-up). To manage the disease, physicians ask patients questions and use physical findings (physical examination, diagnostic investigations). Physicians believe that their reasons for collecting patient information are acceptable to patients.

If the intent of the relationship shifts even slightly towards taking an interest in the personal information about the patient instead of only how the disease is affecting the patient’s life, the intensity of the relationship potentially increases and becomes more personal in nature. Alternatively, if the physician intends to gain an understanding of the patient’s problem and the patient refuses to share information with the physician, then the relationship becomes less comfortable, less intense and more clinical in nature. As mentioned earlier, relationships that are clinical or more personally intense are unusual and are not regularly described by physicians. Physicians seem to be intent upon developing more typical, professional relationships with acceptable levels of relational intensity, allowing them to have enough information about patients to effectively manage the patient’s disease.

Another aspect of this dimension is physicians’ views of humanness. Though the focus of physician relationships with patients is to manage the disease, there is a human dimension that is influential. Physicians view people who come to them with health issues as patients first and some even referring to patients as “cases”, but discussions of their relationships with patients reflect an understanding that the patient is a human being. Physicians acknowledge that patients have a life beyond the disease and they do seek information about that life. As elaborated upon in relation to the intent of their relationships, getting to know a bit about a person’s life helps physicians understand the severity of the disease and allows them to make decisions about appropriate management of the disease.

Physicians’ descriptions of their relationships reflect caring attitudes towards patients that is in the context of managing patients’ diseases. Drs. Carter (M4) and Levis (M5) provide examples:

We care that they’re worried. I mean no one likes to see a worried patient or an upset person. So I think if you acknowledge that and then make sure that they understand that you care about what’s happening with them (M4-111);

He saw so much of me I think [it] made him realize, so it wasn’t [that] I had to spend 2 hours with him each time but he saw me on such a regular basis that he did realize
Another aspect of the human element that emerges is physicians’ genuine admiration for the human spirit. They express amazement at how patients face and surmount serious health challenges. They describe patients as impressive, courageous and having incredible strength. Dr. Reese expresses his admiration for the human spirit:

I see people in these terrible situations with illness, trying to cope as best they can and there are very interesting people who are very courageous in trying to deal with these [diseases]… there’s a kind of big positive uplifting kind of, you know, it’s all that human spirit (M6-325).

Dr. Carter concurs, describing the strength of a particular patient: “There’s something about this lady, where she’s been through so much and a lesser person would have been defeated by this” (M4-335). Dr. Henry provides his perspective: “You meet pretty neat people who are going through very difficult times … it’s her spirit, that’s what you remember” (M1-237-241). Physicians view patients as worthy of their admiration and when they have these feelings they positively influence the intensity of physician-patient engagement.

Physicians also recognize that they are persons themselves, contributing to the human element of the relationship. Drs. Venti and Levis speak about crying about and with patients (M2, M5-329), Dr. Luke acknowledges that giving a patient bad news hurts him (M3-113), Dr. Carter comments that it is difficult to see patients having a hard time (M4-147) and Dr. Reese acknowledges that he finds himself becoming ‘down’ if he is on service for too long (M6-325). Physician recognition of their own humanness perhaps contributes to patients seeing the human faces of their physicians.

Patient/person orientation is evident in physicians’ reflections on relationships with patients. While managing the disease is central to their relationships with patients the degree of relational intensity is influenced by physicians’ inclination towards the person and their humanness. While physicians consistently see a patient with a disease, the more they are able to see the human being beyond the patient, the greater the potential for increased relational intensity. Conversely, when the relationship is characterized by distance with little time spent together, managing the disease becomes the only priority and the view of the patient as person may be lost, resulting in a clinical relationship.

Rapport

A second dimension of managing the disease is rapport. While physicians claim that the
rapport with the majority of their patients is positive and comfortable, there are some physicians who refer to relationships that “click” (M4), some refer to “special relationships” (M3) and other relationships result in what physicians call a “connection” (M1). However, physicians’ descriptions of these more intense relationships are different from those relationships described by ACNPs as ‘connected’. In such relationships, physicians describe having an increased sense of enjoyment of the relationship that comes with liking the patient or finding some common interests in their lives. For some physicians, connecting seems a typical approach to working in their clinical environment. For example, Dr. Henry describes connecting with patients as a standard approach to relationship development, liking and admiring patients to whom he provides care. He believes that he is able to connect with most patients and, though the strength of the connection changes by degree, it is usually a positive experience for him: “I mean most times you can make some connection, maybe not to that degree yeah…most times … most times it’s good, by in large” (M1-273-281). He gives a specific example:

I met a young guy a little while ago who had [the disease]. He just died actually and he was 37… And [he was] the neatest guy and, you know, here’s a guy who’d done everything right again, … he was a fitness nut and everything and got [the disease]… But he had a really supportive family and they were great and we went through a photo album. But someone like that you just connect with, really, so automatically (M1-69-77).

This idea of rapport, or getting along, is consistent across all physicians who acknowledge that they like working with patients and like their work even if they might find it challenging at times. Physicians: “enjoy being their [patients’] doctor[s]” (M4-435), have: “enjoyed the vast majority of patients” (M4-435) and: “like taking care of [patients]” (M1-289). They believe that patients want to feel cared about by physicians and one physician expressed that the only way she can practise is to be “involved” (M5). For her, involved means being honest, open and taking an interest in what is happening to patients with respect to their disease.

Physicians do, on occasion, encounter relationships that they describe as more involved than usual. Dr. Carter introduces a metaphor to illustrate her perspective on relationships that she describes as ‘clicking’:

I certainly meet patients … you’re asked to consult on them or they’re admitted under your service that day and you formulate the relationship in the emergency room. That’s different … to having a … relationship with someone you’ve known since childhood … [It’s like a] relationship with someone you meet that evening at a party or whatever, but you click in certain ways (M4-33).

Dr. Carter contrasts the level of comfort she has with a long-time friend with the comfort she
experiences with someone she has just met but with whom she gets along with immediately. She continues, describing how she adjusts her approach with a patient to enhance rapport and perhaps achieve a ‘click’.

If the patient is… reserved at the beginning but opens up later, one expects that to happen. If one finds that when you speak to a patient that they actually say less or are less forthcoming or their verbal expressions may be that of suspicion or they just look more nervous, then I think my natural response would be, okay let me say something that will change the direction of this (M4-105).

Relationships that are more enjoyable are characterized by sharing common interests with patients. These commonalities are strictly social and are not personal in nature. Discovering commonalities can shift the dialogue between patients and physicians to include topics that are other than disease-related. Dr. Levis provides another example of the rapport she had with a patient with whom she shared common interests and to whom she spoke daily while he waited for a life-saving procedure.

We talked about his illness because you know that’s sort of important, how he was doing that day and any questions … But then I found out that he really likes to refurbish Ferraris and that’s one of his, you know, favourite things in life. … [He] likes to drive fast cars and we talked a little about vino and which vinos are best from Italy, north and south. … you always have some common interests with the patients. I think the patients have to be able to relate to you in some way (M5-125-129).

Dr. Reese also speaks about how he begins his interactions with a particular patient whom he has known for many years and with whom he has discovered common ground: “We usually start with a political conversation and it goes on for a few minutes and then we deal with aspects of his health” (M6-157).

Dr. Carter recalls a memorable relationship with a patient for whom she cared during her residency. As she reflects on her relationship, the disease management elements are clearly evident but she speaks about the patient in a special way, in part due to her clinical circumstances but also because of common interests they discover. Dr. Carter explains:

We really bonded because she was there for a month and we had a really good time together. I mean I don’t know if she really had a great time in hospital, but I really enjoyed having her as a patient you know. And we would eat lunch together as much as we could. So about a few times a week we just, I would say, you, know what let’s try and increase the number of interactions you can have. … So it was just a relationship that developed. … I think the biggest thing was because she was from Nottingham, England and she was, had a cute little English accent and I thought she was just, she looked like the queen, neat hair. I’m a big anglophile so we would talk about all sorts, of war, the royal family, food (M4-151-159).
Despite Dr. Carter’s description of what she calls a “bonded” relationship and the fun she recalls she had with the patient, she clearly states that: “It was fun for me to look after her” (M4-163), reminding us that this is a relationship between physician and patient that has an intermittent social element. This relationship reflects a personal level of relational intensity between physician and patient, offering evidence of shared commonalities between physician and patient.

It is evident that commonalities with patients disclosed by physicians to patients are not deeply personal in nature. In fact, they are safe subjects that are part of human socializing and are commonly discussed by people who meet, even by those who are strangers. When asked about sharing of information that might be of a more personal nature, several physicians categorically deny sharing anything about themselves or their lives with patients. As Dr. Reese explains: “I tend not to speak about myself or my particular private life (M6-377)”.

Physicians also speak about relationships with patients where they don’t have a comfortable rapport. In these cases, the rapport is distant, more business-like and even more exclusively disease management-focused than is usual. Dr. Levis describes the communication with these patients as “perfunctory, very business-like” (M5-173). She elaborates:

You like the majority of your patients, but every once in a while you come across somebody who for whatever reason, because we’re all human, you may not. But it doesn’t mean you don’t provide health care ... you still have to provide the best health care you can, but it’s always nice when you like them (M5-249).

From physicians’ perspectives, sub-optimal rapport can occur when patients don’t meet physicians’ expectations of how they should behave. Dr. Carter provides a description of one such relationship:

He was extremely belligerent the entire time, very angry, very nervous and ... we were keeping him in hospital because ... we were waiting for him to have ... surgery. And over a weekend where I was on call he started becoming verbally abusive... He started screaming at the patients, being very disruptive… So I went to speak to him and usually you’re able to calm people down. But you could clearly tell that this man … was verbally disinhibited and that maybe that was one of his problems. He clearly had problems with managing his anger … he was extremely verbally offensive, extremely belligerent … That’s such an obvious example of a relationship that didn’t work (M4-407-427).

Another example is provided by Dr. Reese who suggests that when there is a mismatch of understanding or expectations between physician and patient, this may result in a compromised rapport: “They’ll say something that makes you realize that you and they were on very different planes and then you really just have to kind of be braced for that” (M6-89). Dr. Reese
recognized that he and the patient did not have the same understanding of the situation. The patient expressed his discomfort and his different understanding. While this was also uncomfortable for Dr. Reese, it led him to step back and then move to where the patient was in his understanding in order to salvage or re-build the rapport.

Rapport is an important element that characterizes the physician-patient relationship. Rapport is almost always comfortable and physicians like the patients for whom they care. On occasion some even engage in social conversations about things they have in common such as books and movies, a feature that indicates increased relational intensity. While less than optimal rapport in physician-patient relationships is uncommon, physicians describe it as being related to a lack of congruence between the physician’s and patient’s expectations or understanding of the disease-related issues and this results in a more distant clinical relationship.

**Time**

Time is another dimension of managing the disease that impacts upon relational intensity between physician and patient. Time is important in terms of the duration of the relationship between physician and patient and the frequency with which they see one another. The amount of time spent with a patient is generally positively correlated with severity of a patient’s illness. If patients are critically ill with life threatening conditions, physicians spend more time, more often with patients. On the other extreme, with patients who are unwell with an acute disease that resolves quickly, the frequency and duration of time physicians spend with such patients tapers off. And for patients who have long-term conditions, physicians may continue to see them regularly as an outpatient. Such circumstances require less frequent physician-patient encounters that are shorter in duration but occur at regular intervals over months or years.

Physician participants discuss the influence that time has on their perceived intensity of relationships with patients. In terms of duration, when physicians know patients for a long time, physicians feel that they have well-established relationships. Dr. Carter explains: “There’s currently a patient on the ward who’s been there since September and he [has]…had recurrent admissions … I’ve looked after him on a number of occasions and you develop relationships with the patient” (M4-175).

When referring to a relationship with a patient who remained hospitalized over a month that reflects a more personal level of relational intensity engagement, Dr. Carter commented: “I think that was special in the sense that the longevity of it, like the month allows you do that” (M4-171). Dr. Venti also comments on the impact that time, both in terms of duration and
frequency of encounters, has on relationships with patients and their families:

I can remember spending an incredible amount of time, not only with the patients but with families, supporting them through, mostly because of being a [specialist physician], a lot of my patients have end-stage disease, and I end up seeing them at a very end-stage of their life, and so a lot of what I might do for particular patients and families is more palliative care than acute care… it evolves into that kind of relationship (M2-18).

Physicians recognize that seeing patients regularly, as often as every week as an outpatient, allows them to develop an effective professional relationship. Dr. Levis describes this reality:

It isn’t one appointment and that’s it. I mean the vast majority of the patients end up, because they go through a process … [of] up-titration of medication and education, they end up seeing a lot of us, especially over the first 3 months [after] they get referred to the clinic and they see us every week, every two weeks and as a result you do build on that rapport (M5-25).

Dr. Levis describes the correlation that severity of illness has with time spent with patients:

The patients who go on [for the procedure], I, we establish, as a team, a much closer relationship to mostly [all of them], although not in all. … But when you go through [the procedure] especially when somebody’s been really sick and waited for [it] in the hospital and you’ve seen so much of them, you do end up with a closer relationship (M5-137).

For some physicians, patients who remain in regular contact, whether they are in-patients or outpatients, almost become part of the family that is the hospital team. Dr. Carter says such patients can become “fixtures” on the unit (M4) and Dr. Luke recalls: “There are patients where it would appear that this [the clinic] becomes their life or that the … unit becomes sort of like a second home” (M3-365). When this happens, physicians describe a comfortable familiarity.

Physicians explain that what they do with patients during the time they spend with them influences their relationships. They describe a need to focus on patients during the time they spend with them. Physicians speak about the quality of the time they spend with patients and less about the actual amount of time. Dr. Carter describes her perspective:

When you walk into the room you focus on the patient. You don’t give the patient the impression that you’re rushed or not interested in what they have to say, that you’re not, say answering your pager or on the phone or speaking to other doctors when the patient is, when you’re present in the patient’s room that you’re sort of giving, you’re giving the patient the attention that they are entitled to (M4-25).

Dr. Venti speaks about the importance of time and how she has chosen to structure her daily appointment schedule:

I think probably the most important is being able to listen, and give them time. That’s
probably the most common complaint that I hear through the patients themselves about other specialists or even their family doctors that they just aren’t given the time to explain what their concerns are. And so I try and provide that opportunity to the patients, to have the time, so I book patients in long time slots, rather than every 7 minutes, or so. Well, actually I book a half hour for every patient… even if they’re an old [repeat] patient (M2-6).

Dr. Henry concurs, explaining: “I think the other secret is actually to find the time to really talk to them, which means sitting down and having eye contact and not backing out of the room as you’re talking to them” (M1-5). Dr. Reese actually believes that not taking time can “mess up” a relationship. He explains his perspective:

I think the way people mess up in these relationships is when they…for reasons of time or other constraints or their own personalities or their understanding of themselves as physicians, surgeons, whatever, they dominate the kind of interaction so that the patient doesn’t feel that they’ve expressed what they wanted to express (M6-77).

Time is also related to accessibility. Physicians recognize that patients require access to resources when they need help. Dr. Venti believes that: “just being accessible for them” (M2-10) is paramount when developing and maintaining a relationship with a patient. Dr. Carter also recognizes the importance of accessibility, particularly in how it affects communication between patients and physicians:

I think most patients are probably understanding that if they call your office and … get the machine or if they call your office and your secretary picks up and says ‘oh I’m sorry she just stepped out … can you call back later?’ Most patients … are not going to be worried about it. But I think it would be different if they called all the time and [are] never given an answer … I think if there isn’t … adequate communication and the patient has a specific question and people need to get on with their … And you know I think doctors need to communicate with their patients (M4-85).

Time is clearly an important dimension that influences the relational intensity between physician and patient.

Team

A final dimension of the relationship between physicians and patients that influences relational intensity is being part of a team. Physician participants regularly refer to the team nature of the work that they do. Team members include physicians, ACNPs, nurses, social workers and others, all of whom are seen by physicians to have skills that contribute to meeting patients’ disease-specific needs. Being part of a team allows physicians to manage the disease while modulating their levels of relational intensity with patients.
Teams allow physicians to share responsibilities as well as the impact of disease management with others. Dr. Reese discusses the challenges the team faces with a patient who is experiencing complications: “When he’s [the patient] been feeling well he actually is very positive but it depends just exactly how his illness is affecting him at the moment, which has made it very difficult for the team as a group to have a consensus about his care” (M6-421). Dr. Reese emphasizes the impact on the team rather than simply on him as a physician:

The importance of teams becomes evident when physicians use “we” and “us” when discussing how they manage patients’ diseases. This language acknowledges the involvement of others in the care of the patient. Dr. Carter speaks about mobilizing the team in order to benefit patients:

I think it [the relationship] works when the whole team gets involved. So I think when you can mobilize everyone in the team, if it’s an inpatient, that you make sure that you’re working with the nurses and the residents and the nurse practitioners, then you know that the patient has been benefited (M4-447).

Dr. Levis acknowledges that the entire team has a relationship with the patient, not just individual professionals: “We establish, as a team, a much closer relationship to most [patients]” (M5-137). When describing a relationship she had with a patient with whom she had strictly a clinical relationship, she reinforces the team relationship aspect of managing the disease: “The [poor] rapport with this entire team was pretty much exactly the same” (M5-193).

Dr. Levis feels very strongly that the team is important in managing the disease and that each member has a role to play, including the patient:

This is an absolute inter-disciplinary team in every aspect and I say this to the patients as well as to the teams. I really firmly believe that there is no one person I think is any more important than any other person on the team. I tell the patients that because it really is the truth … Every single member of the team is critical … for the team to work well. And the patient’s on the team (M5-355).

According to Dr. Carter, patients also recognize the presence of a team and appreciate the efforts of everyone:

They [patients] tend to be very appreciative of … any help that they have and it’s from everyone. I mean I think the nice thing about working in a hospital is when patients tell you the nurses are great. I love my nurse practitioner. You doctors have been so nice (M4-61).

Another interesting aspect of team emerges from the interview with Dr. Luke. He describes himself delegating his direct involvement with patients to team members and reports
more distant, less intense relationships, an approach that fits his style of practice. Dr. Luke describes his perspective on team:

I think that’s part of the reason that I like to work in a team and the team is very broad. Not a team of doctors but a team of professionals. I recognize, you know, my communication style ... how close I want to get to somebody or not close. And that there are other aspects that other people [professionals] do better or ... is part of their training or nature (M3-269).

In situations when Dr. Luke thinks a patient wants a closer relationship with him, he explains his use of team: “I think that ... see we have a rotation system and so if you stay away from the area the other person will take care of it” (M3-285). He is able to defer to the team, avoiding closer contact with a patient.

To summarize, discussions with physicians yield four dimensions that influence the relationships that physicians establish with patients to 'manage the disease': patient/person orientation, rapport, time required to manage the disease and working in a team. These dimensions affect the intensity of the relationship established by physicians with patients. Three levels of relational intensity are evident; clinical, professional and personal. While these labels are similar across all three types of health professional-patient relationships, the levels of relational intensity that are strived for and achieved do vary (as displayed graphically in Figure 7). Physician-patient relationships demonstrate the lowest levels and span in relational intensity. However, the rarity of clinical and personal levels of intensity in physician-patient relationships is consistent with descriptions of ACNP-patient and staff nurse-patient relationships.

**Readiness Conditions for Managing the Disease**

Analysis of physicians’ descriptions of their relationships yields three readiness conditions that must be fulfilled in order for physicians to engage with a patient in order to manage the patient’s disease; assume patients’ trust, something can always be done, and confidence in own expertise. Each readiness condition is described.

*Assume Patients’ Trust*

All physician participants suggest that patients have faith in physicians and trust that they are going to do whatever is necessary to address patients’ health problems. Physicians perceive that patients see them as worthy of their trust and this trust is important if the physician is to be successful in managing the disease. Dr. Carter describes patient trust as automatic and generally expected: “automatically, they’re ready to trust us” (M4-49). This statement by Dr. Carter acknowledges that physicians hold significant symbolic capital in our society. Dr. Reese outlines
the special regard with which physicians are held by patients and suggests that this be used but not abused:

I guess what’s very clear is that the possibility of [a patient] having a positive sort of response to an interaction with a physician…, almost without anything that the physician does, is very high … as a physician sort of understanding that kind of thing, I exploit it shamelessly and I try to teach students to, not to exploit it. I mean I’m being a little facetious but to know that they have …this kind of… power without knowing they have a power (M6 – 17/25).

Patients may come to a physician with prior knowledge of the physician’s reputation, which Dr. Carter believes contributes to the establishment of trust:

They’ll say, you know I heard very good things about you from my doctor or I have a friend who was looked after by you. So they already have … some information about you in the absence of having first met you. … I think that’s a very fortunate thing…that may have already helped establish the trust (M4-53-57).

Physicians also reflect on how trust can be established with an initially mistrustful patient or can be maintained in patients who do trust. Dr. Carter believes the actions of the physician in initial meetings can influence the development or validation of trust patients have in physicians:

But I think what also establishes the trust is, as you’re first assessing your patient. We ask patients questions, we get, we obtain a history… it gives the patient the opportunity to let you know that all things that are bothering them, all their health complaints, sometimes they bring in some of the other issues that may be going on in their lives. And then once you’ve had the opportunity to speak with them, ask them other important questions that pertain to their health and other things, examine them … it’s still a fairly private event and I think that helps establish the trust. After I’ve examined the patient I usually speak with the patient about what I think is going on. This is what I think we should do and … I think that helps establish the trust (M4-57).

A patient sharing personal information with physicians during assessments seems to indicate trust and contributes to its enhancement from the physician’s perspective. Dr. Reese describes how he sees mutual trust develop in the physician-patient relationship:

Patients will tell you things even when they hardly know you, which they would never probably divulge to anyone else. There’s this kind of… relationship that is possible, if you don’t mess it up somehow, that is very intimate and … is very trusting, at least on the patient part and the physician’s part (M6-9).

Using strategies to build on presumed trust is discussed by Dr. Levis, who suggests that eye contact with the patient is one way to convey truthfulness:

The only way I know how to do it [build rapport] is to just absolutely maintain eye contact. So just very intensely, … just not letting the eye contact go, and explaining things and not letting it go because you have a limited window [of time] and if you’re doing this[looking away] all the time, patients don’t tend to trust you in my opinion (M5-81).
Trust can also be enhanced by spending time with a patient. Dr. Carter compares how trust may change over time and as an in-patient becomes an outpatient:

As they see more of you I think patients or human beings increase their level of trust as they, as the relationship continues, as they have more interaction with you… for outpatients … they tend to be less acutely ill … But I think that the trust continues as they know that you’re following up on their test results (M4-61-65).

When physicians assume that patients trust them, they can engage with patients in a way that will allow them to manage the disease. However, even though physicians meet patients with the assumption that they already trust them, some do acknowledge that there are rare situations when trust is not immediately evident, such as when patients have had negative past experiences with physicians (M4-69) or have been influenced by what others have told them about physicians in general (M4-77). Trust may also be assumed initially but it can be eroded quickly or over time. This can occur when a patient perceives the physician to be indifferent to his or her concerns (M4-81), is avoiding him/her (M4-85), may not be listening to concerns and choices (M6-77) or when a patient perceives that he or she is not being taken seriously (M6-77).

Physicians sense that this inherent trust is almost always present and most of them do not have any experience when they sensed that trust was not present. They do hypothesize that if a patient does not trust a physician, the physician may never know this as patients may simply choose not to return to the physician. Dr. Reese recalls a particular patient who seemed to lack trust in him, but who continued to make appointments to see him: “He’s quite convinced that he’s got this serious respiratory problem. But there’s nothing to substantiate [it]… And I have to tell [him] that [he doesn’t] have [the disease]” (M6-205/209). Dr. Reese recalls that this particular patient may or may not have believed what he was being told about his condition but he continues to return infrequently, but regularly, to discuss his condition further. This is an example of a relationship that may reflect incomplete trust in the physician on the part of the patient.

Physicians assume that patients trust them and, on rare occasions when this readiness condition is not fulfilled, a relationship will not be established or it will have minimal relational intensity that is typical of a clinical relationship.

_Something Can Always Be Done_

Another readiness condition that is apparent is physicians’ belief that there is always something that can be offered to patients to manage their disease. Disease management is
primarily about diagnosis and effective treatment in hopes of a cure. However, physicians recognize that the nature of disease means that a cure is not always possible.

In some situations, the ‘something’ that can be offered is palliation, pain management or other comfort care. Dr. Reese conveys this reality while reflecting his belief that physicians do not abandon patients who are in need:

We’re not going to abandon you [the patient] and we’ll try to help you as much as we can. And when things become very difficult there are ways of dealing with that as well, you know medications and so on (M6-161)

Dr. Luke supports this philosophy, speaking about offering alternatives when initial treatment plans fail:

I think that…one always likes to or tries to…show there’s still a plan, that even though you’re getting bad news there’s something else that can be done, that you can either maintain some activity or… dignity…so it’s not the ‘there’s nothing else we can do, goodbye’. We try to avoid that sort of ending to things (M3-117).

Dr. Luke continues and suggests that he focuses on what was done, looking for any benefits from treatment that might be of value for the patient: “You try to reflect on, did anything good happen out of the treatment or from the time of the treatment and sometimes you can, usually you can find something that was beneficial” (M3-121).

Maintaining a sense of hope and optimism that something more can be done is relevant for physicians in their relationships with patients. For example, when Dr. Carter speaks about giving patients bad news, she mentions that leaving the patient with a sense of hope is important: “I think if you take it from that perspective then it’s going to be bad news but you’re going to automatically give the patients reason to hope that they’re going to get through this then it’s not as bad” (M4-255).

Dr. Carter expands on her own sense of optimism and how she sees it impacting upon her own thinking and ability to manage the disease:

I walk in with this unreasonable degree of optimism because my own feeling is that if you don’t wish the very best for your patient then you don’t force yourself to the highest standards about your patient. And therefore you need to push yourself as much as possible. So… I push myself to have this unbelievable optimism and that everyone will do well and then I see it as a, I take it as a failure if they don’t (M4-331).

While physician participants speak about fostering hope, offering false hope is not supported by physicians.

Physicians in this study readily acknowledge that there is always something that can be done to manage the disease for the patient. This readiness condition is enlightening because it clarifies that managing the disease, in their minds, is not always about achieving a cure, although
these participants may begin with this goal in mind. Physicians see their role as offering
treatment with a goal of eradicating the patient’s disease but, when that fails, offering other
options to manage the disease while using resources to ensure comfort and palliation.

**Confidence in Own Expertise**

The last readiness condition that emerges from discussions with physician participants is
their awareness that they are viewed as experts who are sought by patients to manage disease.
Physicians speak about patients coming to them for care, using evidence-based medicine to
address disease-related issues and explain that patients expect them to be able to determine what
is wrong and what to do about it. Physicians expect to be able to help patients and express
confidence in their specialized knowledge and abilities.

Physicians believe that their expertise is assumed. Patients ask questions of them and
expect answers. Dr. Carter explains: “I think we, as physicians, are very fortunate in that I think
patients start off with an assumption that doctors are knowledgeable individuals who have
altruistic beliefs and that they’re here to help you” (M4-49).

Physicians understand patients may not have the requisite knowledge and may not know
what questions to ask, so they offer information. Dr. Henry recounts, in a matter-of-fact way,
how he shared his expertise with a patient in his care:

I said, “you know, you’ll go on a blood thinner for the embolus, no big deal, that’ll settle
down” and I explained why she got the clot. How … patients [with this condition] tend
to clot very aggressively and we see this all the time and its part of the process. And that
she’d be on an injection once a day, you know, indefinitely. And then we talked about
doing the CAT scan and having surgery… She said okay and that’s it (M1-205).

This seems like a matter of routine, nothing out of the ordinary for Dr. Henry. The situation Dr.
Henry describes is clearly complex, but he easily offers the information to the patient and
believes the situation is addressed.

Dr. Carter describes patients in her care as often very sick and in need of reassurance that
she is doing all she can:

I think that’s probably the most, one of the more important components of the
relationship, that the patient believes that you, believes and trust that … you have their
best interest at heart, that you are competent to take care of them, that you’re competent
to make the decisions that affect them (M4-13).

Physicians acknowledge that patients want them to reassure them that they know what
they are doing and that they have ideas as to how to manage the disease. However, at times,
physicians feel they need to persuade patients that they can help them. Dr. Reese recalls a particular patient who was frustrated by the complications he experienced:

So I think that he trusts us to be honest and people really have tried to be as clear as they can with him. They certainly try to persuade him, I mean it’s not to the point of extortion but I mean they really have tried to persuade him, you know, the view that he needs to kind of just carry on (M6-441).

If a patient questions the expertise of the physician, then the relationship can change. Dr. Reese recalls such a situation:

He [patient] made it clear… what his worries were and basically…said “I don’t think you quite understand what…I’m telling you here”… So that was very good because we were just talking on the phone at that point (M6-101).

The patient’s perception was that Dr. Reese didn’t understand his concerns and was not addressing them. Dr. Reese acknowledged the patient’s concern and recognized that he needed to proceed differently with the patient so as to achieve a common view of managing his disease. Dr. Reese subsequently arranged to meet with the patient in person quickly and was able to move towards resolution of the patient’s concern. Physicians are prepared to work things through with patients but the underlying belief is that they, as physicians, have the expertise and the accurate interpretation of events.

These three readiness conditions must be fulfilled before relationships with patients are established. Each condition allows the physician to engage with patients with a focus on managing the disease. Assuming that patients trust them, believing that something can always be done and having confidence in their own medical expertise allow physicians to establish relationships with patients that meet the expectations of both physician and patient; to manage the patient’s disease.

**Relational Strategies Used by Physicians in Managing the Disease**

Physicians use several strategies in relationship development with patients. These strategies are useful in establishing a way of being with a patient that allows the physician to be effective in managing the patient’s disease. All physician participants use strategies with the intent of developing and maintaining the relationship. The four strategies physician participants use are listening, informing, imposing boundaries and humour. These strategies are described.
Listening

Physicians begin initial encounters by finding out why patients have come to see them and what they already know about their health conditions. Physicians admit that they often know the reason a patient is coming to see them prior to the first meeting because another physician has referred the patient and has communicated clinical concerns. All physician participants acknowledge listening as an important strategy in establishing relationships. They view listening as part of the process, part of the job. As Dr. Reese says: “My part of the contract is to listen, to understand as best I can, and to obviously be discreet” (M6-9). Listening is a priority as conveyed by Dr. Henry: “You really have to make sure the patient knows that you’re there and you’re going to listen to them, you know” (M1-117).

Listening to patients serves several purposes. Listening carefully to the patient’s descriptions of symptoms and responses to treatment allows the physician to make adjustments in the management plan. Dr. Luke explains how he uses what he hears from patients and adjusts the management to maximize effectiveness and comfort:

He was going through … a tough program made tougher with the drug that he couldn’t necessarily afford, … so he had all these conflicts and on the background of the ataxia and not feeling very well from that, we’ve modified his … [treatment plan]. So the … [treatment plan has] been modified to try to maintain that rather than knock him around too much (M3-225).

In more general terms, Dr. Reese describes his philosophy when working with patients, reflecting the importance of listening when creating a plan for the patient’s medical care:

[I] listen to their choices and their values and try to work towards some sort of plan for medical care that will both be true to their values, allow them to make the choices within an informed decision (M6-9).

Listening to the patient not only aids in relationship establishment but also contributes to physicians’ ability to manage the disease. In fact, Dr. Luke confides that having more information from the patient about treatment side effects and personal preferences can precipitate feelings of closeness: “I’m probably closer to him than others just because of the … [side effects] he’s had and the fact that he’s had a recurrence and it was an unusual recurrence” (M3-329). The closeness to which Dr. Luke makes reference seems to be related to his enhanced understanding of how the disease is affecting the patient and the time required to address these issues and modify the management plan.

Listening allows physicians to get to know patients but, as discussed earlier, the knowledge gained is used by physicians to understand the severity of the disease, how advanced
it is and to guide decision-making about the management plans. For example, Dr. Luke describes his approach when listening to a patient:

Trying to decide about the treatment course that an individual could benefit from, then knowing what their performance status was, what they were doing just before they got to you, is important (M3-79/81).

Getting to know the patient as a person also involves gaining a sense of a patient’s understanding of his disease. Physicians listen to patients, all the while assessing if they understand the severity of illness, the risks associated with different therapies and the potential for death. Dr. Levis describes what she watches and listens for:

If someone’s never been hospitalized they may still not have a complete grasp of just how sick they are. Whereas if they have been hospitalized, especially if they’ve been in an intensive care unit, then they have a much better grasp of how sick they are (M5-29).

One physician mentions that relationships can be “messed up” by physicians if patients don’t feel they are being listened to. Dr. Reese explains:

The patient doesn’t feel that they’ve expressed what they wanted to express. They don’t feel that they’ve been heard. They think people are not taking them seriously, may believe that people aren’t taking their choices seriously. That’s kind of messing up that will lead to, when a patient doesn’t feel that the physician he’s talked to has listened to him or her, has bothered to think about what he’s saying but has made a decision that’s irrespective of the kind of values and choices that a person wants to make (M6-77).

Listening to the patient is a strategy that physicians consider important and effective in establishing relationships with patients in a way that will enhance their ability to manage the patient’s disease. Asking questions about patients’ lives and then listening to the answers gives them additional important information that guides their management plans. And, as one physician implies, not listening can be detrimental to the relationship between physician and patient.

Informing

Providing information is a core strategy that all physicians use when establishing relationships with patients. Once they ask questions of the patient and listen to the responses, they formulate diagnostic and treatment plans, which must then be communicated to the patient. Informing the patient of the plans is accomplished using an honest (M1-125, M3-175, M5-41, M6-441), straightforward (M1-209, M4-111, M6-409) and clear (M6-49) style of communication. Dr. Levis says that as a physician you: “lay the cards on the table, not beat about the bush” (M5-37).
Part of the contract with patients is to keep them informed each step along the way. Physicians believe that information should be provided to patients in a timely fashion and that patients have a right to know everything that relates to their health conditions. Dr. Carter explains her perspective: “I think you have to go at it from the perspective that it’s your responsibility to do it [give information] and it’s the patient’s right to know the news you’re about to give. So I think it’s not something you should shirk from” (M4-227). Dr. Levis concurs, saying: “I don’t think its right not to tell them”.

Physicians recognize that patients vary in how and when they wish to receive information. They assess individual patients’ needs and preferences and adjust their approach with respect to when and how they communicate information regarding the management of their diseases. Dr. Henry describes this process:

Everybody’s different and some people want to know every detail and others don’t. ‘You have to let me know what it is you feel comfortable hearing about’ and you tell them that you’ll answer anything they ask you honestly. But also if there’s areas they don’t want to go into to let me know that. That’s basically it. (M1-13).

Dr. Henry asks patients directly how much they wish to know at a given time while reassuring them that he intends to be honest with them and answer any questions that they might have. In a similar approach, Dr. Levis describes how she adjusts the pace at which she presents information if she senses it is too much for a patient:

You do strategize and you spend more time or you try to explain … you know I don’t believe you can approach every single patient exactly the same way … so I think it does require honesty but I think … different patients handle it and … I think you can see it on patients’ faces when they’re handling it and when they’re not handling it. And so you know when you can push forward (M5-41).

Dr. Levis adjusts her communication of crucial disease-related information to patients based upon her assessment of patients’ abilities to “handle it”, but her approach continues to be what she calls “brutally honest”. Similarly, Dr. Carter discusses her approach of staging information disclosure with patients with the intent of preventing information overload:

Sometimes if you meet someone and it’s a very complicated issue it’s not fair to try to tell them 12 things that have to happen … You know like that’s information overload that’s not of benefit to anyone. So I think we sometimes need to sort of stage that (M4-111/115).

Physicians also discuss the need to assess patient receptivity to information and recognize that patients must demonstrate a readiness to hear it. Dr. Levis recalls some patients responding in a way that indicated to her that she needed to stop and reconvene with the patient at a later
There’s a look in their eyes, there’s the proverbial deer caught in the headlights and as soon as that look is there, there’s no point in talking any more because nothing else you’re saying is registering. And people really do get that look … they’re trapped. So it’s not stunned as if you’re caught in that headlight … those are people that are listening to you and you need to sort of step back and then bring them back through (M5-45/53).

Information physicians provide to patients varies in its nature. They discuss details related to diagnosis, therapeutic plan and prognosis as well as what patients can expect. Dr. Carter comments that: “You need to give them a lot of, you need to give them information so that they know what to expect in the next X number of hours or days” (M5-255). They describe the importance of providing all information to patients, whether its good news or bad news. Physicians want to explain what is going on to patients. Dr. Carter recalls a patient who was stressed and she sensed he needed to talk; he needed information: “We talked and talked and I tried to reason with him in terms of ‘you really need to calm down … I know you’re stressed out’ … you knew it was because he probably was just very scared and wanted someone to speak to” (M4-415). Dr. Levis provides an example from her practice, illustrating her beliefs that, on occasion, patients need all the information in order to understand their condition at that moment:

So trying to establish a communication relationship with a patient who’s never been told they have … [a condition] and the reason they’ve been referred to me is for a … [procedure], in my assessment with that patient now is to bring them from ‘you have … [this disease], this is your life expectancy, this is where you are and you need a … [specific procedure] (M5-13).

Finally, one physician commented on the impact of communicating information to patients can have on patient-physician trust. Dr. Carter describes the impact that informing a patient might have on evolving trust:

After I’ve examined the patient I usually speak with the patient about what I think is going on. This is what I think we should do and um I think that helps establish the trust. I think it’s the communication that ensues sort of the interaction that starts, helps establish the trust (M4-57).

Dr. Carter continues to discuss the impact of not communicating information to a patient: “If one could be more specific and say is there anything that a physician does specifically that could erode the trust between a patient and a physician probably the biggest thing might be … the perception of avoiding communication” (M4-81).

Informing patients about their diseases and management plans is a key strategy used by physicians to engage with patients and assure them that their disease can be managed. Physicians are honest and straightforward in their approach and make attempts to individualize it
when communicating with patients.

**Imposing Boundaries**

When physicians interact with patients, they use a strategy that serves to establish a comfortable distance between themselves and patients. These boundaries essentially exclude the sharing of personal information on the physician’s part. Physicians describe this imposed barrier as occurring with empathy. Dr. Reese explains: “I’m someone who’s a little bit distanced from that sort of thing [a personal relationship] but who is empathetic” (M6-9). Distance serves as a protective mechanism, allowing physicians to maintain objectivity in order to effectively manage the disease.

Physicians recognize that significant involvement with patients is exhausting and is not necessarily helpful in managing patients’ diseases. Dr. Venti suggests why significant involvement is a disadvantage: “I get too involved … I worry about them” (M2-23/27). Imposing barriers is seen as self-protective. Dr. Luke explains: “I think that you don’t want to get too much into their [patients’] lives, at least I don’t. It’s protective” (M3-105). When Dr. Luke is asked how he manages a situation when a patient is attempting to establish a closer relationship with him, he quickly responded with a laugh: “I’m ice” (M3-273). Dr. Luke is clear that the relationship focus is on the “obvious”, meaning managing the patient’s disease.

Physicians describe the establishment of boundaries between themselves and patients as a way of surviving in their clinical world so that they might continue their work, which they consider important. Their work is emotionally draining and affects them as people. Dr. Reese describes how difficult it can be, working everyday with patients, especially those who are acutely ill and hospitalized:

The work tends to be pretty intense and it’s pretty draining and if I do it for very long at any one block of time it’s depressing. I certainly can have an affective downturn from being in this sort of circumstance of dealing with this stuff every day (M6-325).

Dr. Reese’s comment refers to how he uses his on-service schedule to protect himself. Rotating on and off service at regular intervals can be interpreted as a way of imposing boundaries between himself and patients. Physicians may use this strategy of imposed boundaries because they recognize that they are affected by their experiences with patients.

Physicians maintain established boundaries in a variety of ways. Dr. Venti consciously chooses to: “never call patients by their first name[s]” (M2-110), while Dr. Luke describes establishing a team approach to patient care that allows him to maintain a comfortable distance:
I like to try to keep it in the obvious [disease process]...I think that’s part of the reason that I like to work in a team and the team is very broad. Not a team of doctors but a team of professionals. … the system we’ve set up here probably reflects that a lot (M3-265/269).

Another approach that maintains boundaries is physicians’ use of a flat, matter-of-fact affect when discussing disease management with patients. Dr. Reese explains his perspective:

Often when I’m dealing with really bad pieces of advice, sort of bad news is to present it clearly and as neutrally as I can. I don’t respond to things, at least I try not to respond to things no matter what someone tells me, in a really emotive way. So a flattened affect sometimes helps to kind of get over some of this stuff because it’s pretty trying (M6-337).

Imposing boundaries is a strategy that physicians use when engaging with patients. The strategy serves to establish distance between themselves and patients with the purpose of maintaining the focus of the relationship on managing the patients’ diseases. This strategy also has a self-protection component, allowing physicians to continue with work that they see as stressful and draining, but important.

Humour

A final strategy that emerges from discussions with physicians is related to their use of humour. Physician participants describe irregular use of humour in their practices which differentiates them from ACNPs and staff nurses. In fact, a purposeful lack of humour is evident in physician-patient relationships. Half the physician participants briefly discussed humour. Two of the three physicians who allude to humour indicate that they would respond to humour from patients and one of those responds to patients with “light humour”. When and if physicians use humour, it is in an attempt to lighten the mood between themselves and patients.

Dr. Reese claims he might respond to a patient’s expression of humour but he considers it risky to initiate humour himself, so his strategy is to not use it. He believes there is a chance humour might be misinterpreted so he avoids it entirely:

I decided that … I just don’t make jokes about anything and certainly not about illness. And I doubt that any of my colleagues that work in this area do. It’s just too easy to be … sort of misunderstood (M6-45).

Interestingly, Dr. Reese also mentions that he leaves that part of himself behind, in his personal life, confiding that humour and ambiguity are common and acceptable in his private life, but not in his professional role.
The one physician who speaks openly about initiating humour with acutely ill patients is Dr. Henry. He is the only physician who discusses using humour when he senses there is a good rapport between himself and a patient. It is as if humour is indicative of an increased relational intensity between physician and patient. He tries to explain:

There are certain elements [that can’t be taught], like to be really comfortable and joke around and talk with people and know when that’s okay and when it’s not right … Because some patients you don’t joke with. Most you can, actually … that’s all instinct (M1-301/305).

When encouraged to explain the instinct to which he refers, he could not elaborate further. In fact, he actively resisted attempts to encourage him to offer more detailed explanations of his “instinct”.

So, as mentioned initially, humour is generally conspicuous by its absence when compared with other relationships examined in this study. Humour, while available to physicians, is used very differently and not in the same way that ACNPs and staff nurses speak of using it. For physicians, humour does have its place but, for most part, it plays a limited role in relationships with patients. Since they choose to avoid humour, that, in and of itself, can be considered an intentional strategy in establishing relationships with patients.

Relational strategies are used by physicians to establish relationships with patients focused on managing their diseases. A physician’s goal is to understand the patient’s symptoms, determine the disease or condition responsible for those symptoms, develop a treatment plan and evaluate its effectiveness. Thus, the four strategies; providing information to the patient, listening to patient’s perspective and concerns, imposing boundaries between themselves and patients and, finally, irregular the use of humour; are used by physicians to establish, maintain and control the nature of the relationship, thus allowing physicians to remain in the profession while maximize their effectiveness in managing patients’ diseases.

**Relational Products of Managing the Disease**

The products of a physician-patient relationship are two-fold; physicians see patients *move on with life* and there is a sense that the patient feels *appreciation* for the efforts made by the physician on their behalf. These two products are indicators of physicians achieving a degree of relational intensity that allows them to manage the patient’s disease. Of course, not all patients are able to return to life at home, but physicians realize that moving on with life means different things to different patients. This realization is related to physicians’ beliefs that something can always be done (readiness condition) for a patient, even if that ‘something’ is...
providing comfort as the patient dies. Physicians speak of very few patients with whom they could not establish a relationship that had at least a professional level of intensity. They suspect that such patients might, if clinically able, choose to seek attention from another physician. As a result, these two relationship products are regularly achieved.

Seeing Patients Move on With Life

Patients have a goal of moving on with their lives and physicians consider the achievement of this goal as a consequence of their relationship, one which indicates that the relationship is successful in achieving its intended purpose. Moving on with life may mean that patients have their symptoms effectively managed, their disease is diminished or cured, they are ready to leave the hospital or perhaps they have to come to clinic less often. In essence they are better off than they were before they met the physician. Moving on with life is viewed in the context of where a patient starts (e.g., acuity, severity of illness, likelihood of cure) and what the physician thinks is achievable for a patient.

Physician participants’ comments consistently acknowledge patients moving on with life. Dr. Henry recalls a patient who had a lethal condition, but whom he was able to discharge home: “She went on her old meds and was going to spend Christmas with her family…Nice ending” (M1-221/225). Dr. Venti describes, in general terms, how she views many of the patients for whom she cares: “patients that come in, you fix them, you usually don’t see them again cause they’re doing well. You might see them once a year, and they seem to be doing well” (M2-19). Dr. Luke describes a particular patient with whom he worked and whose disease was well managed so he could get to his occupation and his life: “He’s happy to be back to work. He’s back at work in his firm, doing what it is he does and, you know, … he does about 90% of what he was able to do before” (M3-89). Dr. Luke also recalls a patient whose symptoms were initially problematic but who has now moved on with life: “I think he has taken the attitude now that he is going to try to enjoy life and get out of it what he can” (M3-245).

Dr. Carter describes patients moving on with life as a victory for them:

To see that transformation it was just really, really gratifying … I remember speaking to her [other physician] in the hallway one day and we felt it was almost, it was like a victory for her” (M4-343).

Dr. Levis comments that though physicians see patients move on with their lives, on occasion they must maintain some sort of involvement with the physician and some require reminders of this: “We’ve actually had to say look get your [self] … back in the clinic because we want to
make sure that everything’s okay because they’re so getting out there with their lives, which is great” (M5-137).

Physicians recognize that a result of establishing their relationships with patients, focusing exclusively on disease management, is seeing patients move on with life, whatever that might mean for the patient. Appropriately, this is compatible with the patient’s own goal of resuming life.

Patient Appreciation

A second product of physician-patient relationships is a perception that patients appreciate what physicians do for them. Though they are clear that they don’t need to know that their work is appreciated and they may not receive acknowledgement from each and every patient, physicians report being the recipients of expressions of appreciation on a regular basis. Such acknowledgement is perceived by physicians as reinforcement that they are meeting patients’ expectations and that they have done their jobs well.

Some physicians sense that the more acutely ill the patient, the more appreciative they can be. Dr. Carter offers her perspective: “I think sicker patients are more vulnerable. This is a natural thing and I think that they tend to be very appreciative of … any help that they have and it’s from everyone” (M4-61). Physicians also recognize that acutely ill patients are appreciative of information from physicians and the time physicians spend with patients when they are in a life or death crisis.

Appreciation can be shown to physicians for an entire episode of care or for a specific interaction. Dr. Reese recalls his work with a very ill patient who experienced many complications post-surgery. Once they had discussed therapeutic options together, the patient said: “Thank you for listening to me and I’ll bear with you for now” (M6-417). The patient expressed his appreciation for Dr. Reese’s explanations and agreed to proceed for the moment.

A final example of expressed appreciation is monetary donations. Physicians are aware that patients make donations to hospitals and their associated charitable foundations as a sign of appreciation. Dr. Levis elaborates: “So usually people want to give back in some way, through the Foundation, through a variety of different ways” (M5-229).

Expressions of appreciation are the products of managing patients’ diseases according to physicians. Appreciation may be expressed by patients intermittently as physicians meet or exceed patients’ expectations or as an episode of care draws to a close.
Patients’ Perspectives on their Relationships with Physicians

As discussed earlier, patient participants in this study shared their perspectives on relationships they have with specific care providers who participated in this study as well as other providers with whom they had interacted currently or in their past. Patient participant characteristics were described earlier (Table 7).

As discussed in chapters five and seven, which address ACNP-patient and staff nurse-patient relationships respectively, patients describe some similarities but clear differences in their relationships with various health care professionals. What follows is a summary of the key themes that emerge from discussions with patients about their relationships with physicians.

The main theme, central to the patient-physician relationship from the patient’s perspective, is that physicians manage my [the patient’s] disease. Sub-themes that contribute to managing my disease include confidence in physicians, informing patients, time, incorporating individualism, establishing rapport, and recognizing physician position and power in the organizational hierarchy.

Central Theme: Managing My Disease

The major theme that emerges from interviews with patients with respect to their relationships with physicians is managing my disease and it is noteworthy that this theme is virtually identical to the central focus identified by physicians in their relationships with patients. Patients recognize that the chief issue addressed by physicians when relating to them is disease-oriented. By way of illustration, Mr. Lang says: “All we talk about on their rounds is me, my condition, how I feel, if I’ve got any questions, is there anything else they could do for me” (P6-341) and Mr. Trip recalls: “She’s [the physician] just really into, you know, her work, sort of right like when you talk to her” (P5-481).

In the acute care context, physicians are seen by patients as in charge and taking control of the management of their disease and that is in keeping with their expectations. Mrs. Roma recalls: “she handled everything to do the [procedure]” (P4-668). In fact, one patient described his desire to have the specialist physician manage all aspects of his care instead of a number of different physicians, including his family physician:

“I did phone her one time and say to her look every time I go somewhere somebody changes, somebody changes my mix, my chemical mix that I’m taking. There’s another change going on and this means I have to go to you afterwards and then I have to go to my GP afterwards and then and I said the way I’d really like to work this is that you are the, you’re the one that decides. This is what people are recommending and I’d rather
there was one person who was setting the pace than everybody having … [a] go at it (P2-293).

Patients recognize that despite others being part of the care process, physicians are in charge of establishing the plan. Mr. Parker provides an example: “Dr. Luke would normally give the treatment to her [the ACNP] and she carries it out” (P3-401). Mrs. Roma concurs: “Dr. Carter would tell you … she knows the story and she’ll tell you what you have to do” (P4-1136). Though patients do not always see much of physicians, they are acutely aware of their involvement in the process of planning care. Mr. Kean recalls: “It’s a special unit that they’ve set up where nurse practitioners are pretty well running the show but the doctors are in there on regular rounds” (P2-348).

Patients see physicians as experts with in-depth knowledge of disease management that allows them to help them to move on with life. A physician asks questions of a patient, targeting information that will assist him in developing an understanding of the patient’s disease. Mr. Kean recalls: “He wanted to know all kinds of things and about how I felt and what it was like when I was suffering. And ‘go back right to the start and give me the whole history’” (P2-682).

Despite their views that physicians are in charge of their disease management, patients acknowledge that physicians work as part of a larger team that includes other health care professionals such as ACNPs. Mrs. Tudor offers an example: “She [ACNP] relates that to Dr. X … and then talks to Dr. Y. And then, you know, they will talk and see what will happen, what they’re going to do” (P1-220). Patients are aware that daily rounding of the team contributes to disease management decisions. Mr. Kean recounts: “they [ACNPs] travel with them [physicians] along with all the others and hear what they have to say” (P2-354). Patients also recognise that more than one physician may work together to manage their disease: “She [physician] was always part of it, part of the medical group that, together, well they all worked together” (P4-844).

Patients see ‘managing my disease’ as the central focus of their relationships with physicians. Physicians are experts who endeavour to understand the patient’s disease so they can develop and implement a management plan. Physicians do this as part of a larger team, but are seen as most influential in directing the disease management process.

Sub-themes: Confidence, Informing, Time, Individualism, Rapport and Hierarchy

Six sub-themes emerge from interviews with patient participants. These sub-themes contribute to and influence the accomplishment of managing the patient’s disease. Each of these themes is
Confidence

Patient confidence in physicians encompasses trust in their abilities and in their expertise in disease management. Patients consistently provide examples that illustrate their confidence in the physician(s) responsible for managing their care. They trust that they are in good hands. Mr. Parker says: “I think it’s more to trust a doctor I mean he gives you pills and stuff and you trust that he knows what he’s doing right” (P3-157). In order for a physician to have expertise, they must be viewed as intelligent. Mr. Kean comments on the: “sharpness of her mind” (P2-225) when describing the physician responsible for managing his disease state. This confidence inspires patients to listen carefully to physician advice: “I listen to her, to her advice” (P4-828), and to discuss certain important issues with the physician alone: “some questions [are] just between the doctor and the patient, you know some things” (P6-617).

When patients meet physicians they are confident that physicians are experts and are therefore worthy of their trust. That trust can be enhanced when patients see the same physician over a long period of time. As Mr. Parker suggests: “my relationship with [Dr. X] over the years has gotten strong, so I trust him” (P3-153). Patients trust that physicians always have something to offer: “I think they feel sorry, you know, that it [treatment] didn’t work but they’re ready to fix [it], you know … I always want to know what’s the next step, what can you do for me next” (P6-405/417). The confidence they feel in physicians can foster what Mrs. Roma calls: “special relationships” (P4-844) with physicians. She recalls they have always been there when she has needed them and anticipates the same in the future.

Informing

Patients are aware of the vast amounts of information that physicians convey to them. Patients ask questions of physicians which can help them become informed. Alternatively, a physician might initiate discussion about the patient’s problem and explain the proposed plan. Physicians are also involved in anticipating future events and providing guidance to patients as to what is to come.

Patients report that they ask questions of physicians who usually take time to answer them, providing them with desired information. Mrs. Tudor recalls: “You can ask him anything, anything under the sun. And he will answer your question” (P1-103). Physicians also initiate discussion with patients to explain the disease and appropriate actions to be taken: “She
explained to me what the problem is, and what about what could be done” (P4-748) and: “They really clarify everything they’re going to do” (P6-241). Patients also acknowledge that they need to understand why the plan is established the way it is. For example, Mr. Trip needed to have an explanation for why a particular procedure was being delayed when he thought it was so crucial: “Dr. X explained to me, “you know, your age is a factor”’ (P5-777).

When patients see physicians, physicians will often provide them with feedback as to how they are doing, from their perspective, and patients appreciate being informed of their assessment: “She kept saying, you know, every time I used to go see her once a year she says “oh you’re doing great … Everything’s doing better” so, like, you feel good again … when you leave” (P4-796). Patients recognize that physicians attempt to anticipate the information they might need as well as trying to put the plan in the context of the individual patient. Mr. Kean, who was anticipating requiring a procedure, explains how the physician caring for him minimized the importance of the procedure at that point in time:

[The physician] minimizes it because she doesn’t want me to, I think, trying to anticipate I guess when something might take place or if it’s going to take place. I think she just wants to set it [the procedure] in the background, it’s back there, if need be, but we’re not going to talk about it [now] (P2-890).

Mr. Kean is reassured by this information and it seems to give him permission to put the possible procedure off to the side, as it is not relevant for the moment. Similarly, Mr. Parker appreciates the physician informing him about what the future might hold as treatment proceeds. He discusses: “long-term questions, the future and stuff like that with the doctor” (P3-393). And Mr. Trip also provides an example: “She just says ‘listen, you know, the next time when you come in, if you get admitted again, we’re going to have to do this [procedure],’ right?” (P5-1049).

Physicians inform patients using a variety of styles and these are identified by patients as “gentle” (P1-107), light-hearted (P1), straight-forward (P2-293;P5-1049;P6-217), “friendly” (P2-898;P5), “serious” (P5-469), abrupt at times (P5), and “sincere” (P6). Patients report some variation in the approach depending upon the physician, the type of information being relayed or other contextual factors.

Information and being informed is clearly important to patients and they count on the physician who is managing their disease to answer their questions, explain their disease to them as well as how they plan to manage it and anticipate what might happen in the future. Information allows patients to feel that the management of their disease is the priority in the physician’s mind.
Time

Time is a third prominent theme that emerges from analysis of patient interviews. When discussing their relationships with physicians, patients comment on various implications of time. Time is said to affect the rapport that develops, the intensity of the relationship from the patient’s perspective and the level of comfort patients feel with physicians.

Mrs. Tudor compares a physician with whom she feels comfortable to others: “Other doctors say, “How are you doing? Oh, okay. Bye.”…Yeah. It’s like, “How are you doing? How’s something? Okay. Nothing. Bye” (P1-177/179). The perception of Mrs. Tudor is that some physicians spend very little time and communicate through their interactions that they don’t have much time, e.g., standing at the door instead of coming into the room and appearing uninterested in the answers to their questions. This lack of investment of time seems to result in an unsatisfactory interaction and perhaps an unsatisfactory relationship between patient and physician. Mr. Parker confirms the value he has for time when he responds to a question about the amount of time the physician makes available to him to answer questions: “As long as I need, I mean he’s not rushing me at all and I take an interest and my wife takes an interest to my treatment, so you ask questions” (P3-313). Seeing that a physician will make time is an important contributor to the patient-physician relationship.

Patients generally perceive their interactions with physicians as time-limited but with some flexibility, depending upon their needs at the time. Mr. Lang explains: “They could be here 5 minutes and more times it could run to a half hour” (P6-321). Several patients comment that in comparison with their in-patient experiences, during out-patient appointments, they spend less time with physicians. Mr. Trip comments on his out-patient experience: “Dr. X just comes in, dah, dah, dah, dah, and she’s gone” (P5-1147). When asked how long the physician would meet with him, Mr. Trip responded: “How many minutes? I’d say three …Two minutes maybe, two, three minutes?” (P5-1151/1155).

Time is also implicated when patients reflect on their access to physicians. Patients generally describe being able to access physicians if they have any concerns to discuss. Mr. Parker recalls: “Yeah every couple of weeks I see him so I talk to him about different things that bother me or the like” (P3-185). And Mrs. Roma reinforces the notion that physicians caring for her are always available: “they’ve always been there for me” (P4-704).

Time can also contribute to how well patients feel and how comfortable they are with physicians. Mr. Parker comments: “Over 4 years, I’ve gotten to know him [physician] pretty well” (P3-217). And patients have a sense that the more time they spend with a physician, the
more thorough they believe the physician is able to be in managing their disease. This enhances their confidence levels in the physician. Mr. Kean recalls: “we also have a long talk about how I’m feeling and if there’s anything that is troubling me [emphasis reflects patient intention]” (P2-293).

The concept of time is clearly important to the relationship a patient has with a physician that allows for management of the patient’s disease.

Individualism

Patients comment that physicians personalize treatment approaches and this is appreciated. Mr. Parker recognizes that the physician who manages his disease is open to altering his treatment to meet his specialized needs. He explains: “It was [the physician], he said he’d modify, modify the treatment to suit me right? So they tried that” (P3-305). Patients also notice that physicians try to respect their opinions and desires with respect to disease management. Mr. Lang recalls a positive experience in this regard: “They respect each and every wish I’ve got, but they will explain to me what’s going to happen” (P6-241). Another aspect of individualism that patients identify is the need to know things are going well and that patients are doing the right things. Mrs. Roma recalls a physician acknowledging how well she was doing: “[The physician] used to praise me … look what this person went through and she’s, she’s gotten to this point” (P4-760).

Seeing and treating patients as individuals is acknowledged by patients as valuable, allowing them to feel that they have unique needs that physicians are willing to address accordingly. Patients wish to feel like an individual and value physicians’ approaches in this regard.

Rapport

Rapport between patients and physicians is a mutual process that establishes channels of communication between the two. It is interesting to note that patient participants in this study are clear and unanimous when they confirm that they don’t learn anything personal about physicians who manage their diseases. When asked about mutual self-disclosure, Mr. Parker explains: “I think with, more with the doctor, we talk about the treatment rather than the vacations and small talk, personal talk” (P3-333). When asked if she learns anything about the physician who manages her care, Mrs. Roma responds: “No. Maybe I should, eh?” (P4-736) and she expanded on this, “we didn’t click that way” (P4-744).
Another patient recognizes that having something in common can contribute to positive rapport with a physician with whom she feels particularly comfortable: “Like my rosary. Every time that he [physician] comes to my room, I had my rosary, and every time he has his rosary in his pocket too” (P1-111). Mrs. Tudor, though recognizing that the relationship between herself and this particular physician is traditional, feels comfortable with him. She explains: “It’s deeper in a way, that you can, I think you can talk to him [pause], in a normal patient, patient to doctor relationship” (P1-167). Rapport also contributes to the humanness of the interactions. Mrs. Roma recalls: “they [physicians] make you feel wanted … You feel like … a human being” (P4-656/660).

Comfort with the other is important to patients and they acknowledge the contributions that rapport makes to their sense of comfort with physicians. In fact, patients identify the importance of rapport when they offer examples of their lack of comfort resulting from a poor rapport with a physician. For example, Mr. Trip tried to convey his discomfort with one physician with whom he has interacted: “It feels kind of like, I’m always thinking what is she going to tell me next? Like, every time I see her it’s like she’s going to tell me something weird, or not weird but like bad or something” (P5-977). Mr. Trip’s perception arises from his experience with a physician whom he views as abrupt and blunt in her approach. He is not comfortable asking questions of the physician and negotiates access to information from other sources.

During the interview with Mrs. Roma, she comments that her relationship with a particular physician is very good and when asked why, she responds: “Because you feel comfortable … with some of them” (P4-640/644). In her attempts to explain why she feels comfortable with some and not others, she elaborates: “just the way they explain things to you, you feel like, now I’ve accomplished something today” (P4-704). Informing is clearly important but how that is accomplished and how the patient perceives the approach influences the patient’s degree of comfort with a physician.

Rapport, or ways of communicating with patients, emerges as contributing to patients’ level of comfort with physicians who are managing their diseases. There is no evidence that if patients do not have rapport that they feel less confident in physicians but it does appear to affect how comfortable patients feel with physicians and perhaps how forthcoming patients might be if they are in need of information.
Hierarchy

As described in an earlier chapter addressing ACNP-patient relationships, patients identify a hierarchy of health care professionals in the acute care environment and their perception of the status of care providers influences patients’ perspectives on the nature of the relationship. So, though not discussed often, there are regular references to the status of various health professionals when patients discuss their relationships with physicians.

Patients’ comments about physicians suggest that they see them as in charge of the management of their disease. This is different from their comments about ACNPs being in charge; ACNPs are seen as being in charge of making things happen, with an enhanced level of authority and autonomy to take action and staff nurses are seen as carrying out the directives of physicians and ACNPs. But physicians are viewed as in charge of disease management and are positioned higher in the hierarchy. Mrs. Tudor provides an example: “It’s a different thing” (P1-236) “his position as a doctor” (P1-234) and “[the ACNP] is a nurse” (P1-236). Mrs. Roma acknowledges the position of the ACNP versus the physician when asked to compare the two relationships: “Whereas maybe [the ACNP] is under [the physician]” (P4-1140). Mr. Trip tries to describe the role of staff nurses in comparison with ACNPs and physicians: “When I learned about these other people I was like oh she’s [nurse] not as important as these people [team of physicians and ACNP]” (P5-457).

Hierarchy and health professional status influences how patients see their relationships with health care professionals. Patients see physicians as ultimately in charge of managing their disease and allude to the hierarchy, as they see it, with physicians at the top, ACNPs in the middle and nurses at the bottom.

In summary, patient participant data yield themes that contribute to our understanding of relationships that patients have with physicians in acute care environments. Having reviewed patients’ perspectives on their relationships with physicians, the next step is to examine how patient perspectives compare with physician perspectives on their relationships.

**Patient and Physician Perspectives on their Relationships: How Do They Compare?**

When analyses of patient and physician interviews are compared, patient themes provide significant support for the physician-patient relationship sub-theory. Typically patients seek assistance from physicians for a problem that is assumed to be an illness and they expect physicians to manage their disease. Disease management is central to their relationship. Patients know that their health problem is the basis for relationship development with a physician.
Physicians feel similarly. They meet patients with the goal of understanding the patient’s symptoms, diagnosing the disease and managing it. To illustrate, each patient sub-theme is examined as it relates to the physician-patient relationship sub-theory.

The first sub-theme, patient confidence in physicians’ expertise and trust that they will manage their disease, is reflected in physicians’ descriptions of readiness conditions of their relationships with patients. Physicians assume that patients trust their abilities to manage their disease and patients convey that they do, indeed, trust physicians’ abilities. Another congruent belief is that physicians are experts. Both physicians and patients agree that physicians are assumed to be experts and that assumption pre-dates the development of physician-patient relationships.

Rapport also emerges as relevant to both patients and physicians. Physicians describe rapport as important in relationships with patients. A positive rapport influences the sense of comfort a physician has when working with a patient, while patients describe rapport as influencing their level of comfort with a physician. Both patients and physicians can describe relationships with less than optimal rapport, resulting in discomfort, a feature that is compatible with a more clinical level of relational intensity.

Time is another theme that physicians and patients have in common. Patients describe the length of time physicians spend with them in far more limited terms but acknowledge that time spent with a physician positively influences their level of comfort with a physician. Physicians differentiate duration and frequency of contact when considering relationships with patients. Maintaining contact over a longer period of time may produce an equally strong relationship as those that develop as a result of intense, frequent contact with a patient who is critically ill.

A final theme addressed by both physicians and patients is informing the patient. Patients describe how physicians provide them with information by answering their questions, initiating discussions with them about their disease and the plan and anticipating what patients might need to know or what may happen in the future. Physicians concur, recognizing that providing information to patients and answering questions are important strategies they use in managing the patient’s disease. Patients also describe a variety of styles used by physicians to inform them and physicians are aware of the styles they use with patients.

There are themes that emerge from patient interviews that are not evident in physician perspectives. Being treated as an individual is one such theme. Individualism is demonstrated when physicians alter therapeutic plans to suit patients, show respect for the patients’ views and
goals related to diagnosis and treatment and acknowledge gains patients make. Though not a distinct theme, physicians do describe an awareness of individualizing care when they describe informing as a useful strategy in managing the disease. Physicians respect that patients vary in the way they like to receive information and may make attempts to adjust their approach to suit the needs of individual patients. One aspect of patients’ perspectives on individualism is being treated like a human being. This idea is compatible with physicians’ recognition of the humanness of patients with diseases requiring management.

There are some discrepancies when comparing patients’ and physicians’ perspectives on their relationships. Patients describe a hierarchy of health care professionals though hierarchy is not discussed by physicians. Patients identify a hierarchy in the health care team, with physicians being at the top, ACNPs in the middle and staff nurses at the bottom. Physicians do not discuss disease management in these terms.

Teamwork is an issue that emerges as a dimension of the relationship from the physicians’ perspective that did not emerge as a sub-theme for patients. However, patients do acknowledge that physicians are part of teams but this is seen as part of the central theme, managing their disease.

Finally, physicians discuss the possibility of finding commonalities with patients as part of their rapport building. However, patients do not comment upon this specifically as important in their relationships with physicians.

Overall, when themes emerging from patient interview data are compared with those from physician interview data, there is significant agreement. Both patients and physicians focus on disease management, indicating that their expectations of one another are realistic and well matched. Therefore patient findings provide support for the physician–patient relationships aspect of the overall health professional relationship theory in acute care settings.

**Physician-Patient Relationships Summarized**

The relationships between physicians and patients are focused on managing patients’ diseases and both physicians and patients are in agreement. Interactions are focused on this goal and managing the disease emerges as central to the practice of physicians and the expectations of patients. Managing the disease requires attention to the patient’s symptoms, acuity, how the patient’s life has changed and what the physician has to offer the patient to manage the disease.

Three readiness conditions precede the development of a physician-patient relationship. First, physicians assume that patients trust them to do what is best for them with respect to their
disease. Secondly, physicians believe that something can always be done for patients. In their work to manage the disease, physicians try to cure the disease but they recognize that this isn’t always possible. A final condition that precedes physician-patient relationship development is the belief that physicians are experts. Patients, too, acknowledge the importance of physician expertise and how it contributes to their confidence in physicians.

Relational strategies used by physicians to establish relationships with patients have also been identified. Physicians describe listening to patients, providing them with information relevant to their disease, imposing distance between themselves and patients by establishing boundaries and making conscious decisions about the appropriate use of humour.

Like the ACNP-patient relationship, the degree of relational intensity is influenced by relational dimensions, which illustrate the properties of physician-patient relationships. These relationships vary according to their patient/person orientation, type of rapport, time spent with patients and the degree of team involvement.

The products of physician-patient relationship development are two-fold. Physicians see patients moving on with their lives and they recognize that patients appreciate their ability to manage their disease.

Analysis of patient data substantiates the physician-patient relationship sub-theory (Figure 5) of the overall ACHPPR theory.
Physician-Patient Relationship Sub-theory:

Managing the Disease
[Relational Dimensions: Patient/Person Orientation, Rapport, Time, Team]
CHAPTER 7 – FINDINGS (PART 3): MEETING PATIENT NEEDS: RELATIONSHIPS STAFF RNS HAVE WITH PATIENTS

The purpose of this chapter is to describe staff nurse participants and the nature of their relationships with patients in acute care environments so as to ultimately understand how these relationships are similar and/or different from relationships ACNPs and physicians have with patients. The central focus of staff nurse-patient relationships, meeting patients’ needs, will be discussed including the dimensions that influence relational intensity (ideal versus reality of relationships, what patients need). The process of relationship development including readiness conditions (patients have needs, perceived patient openness), relational strategies (humour, encouraging patient self disclosure, ways of being, acculturation, multi-tasking) and relational products (making a difference, patient appreciation, a sense of accomplishment), is described (Figure 6). These findings contribute the staff nurse-patient relationship sub-theory to the larger Acute Care Health Professional-Patient Relationship Theory that describes how three different health professional-patient relationships compare in the acute care context. At the conclusion of the chapter, a descriptive analysis of patient perspectives on their relationships with staff nurses is presented and discussed in relation to the staff nurse-patient relationship.

**Characteristics of Staff Nurse Participants**

Staff nurse participants were younger than the other health care professional participants, with a mean age of 39 years and 80% were female. Their experience as nurses ranged from 1-25 years, with a mean of approximately 14 years. They reported practising in the study organization an average of seven and a half years and one (20%) was degree prepared. Staff nurse participants reported being responsible for, on average, 5-6 patients per day, spending approximately 93% of their time in patient care related activities (Table 10).

**Table 10. Characteristics of Staff Nurse Participants**

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<td>Age of participants (years)</td>
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Meeting Patients’ Needs: The Focus of the Staff RN-Patient Relationship

The central focus of staff nurse-patient relationships is meeting patients’ needs. When staff nurse participants were asked “What makes for a good relationship with a patient?” they suggested that being “open” to the patient (R2, R3, R4, R5, R6), “honest” (R3), fostering “trust” (R3, R4, R5), providing “support” (R4, R5), and showing respect for patients (R2, R4) all contributed to a good relationship. Staff nurses consistently referred to the needs patients have that require their professional attention and how those needs varied, patient to patient. It became clear that patient needs are central and are the reason staff nurses become establish relationships with patients.

Relationships that meet patients’ needs are characterized by nurses interacting with patients based on their requirements for care and attention from nurses. The care and attention required is related to a patient’s disease and is why nurses become involved with them. When asked to describe what makes for a good relationship with patients, Nicki shares:

I think that from my end, as a health care practitioner, I feel that that would be important, enabling the patient to give me feedback on how they’re feeling and how they’re doing and you know the whole mix of being in hospital (R4-9).

Nicki’s comments highlight this central focus of staff nurse-patient relationships; gaining an understanding of patients’ needs. While patients are viewed as human beings, their immediate disease-related needs are the central focus and impetus for the development of the staff RN-patient relationship.

Meeting patients’ needs keeps nurses very busy and they comment regularly on this reality. Nurses seemingly focus on what needs to be done for patients rather than on patients themselves and when nurses interact with patients, their focus is on the needs that they must meet for that particular patient at that specific moment in time. When nurses move on to another patient, they do so because they have assessed that another patient has a need that requires their attention at that moment. Amber comments on the reaction of some patients when she tries to explain how nurses make decisions about responding to patients’ needs, such as answering patient call bells: “So it’s a lot of explaining because they [patients] get short [tempered] … you have to kind of explain why [another patient’s call] may be answered before theirs” (R6-17).

Physical needs are a priority for nurses and include such activities as hygiene, and medication administration. Karen describes her interactions with patients that reflect a problem-based and predominantly physical focus: “They will tell me if they have anything, anything that’s bothering them or any symptoms that they’re having” (R5-20).
Nurses often describe their involvement with patients as shared among nursing team members and, occasionally, more broadly among the entire health care team. They speak about everyone knowing specific patients when they have long hospital stays in the unit or lengthy involvement with the team. Raj makes reference to this: “He [the patient] was on the floor for over a month so everybody sort of knew him very well” (R2-81) and Judy similarly recalls, “We’ve known him for a long time” (R3-465). The use of “we” reflects a joint or shared knowledge of the patient by the nursing team versus an individual understanding of the patient that one would expect in a highly developed relationship. The knowledge that nurses have about a patient does not always come from direct communication between nurse and patient. It can also come from shift-end reporting or informal professional discussions among nurses about particular patients. For example, Amber conveys a philosophy of involvement with patients, described as a form of shared care by nurses on her unit:

Any time I cover for people I try to make an effort to go into that room … they don’t have to call me … We do morning rounds together [the staff RNs] which is awesome. You go into each patient’s room, so even if you’re not assigned them that day you’re like “hey Mr. So-and-so, I had you a week ago, how’s things?” (R6-401).

Another feature of these shared relationships with patients is the lack of sustainability. No matter what degree of relational intensity that is achieved there seems to be the potential for the relationship to be time limited, ending with the completion of a shift (or series of sequential shifts). Unlike discussions with ACNPs, staff nurses do not describe conscious termination of relationships with patients and though some staff RNs discuss seeing patients when they are not caring for them, there is no sense that a relationship that might have been established continues. It may be that sharing patients among the team contributes to a lack of sustainability of relational intensity in staff RN-patient relationships.

Types of Relationships

There are three levels of relational intensity evident in staff nurse-patient relationships, similar to those described by ACNPs and physicians with patients. The major difference in staff nurse-patient relationships is the focus on meeting patients’ immediate needs and how that impacts upon the intensity of nurses’ relationships with patients. This relational focus is similar to the disease management focus of physician-patient relationships. Though staff RNs occasionally use ‘connection’ to describe some of their relationships, how they discuss such relationships in terms of their nature, focus and intensity differs from those described by ACNPs. Staff nurses describe their ‘connected’ relationship in more superficial terms with respect to
mutual self disclosure and interactions. Judy offers an example that differentiates a clinical from a more personal level of relational intensity with patients:

There are some patients that you click with straight away and that you have … very good rapport with, like from the get go when they first come in and see you. And then there are other times that you just don’t click with a patient and … you have to work at those relationships and I think also admit to yourself well if this isn’t working then maybe I shouldn’t be looking after this patient (R3-33).

Judy, in this one example, alludes to the three kinds of relationships that are possible. Each can be described from the staff RN perspective.

The first type of relationship is common to ACNP, physician and staff RN relationships with patients; the clinical relationship. A clinical relationship is characterized by minimal relational intensity and can be a result of incongruent expectations between a nurse and a patient, when the nurse does not have time to spend with a patient or when one or both of the readiness conditions (patient has needs, staff RN perceives patient’s openness to a relationship) are not met. Judy offers an example of incongruent expectations between herself and some patients:

They want things, they think that they’re the only patient and they want to be seen as soon as they come in the door and get preferential treatment. I find sometimes that very hard to cope with because all patients should be treated as equal (R3-149).

Staff nurses also recognize that they, on occasion, do not meet the expectations of patients which may contribute to a patient’s lack of openness to establish relationships with nurses. Karen offers an example of how she doesn’t measure up to patients’ expectations at times: “It doesn’t matter the information you give them, it’s like they’re not hearing you and they’re asking so many different people the same question to somewhat test you or just to get the answer they want” (R5-512). Raj provides a more personal example, describing his experience with a patient who did not wish him to care for her because of his race: “She was angry with me and then she didn’t want me as a nurse looking after her” (R2-373). Raj was unable to build a relationship with this patient and subsequently had his assignment changed but the incident was upsetting for him and he found it difficult.

Nurses describe clinical relationships that evolve because the patient does not behave as the nurse expects he or she should. However, if the nurse does not meet the expectations of the patient, the nurse may recognise that a superficial involvement has occurred despite attempts to build a relationship with the patient. Patients may ignore the nurse or treat them disrespectfully. For example, Amber recalls a behaviour that signaled a superficial, clinical involvement: “He won’t look at you. Not that eye contact is for everybody” (R6-217).
Staff RNs suggest that the low relational intensity of the clinical relationship results in characteristic behaviour during interactions with patients. Nurses describe their behaviour as polite and formal. It would appear that this type of rapport is an attempt to erect a barrier between themselves and the patient. Nicki offers an example: “I find that when I … am not getting along with a patient I become very formal, “yes sir”, you know … it’s just an automatic response … I … depersonalize myself in a sense” (R4-346/354). Amber offers her perspective: 

I don’t offer anything so it’s not a cold relationship … I go in and I’m like “hey Mr. so and so”. You know, I’m still nice but it ends there. And I find I’m fake but I’m very civil. (R6-189).

A clinical relationship reflects a low level of relational intensity and is a result of unfulfilled readiness conditions such as lack of congruency between expectations of patients and staff RNs with respect to involvement, resulting in interactions that strictly address the physical needs of the patient and nothing more.

A more comfortable and typical relationship is one that reflects a moderate level of relational intensity and is a professional relationship. This is the most common staff RN-patient relationship. Professional staff nurse-patient relationships are characterized by friendly interactions and a comfortable rapport when spending time in one another’s company. Judy describes the relationship she has with most of the patients for whom she cares: “I’d like to think I’m an easy going person and that I do get on with most people” (R3-201).

Nurses speak of the friendliness of professional staff nurse-patient relationship. For example, when asked what she thinks patients are looking for in a relationship with her as a nurse, Karen responded: “That friendship, humour side of things” (R5-504). Nurses do, however, recognize that these relationships are not the same as friendships they have in their personal lives. Judy describes a situation that illustrates her understanding of the boundaries inherent in nurse-patient relationships:

Friendship … I don’t think it’s the deep meaningful relationship that you would have with your spouse or your family members. But I don’t think it’s a superficial relationship either um I think it’s sort of in between (R3-413/417).

Nurses describe this level of relational intensity as typical and they can recognize when it is achieved by how patients behave towards them. The comfortable rapport is also reflected in content of the interaction. Karen describes how she recognizes professional involvement:

When that rapport develops, trust … happens so that they feel that you are being completely honest and open with them. The communication, open communication and feeling like you’re making a difference … I’m making a difference and I’m providing
them this support that they need and information that they need. And that they feel completely comfortable (R5-4).

Nicki has a similar perspective although she tends to use the behavioural cues of patients:

It is because it’s almost instinctual that you’re able to pick up … the subtleties … from a patient. The eye contact is really important. If somebody is willing to communicate with you they will make eye contact. If somebody turns away and doesn’t look at you, they’re not ready to discuss anything with you (R4-142).

Staff nurse-patient relationships that reflect a moderate level of relational intensity are considered typical professional relationships. These relationships are comfortable, friendly and are seen by staff nurses as allowing them to remain focused on meeting patients’ needs.

The third and final type of relationship is also rare and is characterized by slightly more relational intensity, namely a more personal staff nurse-patient relationship. Relationships reflecting this degree of relational intensity are more intense than those of physicians but less than can be achieved by ACNPs. This level of intensity eventuates when patients have significant and serious needs necessitating that a nurse spend a great deal of time with them. Nicki describes a patient with whom she felt personally involved:

She needed a lot of a lot of care … you were in there for 3 hours straight … I catered to everything that she wanted and needed and I was, I felt really glad because I was able to connect with her and I was able to provide her with the care, the exemplary care that I would want for my family member (R4-66-78).

Nicki describes feeling very close to this patient and the time she had to spend with her influenced the relational intensity achieved.

Another characteristic of a personal staff nurse-patient relationship is a sense of increased self-disclosure. Both patient and nurse feel a sense of comfort with the other and are open to sharing things they might have in common with one another. Nicki offers an example that reflects this sense of mutuality and she specifically labels the phenomenon: “It’s a mutual kind of bond that exists between [us], when I walk into the room” (R4-114).

Karen recalls a patient with whom she has spent significant time and, as well, with whom she shares an enjoyment of particular hobby:

I would be her friend if I wasn’t her nurse so … you have to do that division a little bit, I think, to ensure that you are being a health care professional … because I like her so well as a person I would just be, I mean I am her friend as a nurse. But I think that we could be friends even if I wasn’t in this role … Well there’s some little things that you’ll share with patients like for example she cross stitches and so do I. (R5-96/100/136).
Unlike clinical and professional relationships, nurses do not describe clear indicators that confirm personal involvement has been achieved. From nurses’ perspectives, they are able to identify how they feel about the patient and thus a positive rapport that is similar to one that occurs with a friend can be inferred.

Such personal nurse-patient relationships appear to occur rarely in the careers of nurses. Though such relationships are clearly important and meaningful for nurses, the relationships continue to be focused on meeting the needs of the patient in the here and now. They reflect a higher level of relational intensity, characterized by some mutual self-disclosure and a sense of closeness not experienced in more typical professional relationships.

**Dimensions of Staff RN-Patient Relationship**

Relationships between staff nurses and patients reflect varying levels of intensity; clinical relationships are characterized by low relational intensity, professional relationships are moderately intense and personal relationships with patients are reflect the most relational intensity that can be achieved in a staff nurse-patient relationship. Variation in relational intensity is influenced by two dimensions; the ideal versus reality of the relationship and what patients needs (Table 11). Each of these dimensions would seem to vary independently but may also influence elements inherent in the other dimension. Each dimension is discussed in detail in the following section.

**Table 11. Dimensions of Meeting Patients’ Needs**

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<th>Clinical Relationship</th>
<th>Professional Involvement</th>
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<td><strong>Real versus Ideal</strong></td>
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<td>Minimal contact, reduced emotional availability, uncomfortable with the other</td>
<td>Some time spent with patient, emotionally available, some evidence of continuity, comfortable with the other</td>
<td>Able to spend time, emotionally available (“give 110%), perceived continuity of care achieved, feelings of closeness</td>
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<td><strong>What Patients Need</strong></td>
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<tr>
<td>Minimal or low priority needs, RN spends minimal time with patient</td>
<td>Moderately acute needs, RN spends time regularly with patient</td>
<td>Significant needs (i.e., life threatening, time-intensive) dictate that RN spend regular and/or long blocks of time with patient</td>
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**Ideal versus Real**

The first dimension that influences the intensity of relationships nurses establish with patients is what staff RNs know to be an ideal relationship versus the relationship viewed as
feasible in reality. Nurses comment upon the ideal relationship as one that is holistic and comprehensively addresses patients’ needs, similar to the therapeutic relationship that they recall learning about during their nursing education. Nicki explains her perspective on this dimension:

In nursing school we’ve been taught, you know, maintain the holistic approach you know it’s not just physical it’s mental, it’s emotional, it’s spiritual. We have to connect on all those lines and we, we often don’t. We’re just doing the task, we’re task orienting ourselves (R4-29).

Nurses acknowledge that being able to sit with patients and learn who they are as people enhances the chances of building an effective relationship. However, staff nurses consistently describe constraints that prevent them from becoming involved with patients in a way that would allow them to develop the kind of close, personal nurse-patient relationships they’d like. There are three elements that contribute to the ideal vs. real relationship dimension; time, emotional availability and continuity.

Time is by far the most commonly discussed element of this dimension. Nurses see spending time with patients as essential to the development of good relationships with them. Nicki discusses the importance of time as she develops relationships with patients:

It depends on the day. On the weekend maybe when there’s not a lot of tests and there’s not a lot of orders being written you can spend some time with patients and really get to know them. And I work a lot of the weekends so I’m able to see them a little bit more on a different level you know than I would on a weekday. Weekdays are just push, push, push, and you do the work and you can barely get your work done. Weekends are a little bit lighter that way (R4-38).

The element of time is influenced by patient variables (e.g., length of stay, frequency of re-admission, time required to meet patients’ needs), system variables (e.g., unit staffing, shift length, cumulative needs of the patients on a nurse’s caseload, nursing assignments) and nurse variables (e.g., time management ability). Nicki describes her level of comfort with a patient who she had come to know over a number of admissions:

She had come in several times on routine, a few admissions so that’s how I got to know her. And a lot of these patients on the floor you get to know over time because they come in for the same illness … so that’s how you get to maintain a relationship with them (R4-86/90).

With respect to system variables, Raj describes the challenges he faces when trying to address all the needs of patients:

Sometimes it can be difficult … to know the patient. You like to know their problems and … there’s so much, so many things that … you want to do for them and you don’t have time to explore and find out (R2-309).

Nicki suggests that system issues, such as workload, impact her ability to establish an ideal
relationship a patient: “I haven’t really had too much time to talk to Mrs. Roma because … right now … we are dealing with some very, very heavy patients [and its] physically hard for us to manage” (R4-306). Raj concurs, describing how shift length impacts upon his ability to spend time with patients:

I didn’t have time to talk to him … I had him two days in a row but those were like 8 hour shifts and there’s so much you have to do in 8 hour shifts so you don’t really have time to sit with patients and talk to them. (R2-269).

With respect to staffing, Amber recalls her days as a student and a personal involvement she had with a particular patient: “I knew her better because I didn’t take a full patient load because I was a student” (R6-141).

Nurse variables, such as time management abilities are also influential. Nicki shares her concern that she may not be spending enough time with patients when they are in need: “They have their time, their moment, their window of opportunity to connect with you and I’m running away trying to get to my other stuff that needs to be done” (R4-50). Nicki is concerned that juggling the needs of many patients potentially compromises the involvement she can have with them.

Nurses consistently identify taking time to sit with patients as a significant indicator of ideal relationships being established with patients. Being able to sit down with patients indicates that there is enough time and that the patient, nurse and system variables are balanced and under control. Nurses feel that their inability to sit with patients negatively influences their ability to develop an ideal relationship with patients. Nicki explains:

Just sitting with a patient and for us to take that time to sit with patients. I think some of the times we miss the boat on these patients because we don’t have the time to sit with them and let them, allow them to express themselves (R4-25).

The time a nurse has to spend with a patient is an important element contributing to establishment of an ideal relationship and ultimately the degree of relational intensity between nurse and patient. In an ideal world, patient, nurse and system variables would be well balanced, allowing nurses opportunities to spend time with patients and build effective, mutually satisfying relationships.

A second factor affecting the ideal vs. reality of staff RN – patient relationships is nurses’ emotional availability to patients. Nicki describes this factor:

How I’m feeling that day. If I’m feeling like I need to give 110% I will and there are sometimes when I’m not able to give that because I can barely replenish myself. And that’s when I, I have to just for my own sanity, for my own … I give at home, I give at
work, I give, give, give and sometimes I can’t give all the time … if I’m not rested … if I’m rushed, those are my key factors that’ll affect how well I give care (R4-254/258).

Nurses acknowledge that they are human beings with lives away from work which sometimes influences how they function at work. As Nicki recalls, if she is tired, she knows she is not at her best and this will likely influence her relationships with patients. When a nurse is feeling well and things are going smoothly, she is able to offer all of herself, “give 110%”. This state of mind is essential to achieve the ideal relationship with a patient. Raj describes an occasion when he offered to do a little more for a patient who was particularly unwell and with whom he had developed a relationship that reflects personal level of relational intensity. “I asked him, I said: “do you want to eat anything from downstairs I’ll just go and grab it for you, you know, if you want … something else? If you don’t like anything on the tray just let me know” ” (R2-137).

If nurses are experiencing stress, fatigue or if the system, nurse and patient variables discussed earlier are unbalanced, their response may be to become emotionally unavailable. While the nurse may be less available, it is clear that their output never drops to zero. Amber describes how she copes with patient demands in a lower output state: “They’ll ask for things and you really have to set limits because you don’t have a lot of time, like to do the extras unless you plan it” (R6-149). Amber describes the atmosphere on her unit when demands exceed what nurses have to offer emotionally:

You’re so stressed out … this floor is just ridiculous and … you hear a lot of nurses of course … [complaining], bickering. Not bickering amongst [themselves] but just, “oh, this was such a heavy day”. And “doctors this” and “orders that” and you know “oh this appointment was pushed back and I’m dealing with the family” and it gets stressful a lot” (R6-133/137).

No matter what their levels of emotional availability, nurses indicate they are satisfied with their work but recognize the effort that it requires. As Nicki confides: “Actually, at the end of the day you feel like you’ve just given all, you’re spent physically, emotionally” (R4-446).

Emotional availability intersects with time in the context of the ideal versus real nurse-patient relationship. When time is in short supply, the ability to give of oneself can be reduced. Nurses’ discussions suggest that emotional availability is on a continuum. Reduced availability can negatively affect relationships and greater availability may positively influence relationship development with patients.

A final factor inherent in the ideal vs. real relationship is continuity. Continuity, in this context, is characterized by the number of shifts a nurse is scheduled to care for a particular
patient, the number of encounters with a patient or the duration of the shift. Nurses consider caring for a patient who has many needs, over a longer shift (i.e., 12 hours) and over a longer stretch of sequential days, as good continuity, offering opportunities to attain a level of involvement that more closely approximates the ideal relationship with a patient. Raj recalls a situation that emphasizes the importance of continuity: “I had a patient … and I took care of him for 3 straight days, 3 shifts” (R2-53). In contrast, when asked if he knew a particular patient well, Raj’s comments reflect a perception of poor continuity: “Not really, no. … [I looked after him for] two days yeah just two days yeah” (R2-253/257). Amber feels that working with a patient for a three-day stretch has a positive influence on her relationship with the patient:

If you’re on three days in a row they like to assign you to the same … patients so the first day is kind of the getting to know you. And then the second day is, okay I know your routine (R6-145).

Staff nurse participants most often describe a lack of continuity. Raj explains:

Continuity of care is not there because every time you come in you have like different assignments and different patients and, you know, one day you could have one assignment and the next day you could have a different one. So it’s difficult (R2-289).

So, in an ideal relationship, nurses would have time to spend with patients and variables related to the nurse, patient and system would be well balanced to allow this to be realistic. Nurses’ emotional availability to patients is a second element that is deemed important in achieving the ideal relationship. A final element, continuity, is manifested as caring for the same patient over longer periods of time. If a nurse is able to achieve continuity of care, there is a greater potential for an ideal relationship to develop. Each of these elements; time, emotional availability and continuity; influences the achievement of an ideal nurse-patient relationship.

What Patients Need

Recalling that the central focus of the staff RN – patient relationship is to meet patients’ needs, the number and type of needs influence the level of relational intensity achieved. Patients’ needs vary by number, type (e.g., physical, psychological), intensity (e.g., life threatening, chronic) and time required to address them (e.g., patient in isolation). Generally speaking, the more life-threatening the disease, the more significant the physical needs of a patient, the more time required to address those needs and the greater the likelihood that the nurse will develop a more intense relationship with the patient. Karen shares an anecdote reflecting the close relationship she developed with a patient who had ongoing needs and with whom she interacted frequently:
I had to keep in touch with her quite frequently and it’s just sort of continued like that. So that’s sort of how it’s evolved [good relationship]. But from early on, I don’t know, it’s hard to describe exactly how to define when you can tell you click with somebody. Just the comfort and the smile and the, you know, questions that they ask (R5-116)

Nicki recalls a patient whose needs necessitated that she remain in the patient’s room for an extended period of time:

I took care of a lady who, uh, she was dying. She was absolutely total care. She needed a lot of a lot of care and in your 6-patient assignment you had her and when you were in that room you had her completely to yourself … All your other patients had to wait unfortunately and I remember connecting with her because somehow I felt I really needed to be there for her (R4-66/69).

Nurses assess the significance and severity of patients’ needs and then plan their work for the day. Some needs they identify as time sensitive and others less so. Amber describes her thinking about significance of needs:

Somebody that needs assistance to go to the washroom versus somebody that … has an IV going and another one [patient] … [there’s] blood’s hanging … this [a patient’s specific request] wasn’t a number one priority (R6-17).

If there is potential for complications or if a patient’s needs require more of the nurse’s attention, they must be taken into account in planning the use of one’s time. Nicki suggests that she might choose to take a risk that all will remain calm with other patients in her care so that she might spend time with a patient whom she perceives needs her immediate attention:

Sometimes I give up what I have to do and hope for the best and just spend the time with the patient because I feel it’s my inner sense, my instincts are I read I go by them and if I feel that someone really needs me at that moment I’ll try and drop everything even though it’s something that’s urgent you know it depends (R4-302).

The perceived nature and intensity of patients’ needs contribute to a dimension that influences the relational intensity that develops between nurses and patients. Discussions with staff nurses reflect variability in patient need in terms of number, intensity and time required to address them. The greater the intensity, number and amount of time required, the greater the chance of developing a more involved relationship.

**Readiness Conditions for Meeting Patients’ Needs**

Two readiness conditions become apparent when analyzing staff RN-patient relationships; patients have needs and staff nurses’ perceptions that patients are open to developing a relationship with them.
Patients who require health services in an acute care setting have some needs that are addressed exclusively by nurses. Nicki, a nurse caring for patients on an in-patient unit, provides an example: “I took care of a lady who, uh, she was dying. She was absolutely total care” (R4-66). Staff RNs describe their relationships in the context of the care the patient requires. If patients do not require nursing care, there would be no relationship. Subsequently, if a patient no longer requires nursing care, the relationship ends. One nurse, Karen, speaks about the needs of a patient changing and how it results in the termination of the relationship:

[You] spend time with these people preparing them for something and then they’re not a candidate, that’s a very hard thing. And then to some degree that relationship ends. Whereas if they get the news that they are … [a candidate for the procedure] then that relationship continues (R5-320).

There is no relationship between a patient and a nurse if the patient has no need of nursing care. They come into the acute care environment because they have a disease that results in needs that are addressed by staff RNs. Once those needs are addressed, there is no further need for staff RN-patient involvement.

Perceived Patient Openness

As discussed in relation to ACNP-patient relationships, staff nurses describe the development of their relationships with patients as dependent upon their sense that patients are open to establishing a relationship with them as a nurse. Staff RN participants offered a variety of ways they assess patients’ openness for a relationship with them. Patients may express their desire for a different nurse to care for them (R2), they may appear to reject help from the nurse (R5, R6), or they may appear angered by their requirement for nursing care (R4). A perceived lack of openness to a relationship on the patient’s part requires staff nurses to: “work at those relationships” with patients (R3-33), indicating a feedback loop that is reflected in the sub-theory (Figure 6). Staff RNs claim they rarely perceive a lack of openness for a relationship between themselves and patients.

In contrast, patients are perceived to be open to a relationship with a staff RN when behaviours, such as making eye contact and responding positively to the staff RN, are exhibited. One RN, Nicki, describes her assessment of this readiness condition: “The patients’ … eye contact with me, they soften when I enter their room, they’re glad to see me, I’m glad to see them … they tell me ‘oh I’m so glad you’re my nurse today’” (R4-114). Staff RNs take note of patient’s level of comfort with them, their openness in sharing their feelings, fears and concerns
and their readiness to ask questions about their care. All these behaviours indicate a patient’s readiness to establish a relationship with the nurse.

There are two readiness conditions that must be fulfilled for a relationship to be developed between staff nurses and patients; patients have needs and perceived patient openness to a relationship. If one or both are not met, a clinical relationship results and no significant relational intensity will develop between staff RN and patient. These readiness conditions set the stage for the use of strategies by staff RNs to become involved with patients.

Relational Strategies Used by Staff Nurses in Meeting Patients’ Needs

During discussions with staff RNs about their relationships with patients, six strategies emerge as relevant in relationship development. Staff RNs, to initiate, establish and maintain relationships with patients, use these strategies on a regular basis.

Humour

Humour emerges as a commonly used strategy in staff RN-patient relationships. Humour serves a variety of purposes. Many nurses use humour to establish early rapport. Amber says: “I start with humour, that’s totally how I form things” (R6-425). Nicki comments that she uses humour as she attempts to improve the rapport she has with a patient:

[I was] able to make up the headway and … I was able to start joking with him a bit too … So as he got to know me a bit more and I was able to be kind with him and lighten up with him and sort of maintain that threshold with him (R4-398/402).

Amber explains that she commonly uses humour when she does not know a patient well, using it to defuse a situation that might have led to conflict, a less than satisfactory relationship with the patient and compromised rapport:

I said “hey this is Amber ... Room 102 needs a TV. This is an emergency situation. The hockey game is on tonight”. And then they all started laughing and the guy was up for the TV so he [the patient] was happy because I said “okay, this is what I can take care of” and it happened so then that’s how I formed that relationship (R6-453).

Humour is also used to alter the context in which a patient and nurse find themselves. Karen describes using humour as a way of distracting patients from the intensity of the situation: “I find their humour is very important and laughter and you know the sort of joking about the things that a little bit of that sometimes if you didn’t laugh you’d cry? (R5-120). Nicki uses humour to reduce the intensity of a situation: “A lot of times most of them are very receptive to humour you know. They’re going through a hard time but they need, they still need to feel vital
and alive and to [be] part of life” (R4-422). Judy finds that humour is effective in making the uncomfortable more comfortable, allowing issues that are bothering patients to be addressed:

Some of the patients joke about it [sexuality issues] which is fine, you know, you can joke back with them but the underlying thing … [is] yes, there it is an issue with some patients. And maybe with them joking they can get that issue out (R3-509).

Nicki suggests that humour is inherent in her approach with patients: “I think humour is very important in caring for people. I think people need to laugh. They need to laugh within their heart and their soul” (R4-406). Safe sources of humour that are easy to use include current events and entertainment interests. Nicki elaborates:

Maybe what’s happened on the news or maybe what’s been, you know, just outside of the world, outside of what’s going on in here … they like that because then I can relate to them. If I can touch their world outside of the hospital in whether it be, their family or … the recent movie, light conversation is important you know you can’t always be deep with your patients (R4-426/430).

Staff nurses describe two specific types of humour; sarcasm and black humour. When considering the use of sarcasm, Amber discusses how she carefully considers the patient and the situation before she chooses to use it with patients:

I’m picky and choosy with my sarcasm. Like, he’s an older fellow so I’m not, like, because I don’t want him to perceive me the wrong way? Sometimes it’s hard to read sarcasm. It’s a funny form of humour; it’s actually the lowest form of humour on the block (R6-413).

Nurses discuss the prevalence of black humour in their practice and specifically in their interactions with patients. Given the seriousness of patients’ conditions, humour that is introduced may actually be considered black but its intent is to humanize the interaction and the situation. Nicki provides an example:

In health care we … have a little bit of black humour that comes into things. So you know when you think about well how can you joke about something like a … [life saving procedure]? But there are things that do cause people to, you know, laugh (R4-124).

Staff nurse participants are clear about the importance of humour in their interactions with patients. They use it to initiate rapport, de-escalate potential conflict, diminish the intensity of a serious situation, distract patients from the seriousness of their conditions and generally reach out to patients in a way that they see as more humane. They consider humour and laughter as an easy way to establish relationships with patients.
Patient Self-Disclosure

Since patient needs are the drivers of staff RN-patient relationships, encouraging patients to disclose information about themselves is essential to nurses as they seek to understand their needs. Therefore, it is not surprising that, from nurses’ perspectives, this is an important strategy in developing their relationships with patients. Raj describes what he understands patient disclosure to be: “They open up and they talk about, you know, their lives” (R2-5/25).

Encouraging patients to share their perspectives can be difficult and nurses speak about their efforts to ‘break through’ as they develop their relationships with them. Nicki discusses her efforts to work with patients, getting to the point where they will share their perspectives: “A lot of times patients … hold back or they have some guard and once you break that guard then they’re able to let you into their world because you know this is a big hospital and with a lot of strangers” (R4-17).

Staff nurses describe the ways they encourage patients to disclose. Amber explains:

You need to talk to them about their family or you see something on the wall like a picture, a painting, “oh who did that?” “Oh, my granddaughter” or “my daughter” … “oh where are they from?” … you … just establish a relationship (R6-33).

If a patient discloses something about themselves, this may lead to the nurse reciprocating and self-disclosing to the patient. Amber offers an example of how her self-disclosure influenced the development of a moderate level of relational intensity with a patient: “[There was] one girl that was only in here for a week. The next day, I came back she [said] … “did you watch CSI?” So she remembered, too, so I think that’s a form of connection” (R6-169).

Encouraging self-disclosure is a strategy used by staff RNs to learn more about the patient from his/her perspective, which allows them to interact with patients in a way that extends beyond their disease.

Ways of Being

Nurses’ discourses reflect the importance of their ways of being with patients. Their descriptions suggest there is a place for being professional as well as a place for being human.

Being professional involves a variety of characteristics and behaviours that staff nurses use in their professional role. Most commonly mentioned is being honest and truthful, which they believe has a positive influence on their relationships and inspires patient confidence in them. Judy explains:

I think being open and honest with a patient is the most important thing … I find if a patient asks me a fairly difficult question that I find difficult to answer I try to tell them
the truth. Because I think if you lie to a patient and they find out that relationship is just gone (R3-9).

Acting with integrity also contributes to establishing a professional image and inspiring patient confidence. Staff nurses suggest that interacting with patients in an authentic manner without having pre-conceived notions of who the patient is contributes to perceptions of integrity. Amber explains her approach: “Leaving biases at the door … whatever you got in report or if you had a bad experience with him the day before you kind have to be mature and say okay that was yesterday” (R6-5).

Another aspect of professional behaviour described by staff RNs is the need to treat patients with respect. Nurses recognize the importance of seeing the patient for who he is as a person, respecting him as a person and doing all they can to safeguard his dignity. Raj describes how he conveys respect for patients: “Other nurses … they address patients like love and honey and I don’t like those words … I’m strictly professional, you know, you have to address them by their last names” (R2-37/41).

Staff nurses also describe behaviours that convey their humanness to patients. Nicki explains: “I think patients need to feel that we’re just not working there. We need to be human with them and I think that’s a big need” (R4-98). Being human is the most multifaceted of the strategies employed by staff RNs, incorporating self-disclosure, chatting, discovering commonalities and expressing emotion.

Staff RNs describe self-disclosure as occurring in two ways; spontaneous self-disclosure and reciprocal self-disclosure in response to patient self-disclosure. Nurses are comfortable sharing occasional details about themselves, believing that this contributes positively to the relationships they establish with patients. Karen acknowledges: “there’s some little things that you’ll share with patients” (R5-136) and: “the sharing … with any patient, you know, sharing some little aspect of yourself with them (R5-144). Raj ensures he shares some personal information with patients because he believes it helps them to be comfortable with him in his role as a nurse: “I usually tell them that I’m married, I have kids and you know this is how long I’ve been married. And I have, you know, a wife who’s a nurse, she works here” (R2-17). However, there are limits to spontaneous self-disclosure by nurses, as Amber explains: I don’t like going [in] with my … I got a new car so I brought that up …. “I’m very excited” … [They ask] “What’d you do this weekend?” … “Oh, we went out you know but I don’t say … [anything] inappropriate, just very professional (R6-41).
Self-disclosure by nurses also occurs in response to patients’ self-disclosure. Staff nurses use these opportunities to share something about themselves that is relevant to something the patient has disclosed, reinforcing their shared humanness. Karen describes how she uses this approach: “They talk about something, about a grandchild or something about a niece and you can also share that experience with them so there’s a mutuality that happens there … so it makes you more human, I think, to them” (R5-148).

So self-disclosure, whether spontaneous or in response to a patient’s disclosure, is seen by staff RN participants as a strategy that humanizes them in patients’ eyes. Nurses and patients can relate to one another on a level that is not related to the patient’s disease state. For nurses, this helps to establish a relationship with patients.

Nurses consider conversation, often labeled as ‘chatting’, an important part of appearing human, a way of being that is in stark contrast to that of physicians. These light hearted interactions are intended to lift spirits, pass time and focus on topics other than the patient’s disease but it occurs in the context of meeting patients’ needs. Amber says: “I facilitate a lot of conversation” (R6-141). Judy provides a more detailed description of what is involved in chatting:

Just talking about life and their relationships with their families and their kids and or grandchildren if they’ve got grandchildren, just outside interests that they have, that makes them think that you know “there is more to what’s going on in my life at the moment” (R3-85).

Amber uses light conversation consciously, believing that patients want to talk with people while they are in hospital. She suggests that patients seem to be saying: “treat me like a human”, … don’t be afraid to go in there and talk about the hockey game” (R6-29). When nurses chat with patients they feel that they appear, even temporarily, as just another human being who is interested in the world around her/him. This puts a more human face on the nurse.

When nurses discover that they have things in common with patients, they view this as enhancing patients’ views of them as human beings as well as health care professionals. It is noteworthy that discovering commonalities is characteristic of the relationships ACNPs and physicians establish with patients but its importance as a theme is variable. In the case of staff nurse-patient relationships, Amber’s comments capture the sentiment. “You find common threads in your lives” (R6-79). These “threads” are usually discovered while chatting and as a result of patient self-disclosure. Discovering something in common with a patient may trigger reciprocal self-disclosure on the part of the nurse.
Staff nurses recall the discovery of a variety of commonalities with patients; Karen discovers a hobby she has in common with a patient, “she cross stitches and so do I” (R5-136). Being a similar age or from similar backgrounds or places of birth are other commonalities that may ultimately enhance relational intensity between nurse and patient. Amber’s experience is typical.

She asked my last name and I told her my last name and where I was from. It was one of those questions, “oh where are you from? … So I told her where I was from and … [she said] “oh my gosh, my cousin’s from there! (R6-69).

Judy recalls a patient with whom she shared a common cultural bond, which she believes allowed her to be seen as a human being as well as a professional by the patient.

[The patient is] an older Italian lady. And she … just reminds me sort of a bit of my mother … it’s nice just to sit and talk to her and talk to her about you know life in general and I am married to an Italian …So she sort of understands some of the issues that I go through being married to an Italian (R3-113/117).

Discovering commonalities increases the potential for more intense relationships between nurses and patients as there is something more between them than simply the patient’s disease and its related activities. Nicki comments on the “connection” she made with a patient who was also a nurse: “She was in the nursing profession herself and maybe I connected with her on that level but I knew as a person I needed to connect with her” (R4-70). Similarly, Raj recalls a patient with whom he established a strong involvement and who he saw as similar to himself in many ways, fostering a sense of empathy:

It’s because he was close to my age and I sort of like put myself in his position and I was you know like all those treated I was thinking about him as his diagnosis and his prognosis and you and I just thought you know what if it was me? (R2-77).

Finding things in common not only allows nurses to feel they are demonstrating their human side to patients but it also provides opportunities to establish relationships that may extend beyond patients’ disease states, seeing a patient who is also a person. Being viewed in a more human light enhances the level of comfort between nurses and patients and provides a footing for the development of a relationship that fosters effective management of the patients’ needs.

Another way that nurses appear human is showing genuine emotion. Nurses are comfortable showing emotion with patients, whether it be joy or sorrow. Karen regularly allows her emotions to show during meetings with patients:
Sometimes I get very emotional too and I will show it ... if I’m sad I’ll show it to them. So when I’m happy I do too and I think people appreciate that you know and I think they feel that that shows you care (R5-268/272).

Tears associated with discussing bad news with patients are commonly mentioned, as Judy recalls: “He just burst into tears ...I cried as well” (R3-241/249). But tears are not always associated with sad situations, as Nicki explains: “She was completely bedridden and she was so appreciative that she had tears streaming down her face. It made me cry” (R4-70).

Nurses describe showing genuine emotion to patients in response to something that is occurring in their lives but they don’t emote about their own lives to patients. Staff nurses consistently report that showing emotion for a patient’s situation is acceptable to them and contributes to their appearing human in their relationships with patients.

Ways of being, specifically being both professional and human with patients allows staff nurses to establish relationships with patients.

Acculturating

Another strategy used by nurses in their relationships with patients involves assisting them to become acculturated to the acute care hospital setting. Nurses see themselves operationalizing this strategy when they explain rules and routines, read patients’ cues and acknowledge patients’ feelings and preferences.

Staff nurses describe the importance of explaining rules and routines to patients as a way of laying the groundwork for their relationship with patients. They believe that patients appreciate understanding how things work, as they are not generally familiar with what goes on in acute care environments. Nurses view this strategy as important as it provides an orientation for patients so that they might adjust more easily to routines. Judy explains the importance of clarifying expectations:

I try and explain to them upfront and I think if you’re honest and upfront with them and tell them this is what’s going to happen, this is how long you’re going to have to wait and sort of set those ground rules to start with, that they are grateful for that. And then they sort of gravitate towards you because you’ve sort of set those rules down and guided them along the way and I think they because they are frightened when they first come. They don’t know what’s going to happen. And I know I’ve had patients come up to me and said “I was so grateful for what you did on my first visit because it really did put me at ease” (R3-61).
This strategy allows staff RNs to position themselves in the acute care context and offers a way of initiating the flow of communication between nurse and patient. This also allows them to assess whether or not the patient is ready to become involved with them as a nurse.

Reading patients’ reactions and cues is seen as essential if nurses are to prepare patients for their experiences and assist them to adjust to the environment. Nurses describe the need to get to know patients and how they indicate their needs verbally and non-verbally. Nurses who have been in practice longer describe this ability as intuitive or professional instinct. Judy describes the importance of this strategy: “You have to know your patient to know, can I go and come back or do I have to stay and sit with this patient” (R3-317). Nicki describes a specific situation when she had a feeling about a patient and what she needed from her:

I felt she needed me to back away because when somebody, when a patient is telling you “I’m okay” verbally then I think that’s my cue to say “okay. I accept that you need some space”, you know, or “you’re not ready to explore further how you’re feeling?” (R4-230).

Nicki, who has been practising for 18 years, speaks about making assumptions about a patient’s needs based upon what she knows about a patient: “I’m not so sure. I haven’t been able to, I think she wants some compassion and some warmth … I’m assuming but maybe she’s the type of person who’s generally in charge of herself” (R4-270). Nicki felt she had not spent enough time with this particular patient and was lacking confidence in her assessment of the patient’s needs but she clearly had a sense or intuition of what the patient was looking for from her. Time spent with patients seems to contribute to nurses’ ability to read patient’s cues and reading those cues contributes to their ability to effectively acculturate patients to acute care environments.

Finally, staff nurses describe their awareness that patients have preferences and they speak about their interest in these and how these impact on patients’ acculturation. However, nurses’ awareness of preferences does not always translate into their integration into the patient’s plan of care. Amber describes how she attempts to acculturate the patient while building a consensus with patients as to how to incorporate their preferences during hospitalization:

A lot of them aren’t familiar with … hospitalization … They’ve had the disease forever and they’re used to a certain regime, “this is what I do at home”, “that’s great that’s what you do at home but you’re in here now and this is what I have to follow. But maybe we can compromise here” so it’s really just about talking, just getting their perspective and then they can get ours and then we can come to a happy medium (R6-21).

The locus of control appears to remain with the staff nurse as she listens to the patient’s point of view and then identifies which of his preferences she can integrate into usual acute care routines.
but she is clear about how things work in hospitals, making efforts to educate the patient about hospital culture.

Incorporation of patient preferences may be manifested in staff nurse behaviour, such as recalling how a patient prefers care to be provided. Amber recalls: “If you remember … how they take their coffee, for example. Something simple like … “two sweeteners, one milk, right” and she’s like “yeah” and she gets a little smile, you know. So just remembering” (R6-145). Amber’s example illustrates how attending to small things can be significant to an individual and enhance the humanness of the interaction and allowing patient preferences to be respected.

In addition to patient preferences, staff nurses also see acknowledging patients’ feelings and those of their significant others as important. They see this as contributing to patient’s sense of being heard and helping them to get used to the acute care hospital environment. Karen describes how she states up front that she recognizes the impact the illness is having on the patient’s family: “I’ll say “you know this is a life altering experience for everybody not just the patient, for all of you too”. And the family feels that, yes, you know, we’re glad you recognize that” (R5-72).

Assisting patients to acculturate and adjust to the acute care hospital environment is accomplished by educating patients about the rules and routines of the hospital, endeavoring to read cues of patients that indicate their responses to specific situations, and acknowledging and making efforts to integrate patient and family preferences related into their care. Successful use of acculturation by staff nurses is seen as contributing to the development of relationships with patients, allowing them to focus on meeting patients’ needs.

Multi-tasking

A final strategy described by staff nurses with respect to their involvement with patients is multi-tasking; engaging in a variety of actions simultaneously with patients with the goal of meeting immediate needs of patients in an efficient and effective manner. When nurses multi-task, they are usually linking a social, interactive activity, such as chatting, with a task that must be completed to meet a patient’s need related to the disease. Judy offers an example:

If I’m teaching a patient, because you know you do have times to that you have to sit down and teach them about some of the technical skills that they [have] to do … it’s also a time to chat with patients about other things (R3-93/97).

Amber provides another example, suggesting that she integrates conversation about other topics that are not related to a patient’s condition: “You can ask them your central questions, your
assessment but you can incorporate … talk into it … while maintaining professionalism” (R6-33).

Nurses consistently describe the necessity for them to multi-task in order to do everything that is expected of them during a shift. Multi-tasking, however, allows staff RNs to integrate interaction with patients while accomplishing the tasks that are central to meeting patients’ needs.

Staff nurses use a variety of strategies to foster relationships with patients that will allow them to address patient needs; humour, encouraging patient self-disclosure, ensuring they behave as both a professional and a human being and multi-tasking. All of these strategies are used by nurses with the intent of establishing a relationship and becoming involved with patients to ensure their needs are met.

**Relational Products of Meeting Patients’ Needs**

Two products emerge as a result of nurses establishing professional or personal relationships with patients; perceiving a *job well done* and *making a difference* in patients’ lives. These products are a result of the relational intensity that develops between nurse and patient. If relational intensity does not progress, only a superficial clinical relationship is established and nurses may not feel that their job was well done and they may not they have made a difference. On the other end of the continuum, if relational intensity evolves to the level of a personal staff nurse-patient relationship, staff nurses experience a strong sense of accomplishment and view patient appreciation as indicative of a job well done. They also feel they have made a difference in the patient’s life. Each of these products of staff RN-patient relationships is discussed.

*A Job Well Done*

When a relationship is successfully established, staff nurses’ comments convey a sense that they have done their job well. The relationship they establish serves as a vehicle through which they meet patients’ needs. This leads to feelings of personal satisfaction, accomplishment and pride. Patients’ expressions of appreciation reinforce their belief that they have done their jobs well. Such feelings may arise when a patient is discharged after a lengthy stay or even after a single successful nurse-patient encounter. Raj describes what it is like when a patient goes home: “It’s a very rewarding job … you get so many compliments and if you see someone who’s very sick and that person gets well and goes home happy you know so it’s sort of like an achievement” (R2-349). Judy explains how it feels to have a good day with a patient: “Them
saying ‘you’ve really helped me’ today gives me a good sense of satisfaction. And I feel that I’ve done a good job” (R3-533). Such expressions substantiate the impact of their work on patients, motivating them to return the next day.

Patients’ and family members’ expressions of appreciation serve to reinforce a sense of accomplishment felt by staff RNs but they can be humbled and even embarrassed by the thanks they receive. Karen describes her perspective on patients’ expressions of appreciation:

It’s almost too much. I feel embarrassed by it. You know this is the reason that I’m here. I keep saying this to them. This is the reason I’m here, you know, I’m as happy that he … [had the procedure] as you were. So sometimes people are even overly thankful for what we’ve done. And I guess sometimes we feel like well this is why we’re here and that’s okay (R5-164).

Many patients express thanks during their stay as well as when they are discharged. Patient expressions of thanks as well as the pride nurses take in patients moving on with their lives have the effect of reinforcing their value in the health care system and motivating them to continue their work. As Amber reflects: “All of them say “thank you, thank you”, they’re really thankful … it’s good feedback for me. It makes me want to come back” (R6-125/133).

Making a Difference

Making a difference for patients with respect to their ability to cope with their disease is important to staff nurses and relates directly to the central focus of their relationships with patients, meeting patient needs. Making a difference is a by-product of the staff RN-patient relationship but a positive difference isn’t always possible. So there are two arms of this experience. The most common experience for staff RNs is making a positive difference. Karen describes what this means for her in her work with patients:

It’s very important to me to feel like I’m making a difference … that they have the information that they need to feel comfortable at whatever stage they’re at … That if they need more than what I can provide or the physician can provide in terms of social support, social work support or psych involvement, that I recognize that and I make that link too (R5-496).

Making a difference may be the provision of information, as Karen describes, but meeting physical needs and helping patients recover from acute illness is also an important focus. Nicki offers her perspective: “I want to be able to know that I can help them to get better especially when you’ve seen a patient who’s been there for so long” (R4-178). Judy concurs: “A feeling that I’ve made their life a little bit easier during their stay” (R3-529). Staff RNs strive to move patients forward towards their goals by meeting their individual needs on an hour-to-
hour basis. The end point for which nurses strive is that patients will no longer require their services as nurses. As Nicki confides: “[When] they’re going home, I’m happy for them inside because I know I want to see people get better and get out of hospital just as much as they do” (R4-170).

There are times when staff RNs believe they are unable to make the difference that they think the patient deserves and this inspires feelings of frustration, guilt, anger and sadness. Situations such as a patient’s unexpected death may result in such feelings. Raj shares his recollections of a patient’s death:

I get very upset inside … I feel I’m useless, you know. I can’t help them, you know, helpless and useless you know. You want to do something for them and it’s not under your control so you can’t do anything for them and you feel sad (R2-237).

Such feelings can stem from the sense that one is unable to meet all a patient’s needs. Judy offers an example: “I feel frustrated and also lost because I feel that I should be able to say something to them to make them feel a little bit better as a nurse and you know sometimes I can’t” (R3-345). It is certainly understandable that an inability to make the desired difference to a patient would be an unsatisfying experience for nurses whose central focus is to meet patients’ needs.

While there are times when nurses describe being unable to make the desired difference to a patient, these are few in number. In these situations, while nurses express their disappointment, descriptions of their relationships with some of these patients suggest that they did make a difference, just not to the degree that they wished. The majority of relationships described by staff nurse participants provide examples of making positive differences to patients. Making a difference and having a sense of a job well done are outcomes of relationships that allow nurses to successfully meet patients’ needs.

**Patients’ Perceptions of their Relationships with Staff RNs**

As discussed earlier, patient participants in this study shared their perspectives on relationships they have with specific care providers as well as other providers with whom they have interacted currently or in their past. Their characteristics are described earlier (see Table 7).

As discussed in chapters five and six, which address ACNP-patient and physician-patient relationships respectively, patients describe some similarities but clear differences in their relationships with various health care professionals. What follows is a summary of the key themes that emerge from discussions with patients about their relationships with staff nurses.
The main theme, central to the staff RN-patient relationship from the patient’s perspective, is that staff nurses meet my needs. What is important to patients is that nurses: “do what they have to do” (P4-303) and that includes: “exactly what … [the doctor] tells them [nurses] to do” (P4-1060) in terms of the interventions that will allow them to accomplish their goal, to move on with their lives. Sub-themes that contribute to and influence the central theme include time, nurses’ ways of being with them, interchangeability of nurses, and the perceived hierarchy of health professionals. Each theme is discussed in detail.

Central Theme: Meeting My Needs

‘Meeting my needs’ emerges from patients’ descriptions as central to staff nurse-patient relationships, suggesting good agreement between patients and nurses on this central theme. Mr. Lang’s description of the ideal nurse illustrates this central theme:

The ideal nurse, they, to me, don’t forget your patients no matter what they’ve got to do. They some how, some way they’ll fit their paperwork or computer work in between even if they’ve got to stay late but they always make sure their patients’ needs are met (P6-53).

When patients are asked about their relationships with staff RNs, their initial comments reflect their confidence and satisfaction with the care they receive from nursing staff. As Mrs. Tudor says: “I got the best treatment that I could ever have” (P1-16). They are confident that nurses are competent to meet their varied needs. Mr. Kean recalls: “He [nurse Raj] certainly knew what he was doing” (P2-910). The central theme of meeting patient needs is also evident in Mr. Trip’s experience with some nurses who he thought were not as focused on his needs as he’d hoped. He describes how he recalls their response to him: “There would be certain things and they’d just, would say yeah, yeah, yeah and they wouldn’t, you know they wouldn’t do it” (P5-245). Mr. Trip’s descriptions reflect a compromised relationship with nurses who he perceived as not following through with care they had promised to provide.

Patients are able to identify a variety of needs that require nursing attention while they are hospitalized and while they require outpatient services. Their needs might be related to activities of daily living such as hygiene or sleep (P6, P5) or they may be disease related. Patients place a great deal of importance on having needs addressed that have an impact on their well being from a disease perspective. Such needs include vital sign monitoring (P2), administering medications in a timely fashion (P1, P2, P4), wound management (P5) and ensuring bloodwork is taken and reported to the medical team (P3).
It is apparent that if patients perceive that a nurse is meeting their needs effectively, then nurses meet their own expectations of the relationship and it is satisfactory. When patients are asked if nurses could have done anything differently with them, patients generally expressed satisfaction. Nurses generally met and occasionally exceeded expectations. For example, Mr. Kean recalls what a particular nurse did for him: “If you needed something you had it right away. There wasn’t any waiting period … he did everything right at the moment” (P2-790).

Patients also recognize that all patients have needs and that nurses are attempting to see to them all. Mr. Parker describes how he sees his needs in relation to those attending the same clinic: “There’s always people that are worse than me, I think … that they need their attention more” (P3-97). When asked how he feels when nurses must spend more time with others, he replies: “It’s probably uplifting for me because I see somebody that’s worse off than I am” (P3-105). Patients are generous in their understanding of the plight of the ‘busy nurse’. They assume that other patients are in more need than they and understand why they are receiving less attention. The fact that nurses are spending more time with others seems to make patients feel that they are not as sick as they could be.

There appears to be a limited range of relational intensity evident in discussions with patients about their relationships with nurses and patients do not express any discomfort with this fact. Typical relationships with staff nurses are described as cordial and pleasant. Such relationships meet patients’ expectations and are described as “okay” or fine. However, if a patient had experienced a more involved relationship with a nurse in the past, another nurse might suffer by comparison. Mr. Trip offers an example: “When she [more involved nurse] wasn’t on, then somebody else would be there and that …[nurse] was kind of, she was okay … She wouldn’t give me some interaction” (P5-397). In low intensity relationships the interactions are very needs-focused, as explained by Mrs. Roma: “Just kind of ignore them, you know, just let them do, let them do what they have to do and they’ll do it” (P4-391). Mrs. Roma notes a difference in how some nurses interact with her, noting that some are more distant and focused almost exclusively on the tasks at hand.

Less common is a higher intensity relationship that offers patients more involvement with staff RNs. More interaction, conversation and usually some mutual sharing of information about one another characterize this type of relationship between a patient and a nurse. Mr. Trip gives an example of one nurse who cared for him with whom he describes increased relational intensity:
This is just a regular nurse, best nurse I ever had. This lady was amazing” (P5-337). She goes “this is my patient and I’m taking care of him … If he doesn’t want to do anything then don’t force him to do it. And if you’re going to keep forcing him to do it I want you to leave and go back up[stairs]” (P5-361).

Mr. Trip feels that the nurse cares about him and advocated for him with another professional. He feels she understood him and was truly meeting his needs at that time.

Patients are not always sure if nurses are open to more intense relationships. Mrs. Roma discusses how she assesses nurses’ willingness to become more involved with her. She asks nurses a few questions: “If they if they open up … sometimes I get personal and say “how many kids do you have” or … if they’re older then where they go [on vacation] and stuff. Like I get into topics like that … it depends on the nurses too” (P4-373). Mrs. Roma even feels that you might be able to develop a friendship-type relationship with some nurses: “Maybe you could get a friendship with a nurse rather than a practitioner [ACNP]” (P4-1176). But not all patients feel comfortable reaching out to nurses in this way. In fact, Mr. Lang says: “Well I wouldn’t ask anything personal” (P6-85).

Patients feel that when they have a more intense involvement with a nurse, their needs are met in a more personal and individualized way and this has a positive impact on how they feel about their acute care experience. Mr. Trip said of one nurse with whom he had a special relationship even though she only cared for him for 2 days, “It was like she made me feel sort of uplifted” (P5-405). Mr. Lang recalls a nurse who knew that his physiotherapy was important to him and would help him with this on the weekends: “When Amber’s on she’ll volunteer some of her time to come and help me exercise my legs … I appreciate that more … because I want to get well, you know” (P6-93/105). Conversations between patients and nurses were different when there were higher levels of relational intensity. They would talk longer and about issues other than the patients’ needs or disease. Mr. Kean offers an example: “We talked, sure, back and forth. I asked him where he came from and he told me and told me how many kids he had and that kind of thing. And we commented on things that were on television” (P2-810).

Patients know that to move on with their lives, their acute health needs must be addressed and nurses have responsibility for meeting many of those needs. Therefore, it is not surprising that meeting patient needs is the central theme of the relationship with nurses for patients. Patients are generally satisfied with their relationships with nurses if they meet their expectations, mainly to meet their needs. Their descriptions reflect a small range of relational intensity in the involvement they have with nurses. While a patient can establish stronger
involvement with some nurses, this is not typical. Most relationships are comfortable, cordial
and “okay” as long as their needs are being addressed to their satisfaction.

*Sub-themes: Time, Ways of Being, Interchangeability and Hierarchy*

In addition to the central theme of meeting my needs, the analysis of patient participant
interview data yielded four sub-themes; time, nurses’ ways of being, interchangeability of nurses
and hierarchy; each of which influence staff nurse-patient relationships. Each of these themes is
discussed as it relates to the central theme.

**Time**

Patients’ comments suggest that time contributes to the relationship that they have with
nurses in a variety of ways. When a patient has multiple contacts with the acute care setting over
time, nurses may come to know patients. For example, Mrs. Roma, who has been hospitalized
on the same hospital unit many times, says: “When they see me now they recognize me. “Are
you in again?”” (P4-351). Patients acknowledge that knowing a nurse over many days during a
single episode of illness, whether as an in-patient or outpatient, can positively influence the level
of intensity of the relationship. Mr. Trip suggests that this is the case: “I guess time would be a
factor, time spent with that person” (P5-621) and Mr. Parker reflects on his level of comfort with
a nurse whom he has known for several years as an outpatient: “I know her quite well now, I
mean obviously over a period of time … I’ve gone there a long time” (P3-69).

By far, the most discussed time-related factor with respect to patients’ relationships with
nurses is their busyness. Patients see nurses as busy and they attribute their busyness to needs-
related activity in the patient care environment. Mr. Parker recalls: “The nurses are busy.
There’s a lot of people down there so we wait a long time so” (P3-93). When asked how they
recognize that nurses are busy, Mrs. Tudor recounts: “I asked her, “How is your day?” “Oh, so
busy. We’ve got a new admission, the doctor’s in here, giving reports”, you know, things like
that” (P1-49). Mr. Kean also notes behaviour that he interprets as busyness: “He was busy …
everything was on the fly. He … had a lot of people to look after and he was just going, going,
going, the whole time” (P2-786/790). Patients also recognize that nurses’ busyness may impact
upon how their own needs are met. Mrs. Roma recalls: “Sometimes they’re busy, too, so they
can’t give you the attention you need” (P4-431).

From the perspective of the patient participants in this study, time influences the
relationship they have with nurses. Knowing a nurse over time can result in greater relational
intensity between patient and nurse. Time restrictions, exemplified by what patients refer to as busyness, have a potentially negative impact on nurses’ ability to meet the needs of patients and develop a more involved relationship.

Ways of Being

Patients see nurses as being with them in a variety of ways and often the way of being is unique to the nurse. Many nurses are described as beginning their encounters with patients by introducing themselves or reminding patients of who they are if they had met previously. Mrs. Tudor recalls the common introduction. “I’m your nurse tonight. If you need some help, I’ll be your nurse” (P1-51).

A lighthearted approach is another way of being, nurses with patients. This lightheartedness is often characterized by humour and informal conversation. Mrs. Roma explains that she likes to have humour between herself and nurses and cultivates that if she can: “I like, I like joking … Joking around so they you know I might joke around and they, I say “I’m only joking” kind of thing (P4-339/343). In a similar vein, Mrs. Tudor recalls lighthearted discussion about something she had in common with the nurse caring for her. Chatting is mentioned by Mr. Parker as a way of being together: “We just make small talk” (P3-61).

The most common way patients notice nurses behaving with them is being informative. Nurses commonly provide patients with information: “She’ll answer my questions” (P6-189). Mr. Trip recalls a nurse who was open to his questions and concerns: “She’s very easy to talk to” (P5-505). Mr. Trip characterized that same nurse as a guide for him even though he realized that she did not have ultimate control over the path he was taking.

Patients see nurses as being with them in a variety of ways, which contributes to nurses’ ability to meet their needs in the context of a comfortable relationship. Nurses initiate encounters with patients using introductions, are lighthearted in their use of casual conversation and humour and are informative, answering questions and providing information to patients that they perceive as helpful.

Interchangeability

Patients, while usually able to identify several nurses by name, make comments that suggest nurses are interchangeable. Some examples include: “I think they’re all the same, all equal” (P6-121); “They’re all the same” (P4-565); and “He was not unlike the other nurses who came around that did the same things was check the vital signs, fix the bed if it needed to be
fixed, do small things around the bed for you” (P2-802).

Patients’ perceived lack of continuity in nursing assignments may contribute to patients viewing nurses as interchangeable. Mr. Lang offers his perspective: “Well up until, I think it was yesterday, it’s been a long while since I’ve been a patient of Amber’s” (P6-173). Though Mr. Lang clearly appreciates Amber’s efforts in caring for him periodically, he has not seen much of her lately because other nurses have been caring for him. Mr. Kean is unable to recall any significant relationships with nurses while he was hospitalized, saying: “It was different nurses everyday in hospital” (P3-113). And Mr. Trip suggests that lack of continuity contributed to his needs not being consistently met and his subsequent feelings that nurses are all the same: “[The nurse would say] “Okay Mr. Trip, … I’ll fix it for you. Just have it for today and then tomorrow” …Then it’s a different nurse” (P5-261). Mr. Trip’s recounting of this episode was fraught with frustration. He felt like no one knew him and the lack of continuity contributed to his perception that nurses were not meeting his needs.

Interchangeability is not always described in negative terms, suggesting that patients seem to trust that the majority of nurses are able to address their needs despite a lack of continuity. Given that the central theme of patients’ relationships with staff nurses is meeting their immediate needs, then it is not surprising that if staff nurses meet patient expectations, interchangeability is not problematic for patients.

Hierarchy

The theme of hierarchy emerges consistently throughout patients’ descriptions of their relationships with ACNPs, physicians and nurses. Patients view nurses as most junior in the health care professional hierarchy. ACNPs and physicians are seen as having more autonomy and control over plans of care. As Mr. Kean explains: “The level of what he [nurse] was doing was different from what she [ACNP] was doing and what she [physician] was doing” (P2-914). Mr. Trip recalls a time when he was unaware of his diagnosis and a nurse communicated her impressions to him. His recalls thinking: “You’re just the nurse, you know, like, I don’t know, I felt like, you know, like somebody that’s higher should have told me that” (P5-25). So, while patients value contributions nurses make to their care, they see them as the junior members of the health care team.

In summary, patient participant data yield themes that contribute to our understanding of the relationships that patients have with staff nurses in the acute care environment. Patients who experience acute illness have a single goal: to move on with their lives. When considering their
relationships with staff nurses, patients see staff nurses as meeting their needs. This central theme is in agreement with that described by nurses as central to their relationships with patients, meeting patients’ needs. Patients see time as having an impact upon their relationships with staff nurses who are kept busy meeting other patients’ needs, sometimes resulting in less attention for themselves. Patients recognize that staff nurses spend time being with them and do so in a variety of ways that are often unique to the nurse. Of interest is that patients see most nurses as interchangeable, albeit competent to meet their needs. Nurses tend to meet expectations that patients have for them. Finally, patients see staff nurses as the most junior in the acute care hierarchy. Nurses are seen as meeting their needs while having less autonomy and control over the plan than other members of the team. Having summarized patients’ perspectives on their relationships with staff RNs, how patients’ perspectives compare with staff nurses’ perspectives will be discussed.

**Patient and Staff RN Perspectives on their Relationships: How Do They Compare?**

When the findings of interviews with patients and staff nurses are compared, patient themes provide significant support for how nurses view their relationships with patients, making a significant contribution to the overall relationship theory generated from this study. As with other relationships explored in this study, there is good congruence between what patients and nurses convey as the central focus of staff RN-patient relationships.

Staff nurses’ descriptions reflect the importance of meeting patients’ needs and this is the central reason why nurses get involved with patients. Likewise, patients in this study expect nurses to implement plans formulated by other professionals and meet their needs related to their disease. It is clear from discussions with patients that when nurses do not meet a patient’s expectations of how a nurse should behave a strictly clinical relationship can result. If such a relationship evolves, it may be secondary to the nurse not meeting the patient’s needs as the patient sees it.

It is also interesting to note that patients do perceive potential for variation in the relational intensity in their relationships with nurses and some patients will even engage in questioning to assess a nurse’s willingness to pursue a more involved relationship. While nurses speak about engaging in reciprocal disclosure, they do not specifically describe patients asking them questions to elicit information about themselves as human beings. Self disclosure, however, is identified as a feature of being human in the staff nurse analysis. While nurses
describe sharing information that is of a more personal nature with patients in order to appear more human to them, patient participants do not perceive this happening often.

Another common feature of nurse-patient relationships acknowledged by both patients and staff nurses is informal conversation or chatting. This lighthearted communication style is seen as a way of behaving as a person as well as a nurse from the nurses’ perspective and as part of how nurses are with patients (ways of being). Both patients and nurses recognize the importance of chatting about topics that are not related to patients’ illnesses or hospitalizations.

A theme of interchangeability emerges from the patient data analysis, suggesting that patients see all nurses as capable of doing the same things for them. A lack of continuity of nurse provider appears to contribute to this patient view. Though not addressed directly, the idea that relationships with patients are shared by a group of nurses may be related. Nurses’ descriptions of their relationships with patients in their practice settings reflect a sense of sharing patients amongst a team of nurses. Again, continuity (or lack there of), which is an element of the ideal versus real relational dimension of staff nurse-patient relationships likely contributes to nurses’ perceptions of a shared relationship as well as patients’ views of nurses as interchangeable.

Time is a dominant sub-theme for patients and is a feature of the ideal versus real relational dimension of nurse-patient relationships from a staff nurse perspective. Nurses’ lack of time, or busyness, features prominently in both staff RN and patient analyses. Nurses report being kept busy as they attempt to meet all the needs of all their patients and patients are acutely aware of nurses’ busyness. Time also plays a role in the level of relational intensity that evolves in staff nurse-patient relationships from both perspectives. Finally, continuity as a feature of time, is identified by patients as contributing to the how relationships develop with staff nurses and, from a nursing point of view, it is influential and contributes to the degree to which a relationship is viewed as ideal versus real in the context of meeting patients’ needs.

Humour features prominently as a strategy nurses use to establish relationships with patients but this is not as dominant a theme for patients. Patients allude to humour, reflecting it as contributing to a lighthearted way of nurses being with patients.

Finally, hierarchy is a discrepant theme that is reflected in patient data analysis but not in that of health professionals. Staff RN data are not different and they do not suggest that hierarchy is relevant to them when considering their relationships with patients.
Overall, when themes that emerge from patient interview data analyses are compared with those from staff RN interview data analysis, there is an acceptable degree of agreement. Patients and nurses are both focused on meeting patients’ disease related needs and there is mutual recognition of varying degrees of relational intensity. Patients and nurses agree that nurses are busy, influencing the amount of time nurses spend with patients, a feature of the relationship that can negatively influence the intensity of the relationship. Continuity also emerges as a common issue as does chatting. While nurses are aware that achieving ideal relationships with patients is difficult because of a variety of factors, patients and nurses are compatible in their views that the central tenet of their relationship is meeting patients’ needs. The patient perspective lends support for the staff RN view of staff RN-patient relationships.

**Staff Nurse-Patient Relationships Summarized**

Discussions with staff nurse participants indicate that meeting patients’ needs is the theme central to staff nurse-patient relationships in acute care environments and patients concur.

Two readiness conditions; a patient has needs and a patient is open to a relationship with a nurse; must be fulfilled before a relationship of with any degree of relational intensity can be established. If the patient has minimal or no needs or if a patient, for whatever reason, appears to be disinterested in evolving a relationship with a nurse, a significant relationship will not develop.

Staff RNs may use strategies to positively influence readiness condition fulfillment as well as to evolve relationships with patients to whom they are assigned to provide care. Strategies include humour, encouraging patient self-disclosure, being professional but also human, assisting patients to become acculturated to the acute care environment and multi-tasking while caring for patients.

The relationship is situated in the ‘here and now’, emphasizing the immediacy of patients’ needs. Variation on two dimensions influences the degree of relational intensity; staff RN perceptions of achieving an ideal relationship versus what happens in reality and what the patient needs. Three kinds of relationships are evident; clinical relationships with low relational intensity, professional relationships with a moderate level of intensity and personal relationships with a higher level of relational intensity. Products of professional and personal nurse-patient relationships include the nurse’s sense of a job well done and their belief that they make a difference for patients.
Themes that emerge from the analysis of interviews with patients are consistent with those that emerge from analysis of staff nurse interviews. Having their needs met is the focus of patients’ relationships with nurses, which is acceptable to them. Clearly analysis of patient participant data validates significant portions of the staff RN-patient relationship sub-theory of the larger ACHPPR theory (Figure 6).

*Figure 6. Staff Nurse-Patient Relationship Sub-theory*
CHAPTER 8 - DISCUSSION

The intent of this study was to explore and describe the nature of relationships that ACNPs have with patients and compare and contrast those with relationships that physicians and staff nurses have with patients, using the perspectives of health professionals as well as patients themselves. Given consistent references to nurse practitioners offering ‘something different’ in the care they provide to patients (Courtney & Rice, 1997; Donohue, 1995; Sullivan, 1982) and my own clinical experience as an ACNP, I hypothesized that exploring relationships that ACNPs have with patients might illuminate some unique features of ACNP practice. While the literature is replete with empirical studies of ACNP role descriptions, models of implementation, effectiveness and satisfaction with the role, there are no studies describing ACNP-patient relationships. There are also no studies comparing the relationships that three different health professionals have with patients receiving care in acute care environments. Finally, there are very few studies that give voice to patients with respect to relationships they have with acute care health professionals.

When considering the exploration of each relationship, I anticipated that each type would have distinctive characteristics but they might also have elements in common. In the previous three chapters, each health professional-patient relationship was described in detail and graphically displayed. The person, who is the patient, is central to each relationship and processes of relationship development contribute to the theory in its entirety, explaining acute care health professional-patient relationships as specific social processes that occur in acute health care settings (Figure 7). The Acute Care Health Professional-Patient Relationship Theory, describes how each relationship is established within the acute care context and displays relational similarities and differences as well as providing the impetus for the discovery of any complementary features of relationships that each health professional establishes.

This chapter is divided into four sections. Section I provides an overview of and orientation to the Acute Care Health Professional-Patient Relationship Theory in its entirety. Section II addresses the research questions, offering a comparative discussion and analysis of ACNP-patient sub-theory, element by element, and discussion as to how it relates to the physician-patient and staff nurse-patient sub-theories. Complementary features of the three relationships will also be discussed. Empirical and non-empirical literature, as well as philosophical perspectives, is integrated throughout Section II, to demonstrate how the theory is situated in relation to current knowledge. Section III provides a discussion of the limitations of the study and section IV offers concluding comments.
It is important to acknowledge that inherent in the comparative design used in this study is a philosophical tension. It could be inferred that one type of relationship is superior to others because a comparison is being made. This is not the intention of this study. In fact, given the expectation that there would be similarities and differences across the three types of relationships, it was anticipated that this study would illuminate features of the ACNP-patient relationship that have not previously been studied and offer a theory to describe the complementary nature of ACNP – patient relationships to more traditional relationships in the context of providing care to acutely ill patients.

Section I: Overview of the Acute Care Health Professional-Patient Relationship Theory

Each of the relationships explored in this study is represented as part of a larger whole (Figure 7). Relationships between patients and health professionals occur in the context of the patient’s disease, represented in the theory as the outer sphere. In the acute care context, the individual’s disease is all encompassing and is the reason that each of these relationships is established. Within that sphere, at the very centre, is the person who has the disease and within that sphere is the person himself. There is a transition zone between the ‘clinical disease focused’ and ‘person with disease focused’ spheres that represents the opportunity for the relationship to develop. It is in this zone that readiness conditions are achieved, strategies are used, relationships with a particular focus are developed and products of the relationship result. Relational intensity varies as a result of specific dimensions that act as barometers for each relationship.

Readiness conditions must be fulfilled in order for a relationship to proceed, as represented by the intersection of the readiness condition spheres. If readiness conditions are not initially achieved, health professionals may employ strategies in an attempt to influence readiness condition status, represented by the arrow looping back from strategies towards readiness conditions in the vicinity of the outer sphere of the theory. Relational strategies may be used repeatedly and in various combinations, represented by the circular shape of the relational strategies arrow. Effectiveness of relational strategies influences the overall effectiveness and pace of relationship development. Products of each relationship are consequences of the entire relationship development process and relational intensity. These products recycle back into the relationship, potentially influencing relational intensity and sustaining the relationship. This recycling is why they are positioned on a circular arrow as well.
The relationship development process is represented by an arrow or trajectory that begins at the outer ‘clinical disease’ sphere and traverses the disease transition zone, directed towards the central sphere, the person. The proximity of the arrowhead relative to the ‘person with disease’ or the ‘person’ represents the level of relational intensity possible for each type of relationship. For example, in the staff nurse-patient relationship, the tip of the arrow just makes contact with the ‘person’ sphere but the majority of the arrowhead is in contact with the ‘person with disease’ sphere. This degree of relational intensity, labeled as a ‘professional’ relationship indicates the nurse’s interaction with the patient is in relation to the ‘person with disease’. The proximity of the arrowhead tip to the ‘person’ sphere does suggest that a nurse who establishes the rare ‘personal’ relationship makes efforts to focus on the ‘person’ but the limited focus on the ‘person’ prevents a deep understanding of the person and limits the relational intensity.

Each type of relationship has a different central focus or purpose; ACNPs focus on making a connection with patients, staff RNs focus on meeting patients’ needs and physicians focus on managing patients’ diseases. It is these foci that explain what health professionals do when they develop relationships with patients in acute care settings.

While the relationship trajectories inherent in the Acute Care Health Professional – Patient Relationship Theory may appear linear, they should not be interpreted in this way. Iterative processes are reflected in circular relational strategy and product arrows, which depict the potential for re-entry into and recycling through the relationship development process. There are no data to suggest that once readiness conditions are achieved that the relationship ever stalls and returns to this phase so at this early stage of theory development there is no apparent need for a loop back to the early phase of the relationship development process. However, there is apparent movement on the continuum that flows between professional and personal levels of relational intensity so circularity of later phases is essential.

This theory, generated from data collected from health professionals and validated by patients, describes the processes used to establish relationships with acutely ill patients by three different health professionals. It is useful in gaining an understanding of how each health professional views, uses and establishes relationships with patients, allows for comparisons across the three relationships and provides a basis for identifying complementary features of ACNP practice in the acute care health context. The theory is graphically displayed (Figure 7) and elements of the theory are provided (Table 12).
Section II: A Comparison of ACNP-Patient Relationships with Physician-Patient and Staff Nurse-Patient Relationships

While the primary phenomenon of interest in this study is the nature of ACNP-patient relationships, the features of these relationships as compared with those developed by physicians and nurses with patients are also of interest (Table 12). Comparing and contrasting the constituents of the ACNP-patient sub-theory with those of the physician-patient and staff nurse-patient relationship sub-theories allows for the discovery of unique features of the ACNP-patient relationship, contributing to our understanding of how each relationship contributes to meeting patients’ needs.

Relational Intensity

Relational intensity varies across each of the relationships explored in this study and is reflective of the health professional’s view of the focus of the relationship with a patient. In the ACHPPR theory, maximum relational intensity is evident when the patient, at the centre of the theory, is viewed predominantly as a person and the patient role and the disease are interpreted as secondary. Minimal relational intensity is evident when the health professional’s focus is on the disease alone, as represented by the outer sphere of the theory (Figure 7). Maximal intensity is not intended to indicate a relationship of higher quality or importance. It is simply a different type of relationship, which is intended by health professionals to contribute to meeting the acute health needs of patients.

Health professionals in this study describe their relationships with patients in terms that reflect varying degrees of relational intensity, labeled clinical, professional and personal. As previously discussed, the focus of each health professional-patient relationship also varies and these foci feature prominently at all levels of intensity in each type of relationship.
Figure 7. Acute Care Health Professional-Patient Relationship Theory

Physician-Patient Relationship
Sub-theory:

Managing the Disease
[Relational Dimensions: Patient/Person Orientation, Rapport, Time, Team]

Relational Strategies
- Informing
- Listening
- Imposing Boundaries

Relational Products
Patient Appreciation
Patient Moves on with Life

Readiness Conditions
- Patient Open
- Authentic Presence
- Intention to Know Patient

AcNP-Patient Relationship
Sub-theory:

Making a Connection
[Relational Dimensions: Pt/Person Orientation, Mutuality, Interaction, Boundaries]

Clinical - disease

Staff RN-Patient Relationship
Sub-theory:

Meeting Patients' Needs
[Relational Dimensions: Ideal vs. Reality, What Patients Need]
Table 12. Summary of Elements: Acute Care Health Professional Patient Relationship Theory

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Relational intensity is reflected in the way health professionals interact with patients. ACNPs are focused on ‘connecting’ with patients because ‘making a connection’ is central to their establishment of relationships with patients. The strategies they use to foster those connections promote interactivity between themselves and patients and may have little or no focus on the patients’ disease state. ACNPs acknowledge that their relationships with patients are purposeful (Morse, 1991a; Ramos, 1992); they meet patients because patients have disease-related issues but these do not dominate their descriptions of their relationships in the current study. Connection signifies the joining of one with another, to unite in a relationship with another and to establish a rapport based on common interests and opinions. Staff nurses establish relationships with patients to meet their needs and physicians establish their relationships with patients in order to manage their diseases.

When ACNPs describe high levels of intensity in their relationships with patients it is referred to as a personal connection. Staff nurses describe their busy work days and their desire for a higher level of relational intensity with patients but acknowledge that they are not able to achieve this ideal because of the reality of the situation which involves a number of personal, patient and systemic factors. Staff nurses’ descriptions of their relationships with patients emphasize a ‘here-and-now’ way of thinking about patients’ needs. Physicians’ descriptions include acknowledgement of why they develop relationships with patients; because they have a disease that needs to be diagnosed and managed. That is what physicians do and that is what patients expect. Their relationships are a series of interactions characterized by commitment and active participation in managing the issues.

The degree of relational intensity that is potentially achieved in each type of relationship also varies. Each relationship can be described with respect to the degree to which the health professional attends to the person as a person alone, not merely as a patient or a disease. Relationships described as personal are characterized by higher degrees of relational intensity and those described as professional reflect a lesser degree of relational intensity, suggesting more of a focus on the person with the disease and less with knowledge of the person being less of a priority. Clinical relationships are characterized by minimal degrees of relational intensity with an exclusive focus on the disease.

From health professionals’ perspectives clinical relationships are described in similar terms in the current study. These low intensity relationships evolve because readiness conditions are not met or patients do not behave in a way that is expected by health professionals. Clinical relationships are even conceptualized as a non-relationship of sorts (Williams, A.M. & Irurita,
A strictly clinical relationship is consistently described as uncomfortable, causes frustration and even anger (Podrasky & Sexton, 1988), results in an exclusive focus on disease-specific needs and is characterized by use of a formal, distant communication style by the health professional. While a clinical relationship is not what health professionals strive for, some suggest that it may be a perfectly acceptable type of relationship (Morse, 1991a; Ramos, 1992). Patients also exert control over how the relationship proceeds. Morse and colleagues (1997) suggest that if a patient does not have trust in a nurse, they may behave in a way that is construed as “difficult” or “challenging”. Or they may consistently behave in a jocular, non-serious manner, not allowing the nurse to really understand their needs, which might also be interpreted as under-involved (Peternelj-Taylor, C., 2002). In the context presented by Morse, the lower intensity, clinical relationship can be interpreted less negatively and potentially as a type of normal, albeit rare, relationship within which care can be provided “effectively and efficiently” (p. 340). Ramos (1992) describes a similar level of intensity in staff nurse-patient relationships, one that is superficial and strictly task oriented and evolves when the patient remains a stranger or is unconscious, the nurse has minimum time with the patient or when a patient’s instrumental needs are overwhelming. The main difference when applying these findings to clinical relationships described in the current study is that Ramos claims that an instrumental relationship is not always uncomfortable. When health professional participants in the current study describe relationships characterized as ‘clinical’, they do not describe any incidents when such relationships change and increase in intensity. Ramos’ conceptualization of this level of relational intensity includes opportunities for such a change to occur. So, while Ramos, Morse and colleagues are referring specifically to staff nurse-patient relationships, their perspectives are likely applicable to other health professional-patient relationships.

At the opposite end of the continuum, the most relationally intense relationship is considered to be ‘person-focused’ and ACNPs’ personal connections are the most likely to achieve this level, albeit infrequently. Ramos’ (1992) description of a ‘reciprocal relationship’, characterized by mutuality with both an emotional and cognitive bond and Campbell’s (1984) description of ‘skilled companionship’ characterized by closeness, mutuality, commitment and bodily presence, reflect similar characteristics to ACNPs’ personal connections. These are relationships said to be “closer than what is needed for basic care” (Ramos, 1992, p. 503). Due to the focus and nature of physician-patient relationships, physicians’ ‘personal’ relationships with patients are their most intense relationships, reflecting a focus on the person with a disease. Different again, ‘personal’ staff nurse-patient relationships are characterized by a focus on the
person but still predominantly on the person with disease, a level of relational intensity that happens infrequently.

More typical levels are evident when health professionals establish relationships reflecting professional levels of intensity. While there is clear differentiation between clinical and professional relationships, there is more of a continuum of relational intensity between those that are identified as professional and personal. The level of relational intensity reflected in professional relationships is similarly described by Ramos (1992) who claims that such a relationship reflects a “balanced emotional and cognitive connection” (p. 502). This relationship is considered to be unilateral, however, with the nurse retaining control in the relationship.

Relational intensity in helping relationships may be conceptually related to relational competence (Jordan, 2004). While human beings yearn for connection, relational competence is intrinsically linked to it. Jordan claims that traditional views of competence are problematic when one attempts to achieve a connection. Descriptions of competence include an element of competition, which is deemed necessary if one is to be viewed as successful in society, but which is counterproductive in relation to establishing a connection with another. To this end, when competition and competence are considered using a gender lens, women typically view competence differently, opting to conceptualize it in more relational terms. Jordan proposes that relational competence is required if one is to move another person, effect a change in the relationship between two people or have an impact on the well-being of another. This perspective is helpful in interpreting the findings from the current study. ACNPs, who are all female, seek to make connections with patients and this is done in the context of the patients’ acute health concerns. This is a relationship that is intended to have a positive impact on the well-being of another (Jordan, 2004). Of note is that ACNP participants were articulate about the expressive nature of their relatedness with patients rather than focusing on disease-related and more instrumental issues associated with their relationships with patients (Hagerty, Lynch-Sauer, Patusky, & Bouwsema, 1993; Jordan, 2004). When a person is relationally competent, the relationship has value for the person and it contributes to the growth of each person involved. Components of relational competence that emerge in the study of ACNP-patient relationships include mutuality, being open to being influenced, relational curiosity, experiencing vulnerability and creating connection rather than exercising power (Jordan, 2004).

Relational intensity that can be achieved in each type of health professional-patient relationship may be related to health professionals’ relational competence. Medical education curricula, while including patient/provider relationship content, may not allow for extensive
coverage of relevant issues (Branch et al., 2001; Summers, 2002). Some authors suggest that traditional medical education, focusing on the biomedical model, no longer serves physicians well, as patients are behaving more as consumers of their services (Stewart, M. & Weston, 1995). They suggest that a focus on the interaction between professionals and patients is essential if patient-centred care is to be achieved (Branch et al., 2001; Dieppe, Rafferty, & Kitson, 2002; O'Neil, 1993; Stewart, M. & Weston, 1995). The biomedical emphasis of their education may result in lower levels of physician relational competence or in decisions to use different approaches with patients that are in keeping with their goal of maintaining distance and objectivity while managing the patient’s disease. Branch and colleagues (Branch et al., 2001) suggest that exposing medical learners to humanistic role models in clinical settings may enhance their abilities to practice in a humanistic way in the future.

Nurses are educated about the centrality of relationship development with patients in their basic educational programs and are exposed to early theorists who discuss the nurse-patient relationship in great detail (Hagerty & Patusky, 2003; Paterson & Zderad, 1976). However, their experience in putting this theory into practice is limited until they graduate and begin their professional careers. In the acute care setting, some believe that the context in which nursing care is delivered to acutely ill patients serves to maintain a professional barrier between nurse and patient (Morse et al., 1997). While patient relationship models assume a “one nurse-one patient” approach, some authors suggest that administratively, acute care environments are organized to prevent nurses from becoming “involved with patients”, promoting a system of organizing nursing care based on task allocation (McQueen, 2000; Niven & Scott, 2003). When this is true, it may contribute to what patients in the current study recognize as ‘interchangeability’ of nursing staff. As well, when nurses interact in distant ways with patients they legitimize it by focusing on the performance of tasks related to the patient’s physical needs (McQueen, 2000). It has been suggested that nurse-patient interactions can be superficial, routinized and task-related (Hewison, 1995). Nurses are also routinely addressed as ‘nurse’ by patients and others rather than by name (McQueen, 2000; Morse et al., 1997), unlike their medical colleagues, and in the current study, ACNPs. Nurses have, in the past, been encouraged to be busy and maintain a degree of distance from patients so they will not become emotionally involved (McQueen, 2000). Contextual descriptions such as these are also typical of Jourard’s (1971b) description of nurses’ use of character armor to protect themselves from the emotional impact of caring for sick patients. Nurses in the current study, however, do not resist becoming involved with patients and acknowledge that greater relational intensity is in keeping with their
‘ideal relationship’ with a patient. Some of the findings of the current study are comparable to the first level of instrumental relationships described by Ramos (Ramos, 1992). This minimal relational intensity in the nurse-patient relationship develops in four situations; 1) participants are strangers, 2) patient is unconscious or unable to communicate, 3), when the nurse is unable to spend significant amounts of time with the patient, and 4) when the patient’s instrumental needs are overwhelming. Ramos concluded that no connection occurs at this relational level. So staff nurse-patient relationships, while deemed important by early nursing theorists and in basic nursing education, may not always be encouraged and supported in acute care environments. This reality likely impacts the degree of relational intensity that staff nurses can achieve in relationships with patients.

ACNPs, as discussed in an earlier chapter, have a graduate education in nursing. While some purport that nurse practitioner students receive little guidance about how to build effective relationships with patients (Summers, 2002), curriculum standards confirm the importance of the nurse-patient relationship, recommending that it be emphasized along with strategies that can be used to develop a relationship quickly and effectively (National Organization of Nurse Practitioner Faculties, 1995). Since ACNPs have practised as registered nurses, they have experience in establishing relationships with patients and may, indeed, be seeking a role that will allow them to establish closer relationships with patients. These nurses may have realized that relationships with patients are an important component of their care if they are to make a difference to patients’ health. Additional formal education may result in enhanced relational competence of ACNPs and may offer an explanation as to why they focus on making connections thus achieving higher levels of relational intensity with patients.

Contextual factors are likely influential in how ACNP-patient relationships develop. ACNPs are still rare in the health care system and develop specialized knowledge related to a particular patient population (e.g., pain management, cardiology, trauma, emergency). They do not rotate from unit to unit as physicians are required to do (Dahle et al., 1998; O'Neill, Silvestri, & McDaniel-Yakscoe, 2001) and so are consistently involved with the same patients over time. This allows patients and ACNPs to become familiar with one another and the ACNP is viewed as an individual rather than one of a larger group of similar professionals, a feature that differentiates ACNP practice from that of their staff nurse colleagues (Morse et al., 1997). Morse suggests that a staff nurse is not viewed as “an independent therapist but rather as an agent of the physician or the institution” (Morse et al., 1997, p. 328), which, if true, may ultimately reduce their achieved levels of relational intensity. ACNPs are positioned in
leadership positions and are viewed as more autonomous and independent as practitioners, making adjustments to agreed upon plans of medical care to fit the individual needs of patients (Niven & Scott, 2003). Power, as a “feature of everyday interactions with patients” (Hewison, 1995, p. 76), may also play a role because it influences interactions within the context of society as a whole. Since staff nurses are perceived to have less power than ACNPs and physicians in acute care organizations, the wider social forces are important to consider because nurse-patient relationships are played out in this environment. While health professionals do not describe a hierarchy in the current study, patients acknowledge its existence and, indeed, nurses are seen at the bottom of the pyramid. All of these contextual factors likely contribute to different types of relationships and levels of relational intensity between health professionals and patients.

It is evident that relational intensity can vary across the three health professional-patient relationship types. Patients do not identify any expressive elements of their relationships with health professionals rather they focus on more instrumental functions. In essence, patients are looking for their disease to be managed (physician), their needs to be met (staff nurse) and for someone to make sure it all happens (ACNP). The congruence of the perspectives with the respective relationship is evident in patient-staff nurse and patient-physician relationships, suggesting that the levels of relational intensity are satisfactory to patients. While ACNPs see their relational focus as making a connection, if patients don’t recognize this but are still satisfied with their relationship, then that, too, is satisfactory. The level of relational intensity is more explicitly discussed by ACNPs but patient themes suggest that relational intensity does vary in their relationships with different health professionals. The degree of relational intensity that is possible in any of these relationships may be attributed to the parties’ relational competence or behaving differently, either intentionally or out of necessity, so as to achieve the goal of each type of relationship.

Relational Foci

The central focus of ACNP-patient relationships is different from that of physician-patient or staff nurse-patient relationships, as illustrated in the theory of acute care health professional-patient relationships (Figure 7). While physicians focus on managing the disease and staff nurses meet patients’ needs, ACNPs identify their focus as making a connection with patients.
ACNPs Making a Connection

ACNPs are motivated to establish a connection in order to work with patients to address their disease and illness-related needs and contribute to patients moving on with their lives, reflecting what Wilde (1997) calls intentionality, which is an antecedent to making a connection. While ACNPs acknowledge the disease/illness context and are aware of why they come in contact with patients, their discourse about patient relationships focuses almost exclusively upon expressive, interpersonal features rather than those that are more instrumental and task-oriented (Hagerty et al., 1993). In fact, there are times when ACNPs speak in detailed, impassioned terms about the interpersonal nature of their relationships with patients without providing many disease-related details. Although ACNPs are unable to clearly articulate it, they do know when they made a connection with a patient. Beddoe (1999) suggests that the connection is made when the nurse practitioner experiences a “reachable moment” (p. 248) with a patient, a time when patient and practitioner agree that they are on common ground and share a common understanding that is “wide and deep” (p. 248). When a connection is achieved with a patient, it allows them to work effectively together. ACNPs claim that making a connection allows them to understand the person who is the patient, enabling them to address immediate health needs. Making a connection allows ACNPs to feel comfortable with patients and they feel they are making a difference to them. Additionally, there is a degree of mutual self-disclosure evident between them. These descriptions are in keeping with Wilde’s concept analysis of connection as part of caring; specifically, that critical attributes of connection are achieving depth in the relationship and a co-presence, having a sense of truly being with the other.

Connection has been equated to a sense of attachment or bonding between two people (Clayton, Murray, Horner, & Greene, 1991) and is said to be central to human growth and development (Jordan, 2004; Salmond, 2005). Building authentic connections requires one to tolerate “uncertainty, complexity and the inevitable vulnerability involved in real change” (Jordan, 2004, p. 3). Clayton defines connecting as “the transpersonal experiences and feelings that lead to a connection, attachment, or bonding between a nurse and a patient” (p. 155). The central focus of ACNPs’ relationships with patients is in keeping with Jordan’s and Walker’s (2004) view that connection is essential in order to “move others, to find responsiveness, to effect change [and] to create movement together” (p. 5). ACNPs’ descriptions also convey an intention to connect “with the true centre of the other” (Wilde, 1997, p. 21) which is purported to be one consequence of connection, that of co-presencing. Connection may also be consistent
with the solidarity that Fisher (1995) describes occurring between PCNPs and patients. When considering patients’ perspectives on their relationships with ACNPs, however, they see the focus as making things happen, getting things done. While patients make no mention of making a connection, patients’ perspectives on their relationships with ACNPs are in keeping with Jordan’s and Walker’s views regarding movement forward and effecting change. Particular elements of the ACNP-patient relationship sub-theory, such as the readiness condition of being authentically present with the patient and the mutuality dimension that influences relational intensity, are also consistent with an “I-Thou” (Buber, 1970a; Jourard, 1971b), humanistic (Paterson & Zderad, 1976) relationship.

Connected relationships have been regularly described in the nursing literature. Morse (1991a), in her grounded theory study of staff nurse patient-relationships, identifies four types of relationships that staff nurses have with patients and one of those is labeled ‘connected’. Connected relationships are mutual in nature and occur when patients and nurses know each other over a long period of time and when patients have extensive nursing needs. In such relationships, nurses see patients as persons first and patients second and these relationships are considered intensive and close. While Morse’s connected relationship is similar to the nature of connection evident in ACNP-patient relationships, in the current study, connectivity varies in intensity depending upon four dimensions; patient/person orientation, mutuality, interaction and attention to boundaries. Connection is differentiated across these dimensions from professional to personal (Table 13).

While Morse (1991a) found staff nurses engaged in connected relationships, the current study suggests that ACNPs, not staff nurses, are the health professionals who establish this type of relationship with patients. Of particular interest in the current study are the characteristics or dimensions inherent in each type of health professional-patient relationship and how they vary across each type of relationship. Morse’s connected relationship displays characteristics that are similar to connected relationships that ACNPs establish with patients; for example, both are described as close, influenced by the time nurses and patients spend together and emphasis is placed on patients’ individual concerns rather than treatment issues alone (Table 13). The differences, however, are related to variation in what Morse refers to as involvement and intensity.
Table 13. Connecting Relationships: Dimensional Comparison of ACNP-Patient Relationships and Staff Nurse-Patient Relationships (Morse, 1991a)

<table>
<thead>
<tr>
<th>Patient/Person Orientation</th>
<th>Morse’s Connected Relationship (Morse, 1991, p. 457-458)</th>
<th>ACNP-Patient Professional Connection</th>
<th>ACNP-Patient Personal Connection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutuality</td>
<td>First: as a person</td>
<td>Patient with disease first, then person</td>
<td>More equality in mutual self-disclosure</td>
</tr>
<tr>
<td></td>
<td>Implicit mutually agreed upon relationship between patient and nurse</td>
<td>Some mutual self-disclosure; patient disclosure ≥ ACNP disclosure</td>
<td>More equality in mutual self-disclosure</td>
</tr>
<tr>
<td></td>
<td>Becomes ‘connected’ because of circumstances relevant to patient and nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>May include nurse self-disclosure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interaction</td>
<td>Intensive, Close</td>
<td>ACNP-initiated interactions predominate, informal, mutual interest, negotiated partnership</td>
<td>Mutually initiated interactions, ACNP goes the extra mile, informal and familiar, negotiated partnership</td>
</tr>
<tr>
<td></td>
<td>‘Goes the extra mile’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boundaries</td>
<td>Not explicitly discussed</td>
<td>ACNP guard is reduced, comfortable with relationship, no apparent need to be vigilant about boundaries</td>
<td>Flexible boundaries re: personal information and emotions, vigilance re: boundaries</td>
</tr>
<tr>
<td></td>
<td>Does not reach ‘over-involved’ (4th type of relationship), patient becomes person only and ‘friendship’ evolves</td>
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Connection in the current study varies in intensity from a typical professional level to a more unusual personal level. While the ‘patient first, person second’ orientation of an ACNP’s professional connection is more in keeping with Morse’s ‘therapeutic relationship’, the principal focus on patients’ concerns rather than predominantly on treatment is more in keeping with Morse’s description of a connected relationship. ‘Going the extra mile’, a feature that reflects in-depth knowledge that a nurse has of a patient and a view of the patient as a person (Williams, A.M. & Irurita, 1998), is characteristic of Morse’s connected relationship, Ramos’ (1992) reciprocal relationship, as well as the more intense personal connection described by ACNPs in the current study. Interestingly, the ‘person first, patient second’ orientation of the personally connected ACNP-patient relationship may have some similarities with Morse’s ‘over-involved’ relationship, one that is described as focused on the person only with limited or no capacity to address the patient’s disease-related needs in a therapeutic way. Morse describes such relationships as problematic and breeches of accepted therapeutic boundaries. In contrast, ACNPs report that personally connected relationships occur rarely and their dialogue reflects a need to be vigilant about potential boundary crossings (Peternelj-Taylor, C., 2002) in such
relationships. It may be that ACNPs, who are prepared in graduate nursing programs, which include content on interpersonal relationships, have enhanced awareness and are able to accommodate this shift in patient/person orientation while still maintaining appropriate therapeutic boundaries.

A final difference relates to mutual self-disclosure. Morse’s (1991a) study suggests that patients and nurses make decisions about whether a relationship will be established and, from the nursing perspective, self-disclosure may be a feature. As nurses make the decision to get involved (or not) with a patient they may choose to disclose something personal about themselves. Nurses do this in an attempt to “establish common ground” with patients (Morse, 1991a). However, Morse makes no reference to the reciprocal sharing of personal information that is clearly an important characteristic influencing the intensity of the connections ACNPs establish.

Perry (1993; 1998), in her study of nurses working with patients diagnosed with cancer, discusses the complexity and relevance of connection in exemplary nursing practice. She suggests several components that contribute to making a connection which are similar to elements of the ACNP-patient relationship sub-theory. The first is “recognizing the similarities” (p. 104). Mutual recognition of things a nurse has in common with a patient allows the nurse to pursue a close personal relationship with the patient. Recognizing similarities is comparable to ACNPs’ strategy of seeking commonalities with patients, a strategy they use to make a connection. Perry’s second component she calls “seeing the former you” (p. 106). Nurses described their attempts to imagine what the patient was like before the illness. Perry considers this to be a precursor to connecting, allowing nurses to have a total picture of the patient. Similarly, ACNPs speak about gaining an understanding of the person beyond the illness. If they knew patients in better times or since diagnosis, they use this knowledge and reflect it back to patients, acknowledging that they are more than their disease. This is part of their intention to know the patient as a person, which is a readiness condition that appears to parallel “seeing the former you”. A third component of Perry’s view of connection is “participating in the patient’s experience” (p. 108). This is described as nurses sharing patients’ pain or joy and spending time with them in a close way. The ACNP-patient relationship sub-theory suggests that when a connection with a patient has been established, a product of that relationship is the ACNP’s perception that she has made a difference to a patient’s life and this contributes to feelings of professional well-being for the ACNP. ACNPs know that patients wish to move on with their
lives and they partner with them to make that a reality. Patient participants comment on the importance of ACNPs being present with them, which influences the level of comfort they ultimately have with ACNPs. These findings are in keeping with Perry’s “participating in the patient’s experience”. So, like Morse (1991a), Perry explored staff nurse-patient relationships but her findings regarding connection lend credence to the ACNP-patient relationship findings of the current study.

In another study, which used grounded theory method and explored staff nurse-patient relationships, Heifner (1993) asked eight nurses working in psychiatry to reflect on positive connectivity with patients. Four themes contributed to positive connectivity between nurses and patients. The first, vulnerability, reflected nurses’ perceptions of patients expressing their vulnerability by disclosing personal information. Relevant to this theme were nurses’ inclination to self-disclose some personal information. Similarly, in the current study, while in the process of making a connection, patients disclose information about themselves to ACNPs, which can place them in a vulnerable position and ACNPs do report mutual self-disclosure occurring. A second theme, commonalities, reflected nurses’ recognition of things they had in common with patients, a theme that Heifner’s study has is in common with Perry’s (1993) and the current study. Heifner’s third theme, reciprocation, reflected nurses’ sense that connectivity not only offered gains for patients but also for themselves. Nurses felt good about the work they were doing when there was connectivity. In the current study, making a difference to patients is a product of a connected relationship which is compatible with Heifner’s findings. Heifner’s final theme is investment. Nurses reported investing time in relationships with patients who expressed their vulnerability and openness. Investing time also features as a time-related strategy that ACNPs use in making connections with patients. In addition, perceiving that a patient is open to making a connection is a readiness condition that must be met for ACNPs to proceed with making a connection. While Heifner’s small study focused on connected relationships between staff nurses working with psychiatric patients, her findings regarding connection are further substantiated by many of the findings of the current study of ACNP-patient relationships.

The last body of literature addressing relational connectivity includes two studies involving primary care NP-patient relationships. Lewis’ and Bryczynski’s (1994) study, based on Benner’s (1984) original ‘novice to expert’ work, focused on the healing role of the NP and identified two central themes; “little things mean a lot” and “healing begins with listening” (p. 207). The discussions of both these themes include NPs spending time with patients, focused on
the person, not simply the patient, a quality that is evident in ACNP’s making connections with patients. ACNPs’ use of time as a resource is a relational strategy and, in personally connected relationships, they ‘go the extra mile’, taking action that is similar to those described as ‘little things mean a lot’ and “healing begins with listening” by Lewis and Brykczynski. Strategies identified by Lewis and Brykczynski include “using humour with sensitivity” (p. 210). Again, this strategy is used extensively by ACNPs to establish connections with patients.

A second related study used a phenomenological approach to investigate the experiences of primary care NPs interacting with patients with the intent of discovering the essential meanings of those experiences (Kleiman, 2004). Eight essential meanings were revealed and one of those was connection. Kleiman claims that a connection is formed for the NP when he or she acknowledges that the patient has needs. In turn, the connection is made for the patient when he or she turns back towards the NP. Several layers of intensity were noted, “ranging from the primary orientation of recognizing the person as another human being to the intersubjective relationship … characterized by the sharing of subjective meanings” (p. 265). Similar findings emerged when studying ACNP-patient relationships. Patient/person orientation is a dimension that influences the degree of relational intensity and Keiman’s use of the term “intersubjective relationship” suggests an influence of Paterson’s and Zderad’s (1976) perspectives on nurse-patient relationships. Kleiman proposes that qualities of connection include authentic presence, intersubjective dialogue and physical and/or emotional touching. In fact, Kleiman equates ‘connection’ with an ‘intersubjective relationship’, also described by Paterson and Zderad, as well as having qualities of Buber’s “I-Thou” relationship. Another essential meaning revealed in Kleiman’s study was reciprocity, which is similar to the mutuality dimension of ACNP-patient relationships that influences relational intensity. When commenting on the general structure of NP-patient relationships, Kleiman suggests that NPs offer a “constancy that prevails over time and extends beyond the direct, face-to-face presence to a ‘presence in absence’, a ‘being there’ for patients even when NPs are corporeally absent” (p. 268). This finding is further supported by the ACNP-patient relationship sub-theory. Using time as a resource in the development of relationships is a strategy that ACNPs use which contributes to a sense of continuity of care for patients and a sense of ACNPs being there for patients. Patients readily identify that ACNPs know them well and are there for them. Finally, Kleiman’s finding, “getting things done”, strikes a cord in relation to ACNP-patient connected relationships (p. 268). While ACNPs did not explicitly discuss this as their role with respect to their relationships, the central focus of
ACNP-patient relationships from the patient’s perspective is ‘making things happen’, a finding further substantiating the relationship orientation of NPs.

Established evidence addressing relational connection is helpful in validating the centrality of ‘making a connection’ to the ACNP-patient relationship sub-theory. A connected relationship has humanistic qualities (Buber, 1970b; Paterson & Zderad, 1976). Authenticity and a genuine knowing of the other are distinguishing features of strong connectivity, a state that reflects intimacy that has been called a form of love (Campbell, 1984; Thomas, Finch, Schoenhofer, & Green, 2004). Clearly professional and personal connections between ACNPs and patients have some characteristics of an “I-Thou” relationship as described by Buber, which can allow for meaningful change and progress towards health (Jourard, 1971c).

Physicians Managing the Disease

The identification of disease management as central to physician-patient relationships is not surprising and is compatible with traditional views of the role of physicians in society. Patients seek the assistance of physicians in hopes they will be able to cure their diseases because they are seen as powerful, scientifically based (Campbell, 1984) and competent health professionals. In fact, patient participants in this study verify that managing their disease is exactly what they wish the focus of their relationships with physicians to be. Physicians are educated to determine causality and solve problems (Snyderman & Weil, 2002). In her study, Fisher (1995) noted that physicians’ assymetrical relationships with patients are almost exclusively focused on medical issues rather than biographical and social contexts of patients lives. Cohn (2001) suggests that to manage their diseases, physicians interact with patients in what Buber referred to as the “It” world, “one of abstraction, causality, detachment and utility” (p. 171). In fact, Buber (1970b) himself states that “I-It” relationships are characterized by clearly seeing the other as a means, an object with clear boundaries. He suggests that it may not be possible for physicians to achieve an ongoing “I-Thou” relationship with a patient because one loses the details of the other if he is one’s “Thou” and the focus becomes what happens “between” the two persons, a perspective that is not conducive to managing the patient’s disease. That clarity of boundaries and information is evident in the current study and would seem necessary for physicians to diagnose and treat a patient’s disease in a satisfactory fashion.

When physician participants discuss the relationships they have with patients, disease-related issues are always woven into their dialogue leading to a conclusion that physicians are attending to patients’ health concerns and how they can diagnose and treat the disease. This
finding suggests that physicians’ discourse about and with patients in acute care settings reflects what Benner (2004) refers to as a clinical gaze, which is not an uncommon finding in acute care settings. Benner claims this way of communicating reveals an objective, physiological, even Cartesian view of patients and their diseases and is said to be setting aside patients’ life worlds. Using this view allows physicians to seek “explanations for disease that can be visualized whether at the organ system, cellular or genetic levels” (p. 75). This approach is a good fit for physicians as they employ their reasoning processes to manage the disease.

Physicians acknowledge that the purpose for their relationships with patients is to address the presence of a disease (Cohn, 2001). While some physicians do use the term ‘connection’ when describing a few of their relationships with patients, how physicians use the term is not in keeping with others’ descriptions of connection (Clayton et al., 1991; Jordan & Walker, 2004) but it does connote increased relational intensity. In comparison with ACNPs whose relational focus is making a connection with the person who is the patient, physicians’ descriptions of connectivity approach the person with the disease but do not address the person alone. When a physician describes such a connection with a patient it is usually as a result of knowing the patient over time and occasionally engaging in discussions that are more social in nature. However, this type of connection bears only minimal resemblance to the level of intensity that ACNPs describe when a personal connection is achieved between themselves and a patient. Physicians describe limited self-disclosure and though they gain some personal knowledge of the patient, the information is social, not personal in nature. One strategy used by physicians that serves to minimize the strength of connection is their use of imposed boundaries between themselves and patients. Physicians appear to use this strategy in order to be effective in their work and, at times, to protect themselves from the inevitable stress associated with acutely or terminally ill patients. This use of boundaries, in turn, may contribute to a power differential in the relationship which does not allow for authentic responsiveness on the part of the physician. In fact, in relationships where power differentials are being protected, authenticity, which is associated with openness to mutual influence, could be interpreted as a dangerous practice because the result may be a reduction or elimination of the power differential (Jordan & Walker, 2004; Jourard, 1971b). Fisher’s (1995) findings suggest that physicians actively maintain power differentials and perpetuate the dominant position of physicians in relation to patients, which is in contrast to the approach used by NPs who consistently devalued their own status and power in an apparent attempt to achieve solidarity with patients.
This nature of physician-patient relationships in the current study is not supported by the work of Mathews, Suchman and Branch (1993), physicians themselves, who propose that the “therapeutic nature of the patient-clinician relationship lies in its capacity to meet the needs of both the patient and the clinician for connection and meaning in their lives” (p. 973). It is suggested that connections between physicians and patients can occur, albeit briefly, and are described as moments of shared understanding that are meaningful to both patient and clinician. This type of interaction, when it occurs, would be in keeping with descriptions of “I-Thou” (Buber, 1970b; Jourard, 1971b), humanistic (Paterson & Zderad, 1976) relationships. Mathews and colleagues (1993) suggest a number of strategies physicians can use to develop this type of connection with patients, including developing rapport, communicating understanding and silencing internal talk so physicians can truly hear the patient’s experience and not focus exclusively on the diagnostic reasoning process. They recommend that while medicine has significant scientific and technological knowledge, this must be coupled with a systematic knowledge of relationships and there is much for the medical profession to learn in this area. These views are compatible with those of researchers who proposed that physicians adopt a patient-centred approach, focusing on exploration of the patient’s experience of illness and disease, understanding the whole person and finding common ground in order to make a mutual decision (Stewart, M. et al., 1995). In order to make such a shift in practice approach, the physician-patient relationship must be identified as a priority and enhancements made. These perspectives were not apparent in the findings of the current study.

Physicians’ focus on managing the disease might lead one to think that physicians intentionally objectify patients, losing sight of the human being; however this is not the case. In describing the nature of their relationships with patients, physicians refer to humanness. Physicians clearly articulate their recognition of the patient as a human being with a life beyond the disease and they acknowledge that they, too, are human beings who can be affected by patients’ circumstances. Recognition of patients as human beings by physicians is apparent in the modern version of the Hippocratic oath (Lasagna, n.d.) and in the medical literature (Benner, 2004; Branch et al., 2001; Cohn, 2001; Stewart, M. et al., 1995) but, while physicians see the distance they attempt to maintain between themselves and patients as contributing to their objectivity (Kullnat, 2007), others in the profession suggest that a shift towards humanness and person-centredness would be of benefit to both physicians and patients (Benner, 2004; Branch et al., 2001; Cohn, 2001; Snyderman & Weil, 2002; Squier, 1995; Stewart, M. et al., 1995).
The focus of physicians’ relationships with patients differs from those of ACNPs. While ACNPs focus on making a connection and gaining an understanding of the patient who is a person, physicians offer something different, maintaining their distance while doing what is expected of them; managing patients’ diseases. Each offers something different to patients for whom they care and, as described by patients and health professionals, in the acute care environment that is the context for the overall theory, care is provided in teams, allowing each professional’s contributions to potentially overlap but more importantly, complement one another.

Staff Nurses Meeting Patients’ Needs

The focus of staff nurses’ descriptions of their relationships with patients is meeting their needs and those needs are usually immediate and treatment related. Their ‘here and now’ focus is in keeping with a central theme, “identifying patient needs” featured in Williams’ and Irurita’s grounded theory related to the provision of quality nursing care (1998, p. 38). In their study, high quality nursing care was described by nurses as “meeting all the needs of patients or clients you’re looking after” (p. 38), not unlike nurses’ perspectives in the current study. Given the acuity of illness of hospitalized patients, a ‘here and now’ focus could be viewed as essential because it is the care provided around the clock by nurses that helps patients “survive the present” (Keighley, 2006, p. 102). While many nurses describe their practice in relational terms, Gordon (2006) suggests that when observed providing care, the reason nurses have relationships with patients is because they are constantly doing things for and with patients who have physical, medical and technical needs. In the current study, the purpose of the staff nurse-patient relationship is illness focused, similar to physicians’ relationships with patients. In both of these relationships the health professional focus is well matched with what patients expect of them. Staff nurses view their relationships with patients as an important element in meeting their needs but face challenges when trying to establish what they consider to be ideal relationships, characterized by higher relational intensity. This reality could be a result of nurses’ positions in the health care system and the institutional roles that ultimately limit the control they have over their activities (Kleiman, 2004).

Given the earlier discussion of connected relationships and the prevalence of this conceptualization in literature in relation to nurse-patient relationships, it is noteworthy that staff nurse participants in this study do not regularly describe relationships of this intensity. Campbell (1984) suggests that nurses may find it easier to interact with patients when they have a task to
complete, ‘doing to’ the patient in contrast with ‘being with’. Nursing emphasis on ‘doing to’ patients may not be surprising given that nurses’ discourse reflected assessment of patients needs and setting their priorities for care provision based upon the assessed importance of those needs during a given shift, at a given time. However, there is no evidence of nurse participants actively engaging in what Jourard (1971b) called character armor, an intentional distancing of themselves from patients in a self-protective fashion which would result in a relationship characterized by minimal relational intensity.

The structure of the system may provide one explanation for the nature of staff nurse-patient relationships discovered in this study. Rankin and Campbell (2006), in their ethnographic studies of nurses in a health care system being reformed, note that as we strive to improve efficiency in the health care system we tend to categorize patients by condition or clinical status and nurses have learned to treat patients as “instances of categories” (p. 21) which is not in keeping with their traditional values of wholism and may ultimately undermine the quality of patient care they provide. Similarly, Heartfield (2006) suggests that the system is being changed by the concept of time and nurse-patient relationships are being altered to eliminate the ‘relationship’ aspect. Nurses in the current study acknowledge the importance they ascribe to ‘being with’ patients, to use Campbell’s (1984) language, but find it challenging to achieve because of the nature of the work that they do and how the system is organized. Rankin and Campbell offer an explanation for this finding, suggesting that staff nurses are required to function using standard organizational practices that are not in keeping with their own beliefs about good nursing. Daily interactions with patients offer a human interface that, to nurses, is no longer a priority in the system given the numerous demands placed upon them to care for patients as well as maintain the functioning of the system. Morse, Havens and Wilson (1997) are in agreement, suggesting that contextual factors, such as the fact that patients are usually cared for by many nurses in a single day and nursing care is often provided by groups of nurses, significantly influence the establishment of staff nurse-patient relationships. These contextual factors may explain patients’ perceptions in the current study that nurses are “interchangeable” (p. 327).

Consistent emphasis is placed on the centrality of nurse-patient relationships in professional nursing practice (College of Nurses of Ontario, 2006; Paterson & Zderad, 1976; Registered Nurses' Association of Ontario, 2006; Weinberg, D.B., 2006) but Weinberg (2006) also suggests that nurses seem to overemphasize relationships instead of articulating what they do with patients in the context of those relationships. Weinberg claims that in her qualitative
study exploring the impact of health system restructuring on nursing, nurses’ abstract
descriptions of their work did not match with the professional activity she witnessed while
observing them. She listened to nurses speak about the importance of ‘knowing patients’ and
then decoded its meaning. She noted nurses multi-tasking, a strategy used by staff nurses in the
current study, often completing tasks while talking with patients or their family members or
fielding questions. ‘Knowing’ meant knowing about patients’ diagnosis, medical needs and their
progress thus far, “not their personal stories and dreams” (p. 35). Weinberg describes this as a
therapeutic, not personal, relationship. Weinberg’s observations and analysis offers a present-
day context for staff-nurse patient relationships, which is compatible with the staff nurse-patient
relationship findings of this study. The structures embedded in the system, such as position
descriptions, influence how health professionals may function. Staff nurse roles, when compared
with ACNP roles, are more restrictive and traditional. ACNP positions, by virtue of the
leadership responsibilities associated with such roles, are ‘allowed’ to manage their time
differently and so are able to allocate time with patients using different criteria.

In the current study, perceptions of patients regarding their relationships with staff nurses
are congruent with what staff nurses claim is the focus of their relationships with patients:
meeting patients’ needs. Patients did not describe a need for a close relationship with nurses and
this is in keeping with some studies examining what influences patient satisfaction with nursing
care. White (1972) asked nurses and patients to rate the importance of 50 nursing activities that
had been classified as relevant to physical care, psychological care, implementation of medical
care and preparation for discharge. While nurses’ highest rated items were in the area of
psychological care (e.g., taking time to listen), patients rated physical care and implementing
medical care (e.g., hygiene and carrying out doctors orders) as most important. In some respects,
White’s findings are consistent with patients’ perspectives on nurse-patient relationships in the
current study. Patients describe their relationships with nurses as being focused on meeting their
health needs and they view nurses as important in ensuring that doctors’ orders are carried out.
However, patient participants appreciated nurses being with them in ways that reflected their
humanness (e.g., use of humour), an issue not addressed in White’s quantitative study. Another
relevant finding from White’s study is the lack of importance placed on preparation for discharge
by both nurses and patients. This is in keeping with the findings of the current study where
nurses are focused on meeting the needs ‘here and now’ with very little emphasis placed on the
patient’s life beyond the acute care environment. The findings of White’s study may explain
why patients continue to place emphasis on what Wynne (1984) describes as the instrumental,
task-oriented aspects of their relationships with health professionals while nurses continue to value expressive, affective aspects of the relationship. Contrary to White’s study, Niven and Scott’s (2003) detailed analysis of one patient’s experience with an acute illness suggests that a nurse who is competent, courteous, humane and sensitive is perceived by a patient as providing quality care. They also concluded that organizational structure and culture contribute to how care is provided by nursing staff. This is substantiated by a more recent ethnographic study that explored what nursing characteristics patients identify as important. Using participant observation and patient interview data, “nurses’ personal sharing” (i.e., self-disclosure), “kidding” (i.e., humour) and “clicking” emerged as contributing to the process of “getting to know you”. Other core processes included “translating” (including being informative), “establishing trust” and “going the extra mile” (Fosbinder, 1994). While relationships that staff nurse participants in the current study describe with patients include some of the concepts derived by Fosbinder, what is most interesting is that her findings present patients perspectives. In the current study, patient participants appreciated the human side of the nurse but they did not identify expressive processes as priorities in their relationships with them. They valued nurses’ abilities to address their more instrumental, disease-related needs.

In the acute care setting, each of the health professionals in the current study establishes relationships with patients who present for care related to significant illness. Patients usually have little or no choice in their acute care health providers but most are open to establishing relationships with those providing them with care. While ACNPs’ relational focus on making a connection is qualitatively different from the focus of physicians and staff nurses, every health professional views their relationships as vehicles through which they achieve their central focus. Nurses connecting with patients have been well described in the literature so discovering that ACNPs, who are nurses practising in an advanced and more autonomous role, identify their central relational focus with patients as making a connection is not surprising. However, the lack of evidence of staff nurses in the current study achieving this level of relational intensity with patients is noteworthy. The timing of this research may offer one explanation. Studies discussing connection as an element of nurse-patient relationships were published in the late 1980s and 1990s, likely pre-dating significant emphasis on health care reform and hospital restructuring that began in the 1990s (Rankin & Campbell, 2006; Weinberg, D.B., 2006). ACNPs, whose advanced nursing roles are designed to foster practice leadership and autonomy as well as patient care (van Soeren & Micevski, 2001), have enhanced control over their practice as well as increased academic preparation such that attempting to make a connection with
patients in their care is potentially more feasible and a priority for them. Finally, while the concept of connection has emerged more recently in the medical literature, the literature suggests that the ideal of a humanistic interaction between physician and patient has yet to be fully realized in daily practice. However, while physicians, staff nurses and ACNPs all have a different focus in their relationships with patients, their approaches are compatible with what patients desire from them and their approaches are complementary befitting the team environment in which they provide care for patients.

Relational Dimensions

ACNP relationships with patients are influenced by four dimensions; patient/person orientation, mutuality, interaction and boundaries. Variation across these dimensions influences the intensity of ACNP-patient relationships (clinical relationship, professionally connected relationship, personally connected relationship). While most of the dimensions defining ACNP-patient relationships are distinct from those defining physicians’ and staff nurses’ relationships with patients (Table 14), themes related to several of these dimensions emerge in other aspects of the staff RN-patient and physician-patient relationship sub-theories. Only the dimensions influencing ACNP-patient relational intensity will be discussed in detail but the dimensions from each health professional sub-theory are provided for reference (Table 14).

Table 14. Dimensions of Health Professional-Patient Relationships

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<tr>
<th>ACNP</th>
<th>Physician</th>
<th>Staff Nurse</th>
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<tr>
<td>Patient/Person Orientation</td>
<td>Patient/Person Orientation</td>
<td>Ideal versus Reality</td>
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<tr>
<td>Mutuality</td>
<td>Rapport</td>
<td>Patients’ Needs</td>
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<tr>
<td>Interaction</td>
<td>Time</td>
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<td>Boundaries</td>
<td>Team</td>
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Patient/person Orientation

Patient/person orientation is an important dimension that delineates how focused the ACNP is on the person who is the patient. With the ‘person’ who is also someone with a disease as the centre point of the overall theory, it is not surprising that the degree to which the health professional focuses on knowing the person has a significant influence on relational intensity. In the most intense, personally connected relationships, ACNPs gain personal information about the patient and are able to clearly see the person while remaining aware that this is a patient requiring care. ACNPs speak regularly about trying to get to know patients and understand their lives with the intent of understanding what the future might hold for the patient once away from
the acute care environment. While a clinical-disease focus characterizes the minimally intense clinical relationship, ACNPs are motivated to learn about the person with the disease. Morse (1991a) discusses nurses’ perspectives of the patient and person as one dimension of the nurse-patient relationship, concluding that a ‘patient only’ focus is associated with the least intense relationship while a focus on the ‘person only’ can result in an over-involved relationship. In the current study, connection is divided into two levels of intensity that are on a continuum, with a professionally connected relationship defined by a focus on the person with a disease and the more relationally intense ‘personally connected’ relationship focused on the person in addition to the person with a disease. The intent of ACNPs to focus beyond the disease may reflect a unique feature of NP practice which is described by Fisher (1995); that of incorporating the social/biographical context into one’s approach with patients. At the other end of the relational continuum, ACNPs suggest that when a connection cannot be made and a clinical relationship evolves, their focus is on the patient’s disease only, ultimately resulting in feelings of discomfort and frustration.

Patient/person orientation is also evident as a dimension of the physician-patient relationship. In the context of this relationship, physicians’ intend to learn about patients so that they can diagnose and manage their disease. Physicians ask patients about their lives, but they use the information in a different way; specifically, to develop an understanding of the impact the disease is having on patients so they can gauge its severity. While physicians are not focused on the person per se, they do acknowledge and recognize that patients are human beings. They are often impressed with the “strength of their spirits” and are comfortable with patients realizing that they, as physicians, are human beings as well, but their focus remains on managing the patient’s disease. When physicians gain knowledge of a patient and, as a result, engage in social discourse with patients, this can result in greater relational intensity between them. Staff nurses, on occasion, make efforts to obtain personal information about patients but similar to physicians, they generally use it to meet current, here-and-now patient needs related to their disease. A patient/person dimension did not emerge as influencing staff nurse-patient relational intensity. However, nurses do describe ‘ways of being’ including ‘being human’, suggesting that they use their own humanness as a strategy to establish stronger involvements with patients.

Mutuality

Mutuality is the second dimension that defines ACNP-patient relationships. In the context of the current study, mutuality is predominantly reflected by the degree of reciprocal self
disclosure that occurs between ACNP and patient; the more this occurs, the stronger the connectivity of the relationship. Mutuality should not necessarily be misconstrued as equality of the parties in the context of a helping relationship. However, “mutuality involves profound respect and mutual openness to change and responsiveness” (Jordan & Walker, 2004, p.3). In order for one person to grow in a relationship, both must be prepared to grow, involving intersubjective, cognitive-emotional change (Jordan & Walker, 2004; Paterson & Zderad, 1976). As well, both people must recognize that, as human beings, they are vulnerable (Daniel, 1998; Jordan & Walker, 2004) and it is the acknowledgement of vulnerability that allows one to be authentically present with another person. Authentic presence is a readiness condition necessary for ACNPs to move towards making connections with patients.

The concept of mutuality has been analysed by Henson (1997). This author defines mutuality as “a connection with or understanding of another that facilitates a dynamic process of joint exchange between people” (p. 80). Mutuality is deemed a necessary precursor to the achievement of a goal in a satisfactory fashion. Henson conceptualized mutuality as a midway point between autonomy and paternalism with respect to patient-provider relationships. In a paternalistic relationship, the focus is on providers who know best and expect patients to adhere to their expert advice. At the other extreme, autonomy is patient-focused and represents patients with an attitude of freedom and independence with the intention to make their own decisions about how to proceed regarding their health issues. The suggested midpoint, mutuality, is focused on both providers and patients, reflecting negotiation and partnership in the establishment of goals and plans. The provider and patient together “discover the most effective health care plan” (Henson, 1997, p. 79). Given that one of the products or consequences of establishing a connected relationship in the current study is partnership with patients, mutuality, as a dimension of ACNP-patient relationships, is consistent with Henson’s definition of mutuality. Mutuality has also been discussed as a contributor to connecting with patients, termed reciprocity, or a give and take that results in feelings of satisfaction (Kutaka, 2002). As a dimension of the ACNP-patient relationship, as mutuality increases so does the level of connectivity, an effect that can allow patient and ACNP to overcome any barriers or problems that may arise between them in the future (Thomas et al., 2004).

Mutuality is not explicitly evident in the physician-patient sub-theory. While physicians acknowledge that they are interested in patients’ goals, they see the focus of their relationships with patients as managing the disease and they assume that patients trust them and see them as competent to do this for them. Mutuality may appear similar to the physician-patient relational
dimension, rapport, because social conversation results in increased relational intensity. However, the degree to which this happens, even in the most intense physician-patient relationships, is limited. As well, the reciprocal sharing of information rarely occurs and only the patient tends to share what could be called personal information. Given the predominantly one-way direction of information and sharing, rapport is not mutual and reflects more of a level of comfort as patient and physician interact, remaining focused on managing the disease.

While mutuality is not explicitly evident as a dimension of staff nurse-patient relationships, an element of self disclosure is inherent in the staff nurse strategy, ‘ways of being’, specifically that of ‘being human’. This finding is consistent with the results of a study exploring the impact of technology on relationships between nurses and patients (Alliex & Irurita, 2004). Nurses in the current study claim that self-disclosure can occur spontaneously, when they share something about themselves, or reciprocally, when they share something about themselves after a patient shares something about himself. The personal information that they share tends to be of a social nature, such as sporting events, television programs, movies, or, perhaps, a city where both were born. Alliex and Irurita suggest that the purpose of self-disclosure is to draw a nurse and patient closer in a shared humanness, a perspective shared by patients in their study but not expressed by patients in the current study.

Mutuality is an important factor that influences the degree of relational intensity between ACNPs and patients in the current study and has been identified by others as important to relationships in general. Inherent in mutuality is self-disclosure by both parties in the relationship and the degree to which this occurs is the major influence on relational intensity. It is interesting to note that discussions of mutuality in the nursing literature, empirical and otherwise, are most often focused on staff nurse-patient relationships. In the current study, mutuality was an essential feature of ACNP-patient relationships but was not a feature of the staff nurse-patient relationship sub-theory. As discussed in an earlier section, the educational preparation of ACNPs and the contextual and system factors impacting the role they are able to play in the acute care setting may allow nurses to focus on approaches that will allow them to make connections with patients and optimize relational intensity with the intention of addressing patients’ health needs (Seale, Anderson, & Kinnersley, 2006). Physicians’ central focus, managing the patient’s disease, dictates how they behave with patients and mutuality did not emerge as relevant for them.
Interaction

The third dimension characterizing ACNP-patient relationships is interaction, specifically the comfort level with which ACNPs and patients communicate, the formality of the interaction style and the frequency with which they interact. In clinical relationships, ACNPs describe a cool, distant, formal, guarded interaction style that occurs infrequently, descriptions that are consistent with relational under-involvement (Sheets, 2000) and the clinical relationship described by Morse (1991a). In her study of nurse-patient relationships, Ramos (1992) described a “level one, task oriented, instrumental” relationship that can be established that involves only task completion with limited or no interpersonal interaction. However, Ramos claimed this was not necessarily an uncomfortable relationship for nurses. In the current study, when ACNPs establish connectivity with patients, the interaction becomes more comfortable, informal and less business-like. In the most intense, personally connected relationships, interactions become less inhibited and occur more often, even spontaneously. The interactions that occur in professionally and personally connected relationships are similar to connected relationships described by Morse.

As a feature of interactions with patients, rapport is described by ACNPs. Rapport, itself, is a dimension of physician-patient relationships. Physicians describe their professional and personal relationships with patients as comfortable and sometimes even enjoyable and this influences the degree of relational intensity generated between physician and patient. Similarly, in staff nurse-patient relationships, the ideal versus reality dimension reflects some of the character of interaction that defines ACNP-patient relationships. The frequency with which staff RNs spend time with patients is influenced by the degree to which they achieve their ideal relationship and in relationships that reflect a personal degree of relational intensity, staff RNs describe a sense of closeness with patients. The other dimension of the staff nurse-patient relationship, what patients need, also influences the frequency and amount of time nurses spend with patients. The more life-threatening, time-intensive needs the patients have, the more time nurses spend with them by necessity and when nurses spend time with patients, they have an opportunity to interact with them and can take advantage of those interactions to establish rapport.

Boundaries

Attention to boundaries emerges as the final dimension characterizing the relationships ACNPs have with patients. The degree to which they feel they need to pay attention to
boundaries reflects the degree of relational intensity. Vigilance with respect to boundaries becomes most relevant in the most intense, personally connected relationships as ACNPs ensure that they maintain some emotional distance and are aware of their feelings for patients (Ramos, 1992). Attention to boundaries by ACNPs becomes clear when they describe those rare personally connected relationships that they establish with patients. ACNP dialogue reflects concern that patients might penetrate the boundaries they establish resulting in ACNPs’ inability to protect themselves from emotional upset (Kutaka, 2002) and breeching professional standards intended to protect patients (College of Nurses of Ontario, 2006; Pearson, 2003). Boundaries are evident in all human relationships but are particularly relevant in those between professionals and patients. While difficult to define tangibly, a boundary is said to be the ‘edge’ of appropriate behaviour (Gutheil & Gabbard, 1998; Peternelj-Taylor, C., 2002), marking the parameters of a professional relationship (Peternelj-Taylor, C.A. & Yonge, 2003). Boundaries are an important consideration in any health professional-patient relationship because of the inherent power gradient that exists between a vulnerable patient and an expert and powerful professional (Pearson, 2003; Sheets, 2000). Professional boundaries have also been conceptualized as a therapeutic or helping “frame” (Gutheil & Gabbard, 1993; Peternelj-Taylor, C., 2002), which demarcates the boundaries within which a relationship functions effectively and therapeutically. ACNPs’ descriptions of their most intense, personally connected relationships reflect a need to be vigilant about boundaries for fear they might be breeched. Gutheil and Gabbard (1993; 1998) describe two types of boundary transgressions; boundary crossings and boundary violations. Boundary crossings are transient breeches of established boundaries often with a therapeutic intent, e.g., disclosing an experience that relates to what the patient is experiencing, giving a gift that has a therapeutic or educational purpose or accepting a gift that, if rejected, would hurt a patient or compromise the professional-patient relationship (Pearson, 2003; Peternelj-Taylor, C., 2002; Sheets, 2000). In the current study, ACNPs describe some patients ‘slipping through’, or the occasions when they have coffee with a patient’s family members to discuss how family members are feeling and coping, suggesting occasional boundary crossings with those patients with whom a personal connection is established. However, in these ACNP boundary crossings, it is evident that the needs being met were the patients’ and there was an intended therapeutic intent, a criterion that assists practitioners in differentiating problematic crossings (Baker Miller et al., 2004). Covington’s (2005) study of PCNPs suggests that when NPs step across boundaries, it is to relate at an intimate level, allowing a more spiritual bond to be established.
The second type of boundary transgression is boundary violation. Such violations occur when professionals confuse their own needs with those of patients and seek to meet their own needs. Such violations are deemed to be harmful to patients (Gutheil & Gabbard, 1998; Pearson, 2003); the most serious boundary violation is sexual exploitation. There is no evidence of such transgressions in the current study and, in fact, there is a perceived vigilance to prevent boundary violations from occurring. Examples of boundary violations are provided in the literature (Peternelj-Taylor, C., 2002; Peternelj-Taylor, C.A. & Yonge, 2003; Sheets, 2000) and in regulatory statements (College of Nurses of Ontario, 2006).

Boundaries are not a dimension of physician-patient relationships in the current study but are identified, instead, as a strategy used by physicians. In this case, physicians actively seek to impose boundaries between themselves and patients which are different from ACNP-patient relationships where heightened awareness of boundaries is evident as relational intensity increases. Physicians impose boundaries to maintain a comfortable distance from patients and to protect themselves from over-involvement. Considering their focus on managing patients’ diseases, imposing boundaries allows them to remain objective and more able to logically address patients’ health issues. There is no evidence that boundaries were breeched or were even problematic in this study. Interestingly, much of the literature addressing boundaries in medical practice focuses on psychiatric practice (Gutheil & Gabbard, 1998), dual relationships, i.e., treating someone who one knows in another context, (Kullnat, 2007) and the extreme cases of sexual interference or sexual involvement with patients (Foxman, 2006; Gutheil & Gabbard, 1998; Watts, B., 2006). The risks associated with breaching boundaries, such as charges and associated regulatory or legal action against physicians, are well documented in medical literature.

The appropriateness of health professional self-disclosure is also relevant when considering professional boundaries. Self-disclosure of personal information is a component of the mutuality dimension of ACNP-patient relationships and is also an element of staff nurses’ ‘ways of being’ relational strategy. Self-disclosure did not surface in physician-patient relationships. As discussed earlier, as ACNPs establish a connection with patients, there is a tendency for reciprocal sharing of some personal information between patients and ACNPs. Self-disclosure to a patient can be interpreted as a boundary crossing, but not necessarily a violation (Gutheil & Gabbard, 1993; Sheets, 2000). If sharing personal information is intended to have a therapeutic effect, such as increasing a patient’s comfort with the ACNP, then this temporary crossing would not be considered a violation. ACNPs comments about self-disclosure
suggest that the information they share with patients is not related to meeting their own needs or of a highly personal nature. In these cases, such self-disclosure in the ACNP-patient relationship would seem acceptable and not a breech of professional boundaries.

Peternelj-Taylor (2002) suggests that under-involvement can also be classified as a boundary violation. Under-involvement results when a nurse fails to engage a patient and attend to his or her treatment needs. In such situations nurses may avoid a patient altogether or engage in superficial interactions that result in friendly but shallow discussions rather than partnering with a patient to define goals together. One could interpret that the clinical relationships that are established between health professionals and some patients are potentially under-involved. However, under-involved relationships that are boundary issues result in ineffective or no care being provided by the professional and that is not the case with the clinical relationships described by ACNPs, physicians and staff nurses. While such relationships are uncomfortable and frustrating for health professionals, they maintain that they continue to address the disease-oriented needs of the patient, providing the patient with the care required but in a distant, business-like manner.

Boundaries are a feature in physician-patient and ACNP-patient relationships but in different ways. While physicians use boundaries to maintain a professional distance so that they are able to manage the patient’s disease, ACNPs are not usually concerned about boundaries until a personal connection is made. On those rare occasions, nurses expressed an acute awareness of appropriate boundaries, consistent with Ramos’ (1992) view that nurses can remain “psychologically separate from the patient” while describing “an emotional identification ... [that] was real, not devastating to the nurse but a motivator for her” (p. 504).

**Health Professional-Patient Relationship Development**

The development of the three types of relationships that form the ACHPPR theory involves three phases; readiness conditions, relational strategies and the resulting relational products. Each of these phases of the ACNP-patient relationship sub-theory is described in detail using comparisons among the three types of relationships; ACNP-patient, physician-patient and staff nurse-patient.

**Readiness Conditions**

The three readiness conditions that must be met for ACNP-patient relationships to develop include perceived patient openess to a relationship, authentic presence with the patient
and intention to know the patient. Only perceived patient openness is common to both staff nurse-patient and ACNP-patient relationships. The readiness conditions from each sub-theory are presented to illustrate similarities and differences (Table 15).

In acute care settings, patients do not usually choose their providers. Patients are referred to physicians who see them because they have disease-specific knowledge related to patients’ presenting or on-going conditions. Under a slightly different set of circumstances, staff nurses are assigned to patients each shift to provide disease-specific interventions that have been prescribed by other professionals as well as address needs related to how patients’ diseases affect them in the moment. Similarly, ACNPs are assigned to provide day-to-day specialized care to patients, addressing needs, formulating plans and performing interventions related to their disease and how it is affecting and will affect their lives. Though subtle, the difference in how patients come in contact with each type of health professional may explain why staff RNs and ACNPs identify patient openness as a readiness condition and physicians do not. Instead, physicians assume that patients trust them which influences their ability to move forward with the relationship. Understandably, it is not generally acceptable for a physician to refuse to see a patient who has been referred to him or her with a disease.

Table 15. Acute Care Health Professional – Patient Relationship Readiness Conditions

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<tr>
<th>ACNP</th>
<th>Physician</th>
<th>Staff Nurse</th>
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<tr>
<td>Perceived Patient Openness</td>
<td>Assume Patient’s Trust</td>
<td>Perceived Patient Openness</td>
</tr>
<tr>
<td>Authentic Presence</td>
<td>Something Can Always be Done</td>
<td>Patient Need</td>
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<tr>
<td>Intention to Know the Other</td>
<td>Confidence in Own Expertise</td>
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ACNPs’ connected relationships with patients are highly expressive and interactive. Patients with acute health needs are considered vulnerable, which is a precursor to authentic human behaviour, positioning them well to be open to a helping relationship with those to whom they have come for help (Daniel, 1998). Knowledge of the person and their life beyond the disease is deemed important by ACNPs in their practice. This inclination results in two additional readiness conditions; authentic presence and intention to know the patient. Being authentically present with the patient is what Summers (2002) calls “being present in the moment” with a patient which is achieved when an ACNP is able to “clear the mind” in order to eliminate distractions so that they can completely attend to the patient with whom they are interacting (Schwerin, 2004, p. 267). Authentic presence is also an important element of the “I-Thou” (Buber, 1970b) and humanistic relationships (Paterson & Zderad, 1976). Jourard (1971b)
concurs, suggesting that authenticity and honesty are important in relationships and they are achieved through a willingness to disclose one’s personal life to the other person. “Being present” and “spending time” are perceived by patients as important in their relationships with ACNPs, a finding that is consistent with those from a small study exploring the role of ACNPs caring for critically ill infants from the perspective of parents (Beal & Quinn, 2002).

The second readiness condition, ACNPs’ intention to know patients, is consistent with Kutaka’s (2002) reference to “focusing attention on the patient” and Niven and Scott’s (2003) “attention”. An intention to know the other provides a foundation for the development of a caring relationship that eventually allows NPs the opportunity to tailor interventions to meet unique patient needs (Thomas et al., 2004). Of course, patients can also exert control over whether or not a connected relationship can be established and their inclination to develop relationships with ACNPs is communicated in subtle ways to ACNPs who perceive it as patient openness to proceed. Reading signals from patients influences how ACNPs behave and how they will proceed in relation to the patient, a finding that is consistent with an earlier study (Morse et al., 1997). ACNPs are aware of times when they are unable to focus their attention on a patient, a state of being that influences their ability to be authentically present. ACNPs reflect a “desire to understand” and know the patient’s reality in order to move towards making a connection (Schwerin, 2004, p. 267).

These three readiness conditions inherent in the ACNP-patient sub-theory are supported by earlier research exploring nurse-patient relationships, which suggests that relationships between nurses and patients include a cognitive process and are negotiated, with each party having a decision to make about how they will move forward with the other (Morse, 1991a; Morse et al., 1997; Ramos, 1992).

A readiness condition important to staff nurse-patient relationships is to recognize that a patient has needs that they, as nurses, are required to meet. This is a condition that seems obvious and applies to any patient who finds himself in an acute care environment. This condition is met as nurses assess the severity, intensity and time-sensitive nature of patients’ needs which ultimately leads to an awareness of “what patients need”, a dimension of their relationship that influences the degree of relational intensity that evolves. One can assume that this readiness condition would always be met because the patient has presented to the acute care setting and his care has been assigned to a nurse. However, if a nurse assesses a patient’s needs to be minimal, achieving this condition may be compromised. Staff nurses and ACNPs share a
second readiness condition; that is that the patient is open to the relationship, again supporting the notion of mutual negotiation between patient and nurse proposed by Morse (1991a).

The variation in readiness conditions necessary for staff RNs and ACNPs may be the result of a number of factors. ACNPs’ intention to know patients can foster a greater knowledge of the person who is the patient and positions ACNPs well to care for patients continuously over time. Given their enhanced professional autonomy, decision-making authority and system influence, ACNPs are able to influence their patient assignments and care for the same patients on a regular basis. Secondly, ACNPs have graduate education during which relationship development is emphasized from theoretical and practical perspectives. This additional education may influence ACNPs’ perspectives on what is necessary to optimize relationship development with patients, i.e., relational competence (Jordan, 2004). Finally, professional socialization may contribute to this philosophical perspective. Socialization begins when nurses enter their basic education and then continues during employment (Siccardi, 1999; Weis & Schank, 2002). As hypothesized earlier, it may be that nurses choosing to enter graduate programs that prepare them to practice as ACNPs are interested in advancing their practice while remaining close to and focused upon relationships with patients. Nurses who enter graduate programs, as already described, are further socialized, in a way that emphasizes the centrality of relationships with patients which influences how the psychosocial aspects of practice are integrated into in the care they will provide as ACNPs (Lurie, 1981; National Organization of Nurse Practitioner Faculties, 1995).

Different readiness conditions are relevant in physician-patient relationship development. The first is that physicians express confidence in their own abilities and expertise in addressing disease-related needs of patients. This is understandable when considering how patients come to be in the care of physicians in acute care environments. They come to be diagnosed and treated. Secondly, physicians assume that patients trust them to effectively manage their disease. Physicians suggest that they are fortunate that patients usually come to them trusting in their abilities and it is only if something goes awry that mistrust may develop. A third condition, the belief that something can always be done for a patient, is also understandable in the context of acute care. Once a patient is diagnosed, there are treatments that can be offered and tried. Even if a condition is considered incurable, physicians believe they still have a role in providing options to patients and they won’t desert them. They are prepared to continue in a relationship that is focused on managing the patient’s disease, even if they cannot achieve a cure. These readiness conditions are in keeping with the original and modern day versions of the Hippocratic
Oath (Hippocratic, 2001; Lasagna, n.d.). The oath requires that physicians commit to gaining and using the best scientific knowledge and apply it to treat patients’ diseases. The goal is patient recovery but “matters of life and death” are clearly acknowledged. The humanness of the patient is acknowledged. So these readiness conditions are consistent with philosophical perspectives central to physician practice.

Relational Strategies

The acute care health professional-patient relationship theory incorporates relationship-specific strategies that are used by health professionals to establish relationships with patients. Strategies are intentional actions or behaviours used by health professionals to become familiar and establish closeness with patients reflecting an active psychological process and an “injection” of oneself into situations with people (Ramos, 1992, p. 502). The nurse-patient relationship is mutually negotiated and established using specific strategies (Morse et al., 1997). ACNPs use four strategies in the development of connections with patients; humour, using time as a resource, establishing credibility and discovering commonalities. These strategies may also be used in early interactions to achieve readiness conditions. While humour is the only strategy that is common to all three types of relationships, aspects of the other ACNP strategies are present in the physician-patient and staff nurse-patient relationships sub-theories. Only strategies used by ACNPs will be discussed in detail but strategies from each health professional sub-theory are provided for reference (Table 16).

<table>
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<th>Table 16. Acute Care Health Professional-Patient Relationship Strategies</th>
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<tr>
<td><strong>ACNP</strong></td>
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<td>Humour</td>
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<tr>
<td>Making Time Count</td>
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<tr>
<td>Achieving Credibility</td>
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<td>Discovering Commonalities</td>
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Humour

Humour is a complex phenomenon that has not been well studied in health professional practice. It has been suggested that measuring humour is a challenge because it “disappears when one tries to investigate or conceptualize it” (Astedt-Kurki, Isola, Tammentie, & Kervinen, 2001 p. 124). Humour is defined as “any communication which is perceived by any of the interacting parties as humorous and leads to laughing, smiling and a feeling of amusement” (Robinson, 1991 p. 35). In the current study, humour emerges as an important strategy in
ACNP-patient relationships and is strategically relevant in staff nurse-patient and physician-patient relationships as well. ACNPs describe humour in the context of their practice as behaviour or words that evoke a lighthearted mood and even laughter (Perry, 1998). Humour is said by some to be highly relevant in acute care environments where the proliferation of technology in acute care settings can depersonalize patients. Using humour is one way to create and maintain human contact with patients (Astedt-Kurki & Liukkonen, 1994; Perry, 1998; Robinson, 1991; Sumners, 1990), which is in keeping with a focus on humanistic approaches to health care (Alliex & Irurita, 2004; Astedt-Kurki et al., 2001; Penson et al., 2005; Robinson, 1991; Sumners, 1990). Some nurses also believe that using humour allows patients to feel important and cared about (Kutaka, 2002). It has been shown to foster deep and trusting relationships between nurses and patients and can be a ‘leveling agent’ among patients, family members and physicians (Penson et al., 2005; Squier, 1995). In fact, those who have researched humour suggest that it may have evolved in humans as a unique strategy to deal with and attenuate the impact of stress (Sala, Krupat, & Roter, 2002) which is certainly prevalent in acute care settings.

Humour is said to be a cognitive experience while laughter is the physical and physiological response to it; one must perceive something as funny to move from one to the other. Humour has been said to serve three main functions; communication, social and psychological (Perry, 1998; Robinson, 1991). In the current study, ACNPs’ use of humour reflects these three functions. With respect to communication, ACNPs use humour when they are speaking to patients about important issues but want to alleviate some of the anxiety associated with the message being conveyed (Morse, 1991a). Social functions are evident when ACNPs use humour with the intent to modify the tone of a discussion from negative to positive or when they use a light-hearted, jovial tone early in the relationship to establish rapport with patients. The psychological function is reflected in ACNPs’ use of humour in serious situations, to reduce tension and anxiety about the dire circumstances in which patients find themselves. Perry suggests a fourth purpose, that of therapeutic effect, a purpose that is consistent with the use of humour that was identified as a healing role competency of PCNP practice (Lewis & Brykczynski, 1994). These authors found that using humour sensitively was important, especially when dealing with acutely ill or dying patients, a strategy that is further supported in the ACNP-patient relationship sub-theory.

ACNPs describe using humour regularly and with most patients to establish their relationships (Penson et al., 2005), a finding not entirely consistent with the findings of an earlier
study of staff nurses, some of whom believed that humour was inappropriate for use in their practice (Astedt-Kurki & Liukkonen, 1994). ACNPs adjust their use of humour to the specific situation and the patient and they believe that they are generally successful with this, reflecting effective intuition and sensitivity to patients’ needs (Astedt-Kurki et al., 2001; Astedt-Kurki & Liukkonen, 1994; Lewis & Bryczynski, 1994).

Humour is a strategy that is common to each of the health professional-patient relationship sub-theories, but there is variation in how it is used. While ACNPs suggest an intentional use of humour to establish a connection and achieve a purpose, staff nurses spoke about humour as a more spontaneous “way of being” with patients, but they acknowledge that they use it when interacting with patients. Patients also acknowledge humour as one “way of being” that staff nurses use with them. In a related study, Sumners (1990) reported that while humour is recognized as having potentially positive effects on patients (e.g., aiding in problem solving, offering relief from symptoms of illness, diminishing conflict) and can be initiated purposefully, many nurses don’t use it this way. Humour in Sumners’ study was more of a behavioural response to the clinical context, a finding consistent with the current study. Beck (1997) found that some staff nurses actually choose to use humour intentionally, especially as a communication tool to develop rapport with a frightened patient or decrease patient anxiety, depression or embarrassment. Alliex and Irurita (2004) claim that patients see nurse’s use of humour as a way to demonstrate that they are human beings as well as nurses, a finding consistent with patients’ perspectives on staff nurses. ACNPs’ and staff nurses’ use of humour in their relationships with patients in the current study is consistent with findings of the majority empirical evidence addressing the issue of humour.

Physicians’ use of humour differs from that of ACNPs and staff nurses. Findings of the current study suggest that, while physicians do occasionally initiate humour, it is related to socially acceptable or safe issues, such as current events. In fact, some physicians are concerned that if they use humour it can be misinterpreted by patients, resulting in patients feeling uncomfortable or insulted (Astedt-Kurki & Liukkonen, 1994; Squier, 1995). Humour use with patients has been described as high risk especially when patients have a major illness (Penson et al., 2005; Squier, 1995). Physicians’ approaches seem to reflect a belief that health care is a serious business with little or no place for humour (Penson et al., 2005; Robinson, 1991). However, it has been suggested that humour can exist in health care environments in positive, productive way that normalizes the abnormal and humanizes the inhuman (Penson et al., 2005; Robinson, 1991) such that support for physician use of humour is growing (Penson et al., 2005).
Some studies have even suggested that use of humour by physicians can positively influence physician-patient relationships and may even reduce malpractice claims which can be indicative of higher levels of patient satisfaction (Sala et al., 2002). Robinson (1991) concurs, suggesting that all human beings need humour in order to cope with life events. Robinson does, however, discuss the findings of two early studies that addressed humour in health care settings where patients were critically ill and often died, acknowledging that the “staff joked among themselves, but rarely joked with patients or visitors” (p. 71). Since the current study focused on health professional-patient relationships and not the relationships among health professionals, it is not possible to comment on use of humour in the relationships physicians have with those other than patients. Physicians in the current study do, however, describe feeling comfortable responding to humour that is initiated by patients. Patient initiated humour may reflect a need for an outlet to communicate their emotions, attitudes or opinions that they might otherwise be suppressed or exert some control over a difficult situation (Astedt-Kurki et al., 2001; Penson et al., 2005; Sala et al., 2002; Squier, 1995).

Humour is clearly an important therapeutic strategy used by nurses that is substantiated by the findings of the current study. While the literature suggests that humour is important in health care environments (Astedt-Kurki et al., 2001; Penson et al., 2005; Robinson, 1991), physicians in this study tend not to initiate humour. While this hesitancy is also prevalent in the literature, it is recommended that health professionals consider using humour as long as receptivity has been assessed in the patient. How health professionals are able to use their time may influence their ability to do this. It has been said, “laughter is the shortest distance between two people” (Robinson, 1991, p. 55). If this is the case, then the degree of relational intensity which ACNPs and staff nurses strive to attain may be influential in their choice to use humour as a strategy in relationship development with acutely ill patients. With a lesser span of relational intensity in physician-patient relationships, physicians may be maintaining a degree of equity so as to provide the same standard of care to all patients.

Time as a Resource

Time to care is not a new concept in nursing (Pediani, 1998) so it is not surprising that time features prominently as a strategy used by ACNPs in developing relationships with patients. Kutaka (2002) found that “spending time with patients” (p. 84) eases the development of a connection and establishes intimacy between nurse and patient, which then results in more accurate clinical judgments. In the current study, ACNPs describe making time for patients,
spending time with patients, they are “there” for patients, they speak of making an investment of time in patients and they offer patients time to process their situations, all of which support Kutaka’s earlier findings. While time is also a feature in physician-patient and staff nurse-patient relationships, it is not characterized as an active strategy that is used by to establish relationships with patients.

Time is considered a valuable nursing resource (Donohue, 2003; Heartfield, 2006; West, Barron, & Reeves, 2005) because it allows patients to believe they are cared for and it has the potential to enhance patient’s ability to cope and reduce feelings of helplessness (Donohue, 2003; Pediani, 1998). As ACNPs strive to make a connection with patients, maximizing their use of time with patients is seen as a priority. They spend time with patients as individuals, alone, listening to their stories and trying to get to know them, allowing ACNPs to participate in the patient’s experience (Perry, 1998). According to the ACNP-patient relationship sub-theory, the more personally connected the ACNP-patient relationship becomes, the more time she reports spending with the patient, offering additional evidence that nurses spend more time voluntarily with patients with whom they experience high relational intensity (Ramos, 1992).

Time is frequently described and evaluated in the empirical literature however it is not usually conceptualized specifically as a relationship establishment strategy. Spending time with another person would seem to be important in developing a relationship and is considered a crucial contextual factor (Williams, A.M. & Irurita, 1998). The issue of time is regularly discussed in medical and nursing literature, albeit with varying emphases and foci. Much of the evidence related to NP use of time with patients is discussed in relation to primary care NPs and the importance they place on spending enough time with them. Nurse practitioner consultations are generally longer (Horrocks et al., 2002), with NPs spending, on average, more than twice as much time (10-15 vs. 4-6 minutes) with patients as their family physician counterparts when seeing patients with similar complaints (Seale et al., 2006; Williams, A. & Jones, 2006).

What happens between practitioner and patient during the time they spend together is also important, perhaps more important than length of time (Torn & McNichol, 1998; Wilde, 1997). From a content point of view, PCNPs tend to focus on treatment-related information such as treatment details, how to treat, associated costs and side effects (Seale et al., 2006), and explanations (Donohue, 2003), both of which are compatible with expectations of patients in the current study. Williams’ and Jones’ (2006) study of patients’ views suggests that not only are they satisfied that NPs use time wisely with them but that they are also highly satisfied with NPs’ style of questioning and consultation as well as their use of a variety of strategies besides
prescribing to address their health issues. From a process perspective, Summers (2002) suggests that NPs spend time in “intentional dialogue”, which “enables tuning into one another in the patient/provider relationship” (p. 21), allowing each to experience ease with the other and achieve common ground. Spending time with patients, being “alongside” them (Pediani, 1998, p. 693) is actually not considered an advanced practice competency but practising in this way, as ACNPs in the current study do, reflects a belief and an understanding that giving patients time ensures that patients “will tell you everything you need to know” (Pediani, 1998, p. 693). These perspectives are highly relevant in relation to the current study because a product of ACNPs’ connected relationships is ‘comfort with the other’, which will be discussed later. The goal of establishing common ground seems to require one to give the patient time and being comfortable with silence, because if one is to understand what the patient knows or understands about his or her condition, the provider may need to wait, not interrupting the silence (Summers, 2002). ACNPs describe sitting with patients, offering them the time to process information and consider their situation before continuing with a discussion which contributes to making the connection. The concept of common ground as it is described is a good fit with making a connection. ACNPs strive to make a connection that at least achieves the level of relational intensity of a professional connection. Even with that degree of relational intensity, common ground can be achieved and the relationship is the vehicle through which ongoing plans can be made to address the patient’s health needs.

Making time count is a strategy used by ACNPs to spend time authentically listening to patients’ stories, hearing what Summers (2002) refers to as the “joy, struggle, dreams and aspirations” of patients. Spending time, from the patient’s point of view, is important to their sense that the NP cares about them, is not going to rush off, and is focused on them as individuals (Donohue, 2003). Patients in the current study recall that ACNPs spent more time, more often, with them when compared with physicians and staff RNs, but the amount of time was still not extensive. Unlike their perceptions of staff nurses, patients did not view ACNPs as too busy to spend time with them.

Some patient participants in the current study suggest that knowing the ACNP over a longer period of time was beneficial, allowing them to increase their feelings of comfort with the ACNP. While there is some support in the literature for this finding (Williams, A.M. & Irurita, 1998), there is also evidence which suggests that good levels of relational intensity and comfort with one another are not always dependent upon the duration of the relationship (Kutaka, 2002) as also described by ACNPs in the current study.
A final time-related issue, continuity, is relevant because ACNPs describe “being there” for patients over time. Continuity of contact with the same nurses has been described as essential to relationship development (Williams, A.M. & Irurita, 1998) and it is one way NPs can contribute to safe, quality patient care (Brykczynski, 1989). Continuity, itself, is a contentious issue and can be defined in a variety of ways. In the context of the current study and from the patient’s perspective, continuity can be defined as “the experience of care as connected and coherent over time” (Reid, Haggerty, & McKendry, 2002, p. iv). Continuity of care is usually considered to be achieved when a patient experiences regular interaction with the same care provider(s) over time. This conceptualization, while inherently problematic because of the impossibility of a single provider caring for a patient 24 hours/day, seven days/week, is often used to evaluate success in achieving continuity (McAllister, 2006). Though ACNPs are not available to patients 7 days a week, 24 hours a day, the model of practice used promotes consistent involvement of an ACNP with particular patients over time. This is seen by ACNPs not only as a strategy to foster connections but also to enhance their understanding of the patients’ unique needs and issues. From a patient perspective, patients knew the ACNPs working with them by name and all considered their relationships with ACNPs as important in their illness trajectory. Given that patients identify that ACNPs make things happen on their behalf, one can conclude that they perceive the care they receive from ACNPs as connected and coherent. So, while continuity of provider is recognized as a potential problem in the sector of the health care system in which PCNP-patient relationships development occurs (Summers, 2002), this is not apparent in the acute care context of the current study.

While the use of time does not emerge as a relational strategy in the physician-patient relationship sub-theory, the amount of time physicians spend with patients is a dimension of their relationship that influences the degree of relational intensity that develops. Physicians’ dialogue suggests that the more time they are required to spend with a patient, the more likely they are to have a more intense relationship with him or her. Factors that influence time spent with a patient are the immediacy of their needs and the acuity of their condition, a reality that also features prominently in the ‘patient need’ dimension of staff nurse-patient relationships. The intensity of patients’ needs seems to act as a barometer, which allows physicians to adjust their time management accordingly. Of note is that patient participants in the current study suggest that most physicians, while spending adequate time with them, spent less time with them in a day and see them less frequently than their ACNP colleagues.
Wilsons’ and Childs’ (2002) systematic review of physician consultation length, process and outcomes in general practice reported that the time physicians spend with patients is positively correlated with some aspects of patient satisfaction and with patient enablement, but is negatively correlated with prescribing rates. In addition, they found that female physicians had slightly longer consultation times and that physicians who had longer consultations times tended to be more patient-centred in their approach. They concluded that while there is no evidence as to an ideal consultation length, patients who see a physician who consults more slowly is more likely to have important aspects of care addressed. These conclusions are supported by patients’ dialogue in the current study when they describe some situations with physicians that were less than satisfactory. Such interactions are described as brief and physician behaviour is interpreted as indicative of their busyness with minimal time available for them. Their comments indicate lower overall satisfaction with such physicians. These perspectives are in keeping with findings of another primary care study comparing PCNPs and physicians in general practice. Patients perceived physicians as having less time to spend, which led to dissatisfaction and a preference for PCNP consultation (Williams, A. & Jones, 2006). So physicians may adjust the time they allocate to each patient based on physician assessment of need and patients may also influence this process by choosing not to introduce issues for discussion because they perceive physicians as busier than NPs. It is also possible that adjusting time spent with patients using acuity and immediacy of need is another way for physicians to maintain adequate distance from patients so as to remain objective and provide an equivalent standard of care to all.

To say that “time is scarce” (Stewart, M. et al., 1995 p. 102) from a physician’s perspective, is an understatement. How much time is enough time to spend with each patient is regularly discussed but is rarely answered (Curry, 2006). In a study designed to investigate how long patients need to present their concerns, it was concluded that if internist physicians in a hospital ambulatory clinic remained quiet and did not interrupt patients, 78% of patients completed their initial statement within 2 minutes and all patients had stopped speaking spontaneously by 5 minutes (Langewitz et al., 2002). These findings suggest that how time is used in consultation with patients may be important in relation to hearing patients’ concerns.

Some authors suggest that spending time differently with patients may result in increased satisfaction for all involved. In a primary care context, Stewart and her colleagues (1995) suggested that it should take no more time to achieve a patient-centred interaction during a consultation, focusing on gaining an understanding of the patient’s illness and disease, an understanding of the person and achieving common ground between physician and patient.
Recall that common ground was associated with connectivity (Summers, 2002). Stewart and her colleagues suggest that a key strategy to achieving a patient-centred approach is enhancing the physician-relationship. Others concur but add that simply increasing the amount of time physicians spend with patients without changing physician approaches to patients during encounters may have no impact on patient satisfaction with physician care (Ridsdale, Morgan, & Morris, 1992; Williams, A. & Jones, 2006).

The findings from the current study suggest that time spent by physicians with patients is dependent upon physician assessment of the needs of the patient. This assessment may not always be well synchronized with what patients would like or expect from physicians. However, one other factor must be considered when drawing conclusions about these findings; how physicians are compensated for the work they do with patients. Physicians are educated and socialized to provide patient care and many are paid by how much they do for patients using a pre-determined fee structure (Curry, 2006). These structures no doubt influence how physicians organize and use their time because their livelihoods depend upon it. Changes in some acute care environments, including alternate payment plans (i.e., salaries), may allow physician practice to change, allowing patient preferences related to time to play more of a role. In addition, if those in charge of medical curricula are influential in establishing new expectations for “new” physicians (Toynbee, 2002) and promoting new approaches to patient care, such as patient-centred care (Stewart, M. et al., 1995), then the next generation of physicians may be prepared to use time differently with patients, acknowledging a new trend, that the “patient is the master now” (Toynbee, 2002 p. 718).

Continuity is has also been associated with time in the current study. While not explicitly discussed, physician participants describe their commitment to continuity as remaining involved with those patients discharged from their patient care service as well. Such relationships can continue for months, even years. Hospitalized patients in the current study, in the acute phase of their diseases, are cared for by a rotating group of physicians, with rotations usually being one week in length. Physicians also provide on-call coverage on weekends. As a result, patients with long lengths of stay would receive care from the same physician episodically over their admission. Physicians communicate relevant information to one another as they rotate “off service” but the degree of continuity of care provider is limited, although, in this study, not as limited at that provided by staff nurses.

As already mentioned, time does not emerge as a strategy in the staff nurse-patient relationship sub-theory but it is relevant to the dimensions of the relationship that ultimately
influence relational intensity; ideal versus reality and what patients need. While nurses recognize that spending time with patients is important in developing relationships with patients, they identify a number of variables that influence the degree of relational intensity achieved, including those related to the nurse, the patient and the system. They recognize that these variables may coalesce to allow more or less time to be spent with a patient and ultimately negatively affecting relational intensity. However, as patients in hospitals are more acutely ill and lengths of stay are becoming shorter, some claim that having time with patients is becoming a luxury. This reality can negatively affect nurses’ satisfaction with their professional work (Ramos, 1992). However, some nurses claim that if they decide to establish more intense relationships with patients, then they may decide to not allow system and time issues to constrain them (Ramos, 1992).

In their study of nurse-patient relationships, Williams and Irurita (1998) concluded that the amount of time nurses spend with patients allows them to get to know one another, subsequently influencing the intensity of the relationship that is developed. As nurses in the current study describe, the more needs that patients have and the more patients are able to respond to nurses, the more time nurses spend with them (Ramos, 1992; Williams, A.M. & Irurita, 1998). Alliex and Irurita (2004) labeled this phenomenon as nurses ‘giving time’, which they claim contributes to maximizing the relationship that nurses are able to achieve with patients in the presence of significant technology typical today in acute care environments. Of note, however, is that allocation of time to a patient based upon the quantity and acuity of physiological requirements may not offer an accurate reflection of what a patient actually needs from a nurse. Niven and Scott (2003) suggest that psychological vulnerability may not be reflected in such assessments of patient acuity.

It is currently acknowledged that nurses are constantly facing significant time constraints (Clarke, 2006; Pediani, 1998). Staff nurse participants in the current study regularly refer to how busy they are, feeling like they are short of time to do the things with patients that they think would foster the increased relational intensity associated with what they view as the ideal relationship with them. Their workload significantly influences their ability to spend time with patients and staff nurse participants experience frustration with this reality. McQueen (2000) suggests that when nurses are lacking in time, their feelings about being rushed and overworked “can override their feelings for individual patients and … these can spill over into their manner and behaviour [with patients]” (p. 727). Patients in the current study describe nurses as busy, recognizing this as impacting on the amount of time nurses had available to spend with them at
any given time. This finding substantiates Pediani’s (1998) research, which demonstrated that when patients detected nuances in nurses’ behaviours suggesting busyness, they may respond in a way so as not to be a further burden on the nurses’ time. Busyness has been associated with the demands being placed on nurses’ time by patients, the system and the profession, all while nurses are expected to complete particular tasks in an allotted time frame (Pediani, 1998). Nurses report that the difficulties they experience in establishing relationships with patients are related to inadequate time and resources (Williams, A.M. & Irurita, 1998). The pressures that nurses feel are juxtaposed with their desire to achieve the ideal relationship with patients, which is rarely if ever achieved in their view.

Changes in the health care system secondary to restructuring and refocusing on business models to manage care may be playing a role in time constraints placed on nursing practice, as documented in the literature (Rankin & Campbell, 2006). Rankin and Campbell, in their study of nurses at work, observed them “adapting, making do, cutting corners and coping with multiple demands and disruptions” (p. 165) in their efforts to meet patients’ needs. One of their conclusions is that nurses are being forced to spend their time with patients differently.

As discussed earlier in relation to ACNPs and physicians use of time, how nurses spend their time with patients influences their relationships with them. If they have many tasks to complete, their focus may be on what Campbell (1984) refers to as “doing to” rather than “doing with”. Busyness may also be viewed as a form of “character armor” (Jourard, 1971b, p. 180) but given nurses’ descriptions of their desired ideal relationship, this seems unlikely. While patients may want a nurse to just sit with them for a while (Pediani, 1998), nurses feel they are unable to do this due to competing demands from they system and other patients, as evident in the current study. A recent study reported that, during a typical 8 hour shift, each nurse was found to complete an average of 160 tasks taking approximately 2.48 minutes each which confirms nurses are indeed busy with a variety of tasks and may not able to spend significant time with patients (Tucker, as cited in Salmond, 2005). However, as described by nurses in the current study, one could conclude that if an individual patient required a number of tasks to be completed in relation to meeting their needs, the nurse might be able to spend a bit more time with him or her, which nurse participants cite as increasing the likelihood of establishing a more intense relationship with that patient.

How nurses spend their time does not always feel within their control because of varied and competing demands. Nurses suggest that having their focus re-directed to adjustment of staffing ratios, attendance at meetings and completion of paperwork reduces the time they have
available to build relationships with patients (Kutaka, 2002) and nurses in the current study and others suggest that relationships are important in providing patient care. It has even been suggested that when nurses feel they have too much to do, they simply feel unable to address important issues like managing symptoms such as pain or attending to a patient’s anxiety and emotional concerns (West et al., 2005).

The frequency with which nurses are assigned to care for specific patients also influences how much time a nurse has with a specific patient. Staff nurse participants in the current study suggest that continuity of care is rarely achieved. If they are scheduled to work a few shifts sequentially, they usually have the same assigned patients, but not always and when they return to work after a few days off, they are not re-assigned to the same group of patients. In their minds, this practice compromises the amount of time a nurse might have to establish a relationship with a patient and may ultimately have a negative influence on relational intensity. Continuity has been suggested as pivotal in relationship development (Williams, A.M. & Irurita, 1998). In the current study, this lack of continuity appears to contribute to patients seeing nurses as interchangeable, with all of them viewed as similar in their ability to meet their needs.

With respect to nurse patient relationships, Rankin and Campbell (2006) conclude that system changes have resulted in nurses knowing patients in a “strictly scientific and objective way” (p. 165), which leads to less attention and time spent with patients versus treating them as individuals with needs beyond what can be measured or counted. Their assessment is cause for concern as it suggests that a nurse-patient relationship will be unidirectional, focused exclusively on provision of technical care, an outcome that is incongruent with what nurses are taught and what is suggested as essential when meeting patients’ needs (Paterson & Zderad, 1976). In order to influence the system in a way that benefits patients, Gordon (2006) and Weinberg (2006) suggest that nurses focus their discourse less on the relationship with patients itself and focus more on what the relationship allows nurses to achieve with patients, addressing the achievement of positive, efficient and effective outcomes. Several authors have suggested that nurses consider using their time differently with patients (Clarke, 2006; Rankin & Campbell, 2006), such as techniques demonstrated in Wright and Leahy’s “Maximizing time, minimizing suffering: The 15 minute (or less) family interview” (Rankin & Campbell, 2006 p. 155), a video that offers a different approach for nurses to use their time with patients that still allows them to accurately and but more efficiently assess patients’ and families needs.

Time and how it is used has a significant impact on the relationships staff nurses are able to establish with patients. In the current study, they describe having little control over what
kinds of relationships they can develop with patients and they use their assessment of patients’ needs (acuity, intensity) as a mechanism to allocate nursing time to each patient, not unlike physicians. While they recognize time’s influence, staff nurses feel powerless to change their current practices related to daily time management and interruptions in continuity over time. Relating to patients in a manner that is affected by their “busyness” may make nurses feel as if they have not played a meaningful part in the care of patients (Pediani, 1998).

Time is a feature of all three sub-theories, albeit in different ways. The findings of this study substantiate earlier research which suggests that patients view nurses as busy and may assume that of physicians are as well. While not explicitly stated, patients’ dialogue reflects that ACNPs have time for them on a more regular basis. These three health professions work differently in the same environment and while time features differently, it likely contributes to relational complementarity.

Earning Credibility

Nurses are consistently cited as the health care professionals most worthy of public trust in public surveys (Leger-Marketing, 2007). However, when the reasons for according such trust are investigated, public knowledge of what nurses do is limited and vague. This means that public expectations of nurses may vary. Expectations of physicians are more consistent. In fact, physicians are also highly trusted by the public (Leger-Marketing, 2007) and have long-standing credibility in modern society (Campbell, 1984). They are afforded significant symbolic capital (Bourdieu, 1985) with an end result being implicit trust in them to manage their diseases. ACNPs, while nurses, are an unknown professional to most patients who find themselves admitted to hospital. Increasingly, it is possible that a patient will have interacted with an NP in a primary care setting in Canada, but those patients are still in the minority. As a result, patients do not know what to expect from this ‘different’ nurse. If they have strongly held beliefs that they should receive their care from a physician, then an ACNP may not be a welcome addition to the care team. However, given the dependency that occurs just by entering an acute care setting, it is also possible that patients will watch ACNPs to figure out what they do. None of the patients in this study had received care from an ACNP prior to this acute care experience. So patients receiving care in or from acute care hospitals did not have any way of knowing what to expect.

It is possible that this is why earning credibility is a strategy ACNPs use in their quest to make connections with patients. Credibility as a health professional is singled out by ACNPs as
important in establishing trust with patients. Credibility and trust appear to be linked in the current study. Both are also implicated in the readiness conditions of the physician patient relationship sub-theory and neither emerges as relevant to staff nurse patient relationships.

ACNPs use honesty and a straightforward approach in their interactions with patients which Summers (2002) claims contributes to achieving common ground between care provider and patient. Common ground is defined as “the shared surface between the patient and the NP, which develops with the accurate perception of cues” (Summers, 2002 p. 22), a state that is relevant to making a connection.

Gaining a patient’s trust has been found to occur as a result of initiating rapport, which then encourages the patient to share his or her concerns with the nurse so that he or she is better able to meet the biopsychosocial and spiritual needs and reduce vulnerability (Williams, A.M. & Irurita, 1998). While Williams and Irurita explored therapeutic relationships between staff nurses and patients, their findings validate the importance of trust and credibility in establishing relationships with patients, which is applicable to ACNP-patient relationships.

ACNPs find it important to convey a sense of professional self-confidence as well as knowing their limitations in order to convince patients that they are credible as a care provider, a finding consistent with findings from a study of PCNPs interviewed about their role (Torn & McNichol, 1998). Competence as a care provider requires NPs to integrate theoretical knowledge with experience as a nurse and an NP and apply this to the provision of quality care to patients. Conveying a sense of confidence and competence has been shown to be reassuring to patients (Kleiman, 2004), further validating the importance of earning and demonstrating one’s credibility in providing patient care. In fact, Donohue (2003) reported that patients in a primary care setting looked for a sense of security and confidence in the NP and that NPs were able to achieve this quickly with patients.

Physician participants in the current study do not describe a need to earn their credibility or establish trust with patients who come to them with health concerns. In fact, physicians acknowledge that they are fortunate to be assumed as trustworthy by the majority of patients who present to them for care, an assumption also discussed by Coulter (2002), and identified as a readiness condition in relationship development in the current study. Physician participants believe that if patients do not trust them, they may choose not to keep the initial appointment or may leave the practice and see another physician. However, they assume that the vast majority of patients trust physicians, which, in turn, means there are rarely situations when the readiness
condition of trust is not met. Patient participants’ dialogue reflects their trust in physicians, validating this assumption in the current study.

Niven and Scott (2003) found that a practitioner’s behaviour could inspire and solidify a patient’s trust in them. Patient participants in the current study do not make any reference to a lack of trust in ACNPs involved in their care. They see them as “making things happen” on their behalf, making a significant contribution to their ability to move on with their lives. In particular, they view ACNPs as able to anticipate their individual needs, they trust that they are working closely with the physicians in charge of the overall plan and they are confident that ACNPs can and will discuss the plan with them, translating it into language that they will understand. They see them as having more responsibility and decision-making authority than staff nurses. Patients’ dialogue reflects satisfaction with their relationships with and the care they receive from ACNPs, findings that mirror earlier studies (Drury, Greenfield, Stilwell, & Hull, 1988; Gutyher & Sobal, 1982; Langner & Hutelmyer, 1995; Rhee & Dermeyer, 1995). Patient perceptions in the current study indicate that either ACNPs are effective in earning credibility as they provide humane competent care (Gordon, 2006) or that credibility is actually a non-issue for patients, perhaps because they see them as nurses and therefore inherently trustworthy.

Finding Commonalities

Finding commonalities is identified as another strategy used by ACNPs. Staff nurses also mention finding commonalities as a feature of their “ways of being” strategy, but it does not feature as prominently as it does in the ACNP-patient relationship sub-theory. Physician participants’ dialogue does not reflect any motivation to discover any similarities they may share with patients because their focus is exclusively on the patient’s disease. Patients, however, describe their interest in knowing about the physician as a human being and suggest using strategies such as talking with other patients or searching the internet to discover physicians’ personal details. However, physicians are clear that they don’t share personal information with patients.

A number of researchers ascribe value to nurses’ discovery of commonalities or similarities between themselves and patients in developing therapeutic relationships. Mutual sharing of information about themselves by nurses and patients has been described as therapeutic reciprocity (Williams, A.M. & Irurita, 1998). Finding commonalities allows a nurse and patient to get to know one another and it usually is part of a process of initiating rapport. When
common interests are established, patients have a sense that nurses will not run off quite as quickly, spending more time with them (Williams, A.M. & Irurita, 1998). Discovering shared experiences and recognizing similarities are said to enhance the connection between nurse and patient, allowing each person to identify with the other, a finding that validates the utility of such a strategy for ACNPs (Kutaka, 2002; Perry, 1998).

Self-disclosure is necessary for, but may not necessarily result in, discovery of commonalities with another. Mutual self-disclosure is a prominent feature of relationships between ACNPs and patients that have high relational intensity as well as between staff nurses and patients. A gender effect may be at work as Jourard (1971b) reported that females are more likely to self-disclose than males. In the current study all ACNPs, 80% of staff nurses and 50% of physicians are female, but some degree of self-disclosure is only evident in ACNP-patient and staff nurse-patient relationships. The strategic use of self-disclosure in the process of finding commonalities between themselves and patients may be explained by the relational competence of ACNPs. Baker Miller and her colleagues (2004) suggest, in the context of psychotherapy, that as one becomes more relational in approach, one feels more comfortable sharing one’s own experience as long as it contributes to movement in the relationship. This is considered to enhance the authenticity of the relationship (Baker Miller et al., 2004; Jourard, 1971b). The effectiveness of this strategy by ACNPs, and to a lesser degree, staff nurses, is supported by Jourard’s (1971b) study of student nurses. He found an association between the degree of student nurse self-disclosure and the closeness of their relationships with patients. By way of contrast, Jourard also suggested that health professional behaviour towards patients that is rigid, distant and inauthentic can inhibit patient disclosure which would prevent the discovery of any commonalities. The extremes of such behaviour may contribute to the use of “character armor”. Physician use of “imposed boundaries” and staff nurse “busyness” may result in such behaviours, which can impede increasing relational intensity.

For ACNPs, ‘finding commonalities’ is a key strategy used to make a connection with patients. Perry (1998) offers a poignant poem, which nicely summarizes the importance of discovering similarities with patients. “We are different. We are the same. We are essentially the same! Finding that point where we are the same, makes caring for each other so natural” (p. 106). Realizing what one shares with another person allows two people to share a “between” (Buber, 1970b; Paterson & Zderad, 1976), which enhances the potential for a connection to be made.
Relational Products

Making a difference is a product that is common to both ACNP-patient and staff nurse-patient relationship sub-theories. There are no common products between physician-patient and ACNP-patient relationship sub-theories but patient appreciation is a feature of both physician-patient and staff nurse-patient relationship sub-theories. These products are the result of the establishment of a professional or personal level of relational intensity and are both consequences as well as forces that potentially sustain the relationship that has been established. Only the ACNP-patient relationship products will be discussed in detail but products from each health professional sub-theory are provided for reference purposes (Table 17).

Table 17. Acute Care Health Professional-Patient Relationship Products

<table>
<thead>
<tr>
<th>ACNP</th>
<th>Physician</th>
<th>Staff Nurse</th>
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<tbody>
<tr>
<td>Making a Difference</td>
<td>Seeing Patients Move on with Life</td>
<td>Making a Difference</td>
</tr>
<tr>
<td>Partnership</td>
<td>Patient Appreciation</td>
<td>A Job Well Done</td>
</tr>
<tr>
<td>Comfort with the Other</td>
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Making a difference

ACNPs identify that making a difference is a natural consequence of making a connection with patients, a finding that is supported by Perry’s (1998) study of exemplary nursing practice. Making a difference has also been described in earlier empirical literature. Kutaka (2002) claims that making a difference occurs as a result of the work nurses do with patients that enhances and enriches patients’ lives. When a close bond with a patient is established in the context of providing quality patient care, nurses can “make a difference” (Ramos, 1992 p. 504). Making a difference is said to have the effect of affirming nurses in their role with patients and allows them to find meaning in their experiences and they are changed as a result (Perry, 1998), which is consistent with the a humanistic relationship (Buber, 1970b, 2004; Paterson & Zderad, 1976). Making a difference parallels a finding from an earlier NP-patient relationship study, enhanced personhood, suggesting that the relationship can enhance the lives of those in the NP’s care (Thomas et al., 2004).

While making a difference is a product common to relationships that both ACNP and staff nurses establish with patients, the focus of the activity that makes a difference varies. ACNPs’ central focus, that of making a connection, is in keeping with Perry’s (1998) view that nurses seek to make a unique contribution to patients’ lives beyond the acute illness and recall feelings of satisfaction and reward when this occurs. The difference they make contributes to patients’ achievement of their overall goal, to move on with their lives. Staff nurses, with their
more narrow focus on meeting here-and-now needs, make a difference by helping patients cope with their diseases while in the acute care setting. Staff nurse dialogue does not only reflect making a difference to patients but they also recount when they are unable to make a difference to the degree that they wish, which results in feelings of sadness, frustration and even anger.

ACNPs provide concrete evidence of making a difference in patients’ lives. They receive visits from patients who are returning for appointments, telephone calls and messages with updates on their progress, small gifts that often reflect shared commonalties and interests and greeting cards. One ACNP mentions that she has kept every card that she has ever received from a patient/family. Perry (1998) acknowledged that such gestures and greetings as prized symbols of making a difference. Staff nurses do mention similar symbols as important but they are regularly directed to groups of nurses or the entire unit rather than individual nurses.

As already mentioned, physician participant dialogue does not suggest that making a difference is a distinct product of their relationships with patients. The two outcomes of their relationships with patients include expressions of patient appreciation and seeing a patient moving on with his/her life. When considering these products it may be that when the two are merged together this creates a sense that physicians recognize that they achieve their focus, successfully managing the patient’s disease, and have actually made a difference to the patient, which results in feelings of satisfaction.

Making a difference is a product of making a connection with patients for ACNPs and it is a product that is similar but qualitatively different to what staff nurses describe as making a difference in the context of their relationships with patients. Making a difference was not explicitly discussed but is likely inherent in them seeing patients move on with their lives which is usually indicative that things are better for them.

Comfort With the Other

Comfort with the other is one of the two products that are unique to connected relationships that are established between ACNPs and patients (Table 17). As discussed earlier, comfort with the other is reflected in the “interaction” dimension of making a connection. In fact, as ACNPs’ feelings of comfort with patients increase, so does relational intensity. ACNPs’ attention to readiness conditions and their effective use of relational strategies to achieve a connection are precursors to achieving comfort with the other. One strategy in particular, spending time with patients, has been previously found to influence the degree of comfort that is produced in a relationship (Summers, 2002). Overall, effective relationships with patients have
been shown to yield increased levels of comfort as well as more positive outcomes (Ramos, 1992). Comfort with the other is also an expression of the perceived humanness of the other (Beal & Quinn, 2002). In essence, if a connection is established, ACNPs report feelings of comfort with patients, the relationships are more relationally intense and they feel the relationship has been useful to patients (Ramos, 1992). Comfort may also indicate that the nurse has shared in the patient’s experience (Perry, 1998).

Comfort with the other is not an explicit product of physician-patient relationships but is evident in the “rapport” dimension of physician-patient relationships (Table 14). Similar to ACNP-patient relationships, as relational intensity increases between physicians and patients, levels of comfort also increase. Comfort with the other also contributes to the nature of the staff-nurse patient relationship in the dimension “ideal vs. reality” (Table 14). As staff nurse-patient relationships become more like the ideal, the degree of comfort between nurse and patient increases. So, while comfort with the other is evident in each sub-theory it also emerged as a discreet product of connected ACNP-patient relationships.

Partnership

The final product of connected relationships between ACNPs and patients is partnership between the two. Partnership is a product that is unique to the ACNP-patient relationship sub-theory (Table 17). Partnership in nursing has been defined as an “association between nurse and patient where each one is a respected, autonomous individual with something to contribute to a joint venture and in which both work towards an agreed goal” (McQueen, 2000 p. 726). While McQueen suggests that the two parties are not necessarily equal, in the context of the professional – patient relationship, partnership does require a move away from authoritarian, paternalistic approaches traditionally used by health professionals in caring for patients and towards partnership and valuing patient autonomy. This is said to have positive effects on patient well being (Courtney, Ballard, Fauver, Gariota, & Holland, 1996; McQueen, 2000), ensures that services meet patients’ needs (Niven & Scott, 2003) and encourages individuals to realize their own power in managing and improving their own health (Courtney et al., 1996). Cahill (1996) offers an alternative view, suggesting that in order for partnership to develop, both parties must have equal control and this is not achieved in nurse-patient relationships. She suggests that what is achievable between a nurse and a patient is participation, a precursor to partnership. In the current study, ACNPs acknowledge that patients are experts in their own lives and in their own care. They learn about the person with the disease, which is intended to
help them understand patients’ goals and negotiate a relationship that allows them to move forward together to reach those goals. While the perspectives expressed by ACNPs in the current study are not in keeping with Cahill’s view of partnership, they do reflect elements that are characteristic of the earlier proposed definition, namely joining together with patients, respecting them as individuals, seeing them as being expert and having some control and working towards mutual goals. While an imbalance of power persists in even the most connected relationships, partnership seems a better description of this relational product than simply participation. Patients’ perspectives are consistent. They report that ACNPs know them well as individuals, anticipate their needs, ensure that they always understand what is happening and work with them to individualize the plan of care to help patients move on with their lives. While they do not use the word “partnership”, their perspective is in keeping with previous work that reflects a more instrumental mode of participating in their health care (Avis, 1994).

Interest in health professional-patient partnerships arose during the consumerism movement of the 1990s and legislative changes related to patient rights reflecting a move towards individuals taking responsibility for their own health (Avis, 1994; McQueen, 2000). In response to these realities and its assessment of health care needs of the future, the Pew Health Professions Commission highlighted the importance of involving patients and families in health care decision-making processes as a core competency to be achieved by all health professionals by the year 2005 (Shugars & Bader, 1991). Interestingly, Brykczynski’s (1989) research, which pre-dates this report, concluded that PCNPs and patients are “partners in health care” (p. 93) and identified that one core competency of PCNP practice was “maximizing the patient’s participation and control in his or her own health/illness care” (p. 91), a finding that is compatible with those of Sidani and colleagues (2006) who found that patients reported higher levels of participation in care when they received care from ACNPs as compared with physician residents. Likewise, Mundinger (2002) suggests that NPs use differentiated practice, providing primary care while focusing on patient preferences, maintaining engagement with patients and fostering patients’ abilities to follow the mutually agreed upon approach to their care. So, it would appear that graduate nursing curricula had already integrated content to prepare nurse practitioners to be competent in fostering partnerships with patients, which may contribute to our understanding of the unique contributions NPs make in the provision of health care.

While partnership and participation are discussed regularly in community and primary health literature (Courtney et al., 1996; Stewart, M.J., 1990), these concepts are less prevalent in literature addressing acute care contexts. This may be because the degree of patient participation
in decision-making is influenced by severity and type of illness, organizational structure, patients’ knowledge base and patients’ desire to participate (Cahill, 1996). In primary care, patients are seeking help with episodic or stable chronic conditions and usually have the luxury of time and an ability to choose a health professional and a course of action. This context is more conducive to patient participation and partnership. In acute illness, however, the patient usually requires urgent attention and so does not have a choice in the health professionals they see. These conditions may not foster participation and partnership in care. Furthermore, patient preference will vary and not all patients will want to make all decisions regarding their own care. However, partnership and emphasis on patient autonomy does not negate this option; patients may still be in partnership with health professionals and have the control to make decisions should they wish to (Avis, 1994; Cahill, 1996; McQueen, 2000).

Partnership has been said to be a process of “working with” not “doing to” patients (Cahill, 1996). This conceptualization is consistent with Campbell’s (Campbell, 1984) perspectives on nurses’ skilled companionship, which can be viewed as a way of engaging in partnership with patients. This also reflects nurses’ professional ability and ‘caring about’ not simply ‘caring for’ patients in their care. Relationships that ACNPs establish with patients have qualities that reflect skilled companionship and partnership. While they describe the things they ‘do to’ patients, they discuss the time they spend ‘being with’ patients, getting to know them and ensuring that patients’ needs are being met. Patients see ACNPs as highly focused on “making things happen” on their behalf and comment on the time ACNPs spend ‘with’ them, while infrequently mentioning anything that ACNPs ‘do to them’.

Another characteristic of partnership is that it can only occur in the context of a relationship in which a nurse must surrender some of her power or control to the patient (Cahill, 1996). In Donohue’s (2003) study exploring primary care NP-patient interaction from the NPs’ and patients’ perspectives, she concluded that patients wish to “work with [their] health provider” and that NPs and patients “are working together” (p. 721). Similarly, Langner & Hutelmyer’s (1995) patient satisfaction survey demonstrated that patients were highly satisfied with NPs willingness to involve them in planning care. Given the relational context of the current study and the relational intensity potential evident in the ACNP-patient relationship sub-theory, it is not surprising that partnership can evolve as a product of their established relationships.

Imbalances in power and status are important barriers to effective partnerships between patients and health professionals (Avis, 1994). Avis suggests that health professionals perpetuate
these imbalances by controlling information disclosure to patients and their involvement in decision-making. Paterson and Zderad (1976) propose that in a humanistic relationship, nurses encourage patients’ maximum participation. They are “alert to opportunities for the patient to exercise his freedom of choice within limits of safe and sound practice” (p. 17). In Fisher’s (1995) comparative study of PCNPs and physicians caring for women with episodic illness, PCNPs were observed to enter into a relationship of solidarity with female patients, letting go of their ultimate authority to control the interaction and the therapeutic plan (p. 199), behaviour that ultimately reduces the power/status imbalance and is characteristic of partnership. These findings suggest that nurse practitioners behave in ways that promote patient empowerment and involvement in their care, a feature characteristic of relational competence and ultimately, connection (Jordan, 2004). Patients in the current study report that ACNPs spend time with them, use a straightforward way of being present and often anticipate what they might need to know and volunteer information, all nursing behaviours identified by Henderson (2003) as associated with diminishing the power gradient between nurse and patient and sharing control. NPs have also reported using egalitarian approaches that empower patients by engaging them in treatment decisions and helping them to develop skills to be healthy without depending upon health services (Torn & McNichol, 1998). In the context of making a connection, ACNPs use a variety of strategies but the purpose of the connection is to work with patients on their health issues and help them move on with their lives. Patients see ACNPs as involving them in decisions about their plan of care and taking their individual needs and desires into account when making things happen on their behalf. These actions are in keeping with a philosophy of patient participation and partnership.

Negotiation is another process that is inherent in partnerships. Not only is it used to initially establish partnerships, it is also necessary as partners strive to achieve mutually set goals. Bryczynski (1989), in her study defining domains and competencies related to NP practice, found that NPs were adept in “negotiating agreement about how to proceed when priorities of patient and provider conflict” (p. 91). As an illustration of this competence, PCNPs have been observed to suggest options to patients and when patients were clearly resistant to those suggestions, NPs suggested alternatives and negotiated a compromise, which was ultimately acceptable to patients (Fisher, 1995). Similarly, ACNPs in the current study describe adjusting options or negotiating different sequences of interventions with patients in order to come to a compromise that is acceptable to them both. Such compromises and agreements are
positive benefits and are necessary elements of partnership (Cahill, 1996). Abilities to negotiation and compromise are indicative of competence in the NP role (Brykczynski, 1989).

Partnership did not emerge from physician-patient relationship data. While there is a humanistic nature to the relationship, the central focus of managing the disease reflects traditional roots. Fisher (1995) suggests that physician-patient relationships are asymmetrical because the ‘medical voice’ dominates that of the “patient’s lifeworld” which perpetuates a power or status imbalance. She suggests that if physicians humanize their relationships by changing how they interact with patients; giving them information, focusing on their lives as well as their disease and encouraging them to take an active part in decision-making; then a more egalitarian relationship could be the end result and partnerships between patients and physicians would be possible. In their comparison of a professional versus partnership model, Courtney and colleagues (1996) state that traditional professionally-oriented relationships offer services using “unilateral action by the professional to diagnose the problem, establish intervention, assess progress and revise interventions as needed” (p. 179) whereas partnership is characterized by “joint action and assessment … [and] includes ongoing negotiation of roles” (p. 179). While the idea of unilateral action is extreme and was not consistently found in the current study, physicians do see it as their responsibility to manage the disease which involves diagnosing, intervening and evaluating that process rather than jointly assessing and negotiating. Recall that a readiness condition in the physician-patient relationship sub-theory is that physicians have confidence that they have expertise and therefore are able to manage patients’ diseases. As well, physicians are aware that the only reason they meet patients is because they need to have their diseases managed. Physicians’ dialogue in the current study, while attuned to listening to patients’ health related desires, does not reflect a ‘patient as consumer’ perspective. However, this is not problematic because patients in the current study express confidence that physicians have expertise in managing their diseases, they answer their questions, volunteer information that they think the patient needs to know and are responsive to individual needs when developing treatment and evaluation plans. So while there is no mutual language of ‘working together’ there is no apparent discomfort with physicians’ approaches except in extreme situations when patients express dissatisfaction with physicians who don’t spend enough time with them, seeming only to be focused on their own agenda rather than patients’ concerns. So, physician-patient relationships are lacking some of the elements that characterize partnership but this reality does not appear to be problematic in the acute care context.
As in the physician-patient relationship sub-theory, there is explicit evidence of partnership in the staff nurse-patient relationship sub-theory. Henderson (2003) proposed that the imbalance in power between nurses and patients is a major contributor to a lack of partnership between nurses and patients. In their grounded theory study, some nurses did not wish patients to have the information they needed to fully participate in decision-making regarding their own health care because they believed they knew what was best for patients. A few nurses were inclined to share information and decision-making control with patients. These nurses tended to spend time talking with them, volunteering information to them, actively listening and accepting their decisions. In essence, they actively engage in strategies to reduce the power imbalance between themselves and patients (Henderson, 2003). Staff nurse participants in the current study express frustration with the volume of work they must complete making an “ideal” relationship with patients unattainable. This leaves them feeling that they are completing a series of tasks, which is not conducive to developing partnerships with patients. In fact, establishing partnerships requires time (McQueen, 2000) and, as already discussed, staff nurses see time as being in short supply. Patient participants in the current study view nurses as “informative”, answering their questions and occasionally volunteering information, but the limited time they are able to spend with patients likely impacts upon their ability to truly empower patients in decision-making, preventing partnerships from evolving. However, in the current study, patients describe humanistic interactions with nurses that are not characteristic of what Henderson describes as “medical surveillance” (p. 505), where hospitals are conceptualized as prison-like, with physicians and nurses constantly monitoring patients who are viewed as objects of interventions rather than people requiring care. That being said, while patients are satisfied with the relationships they have with most nurses, they perceive a degree of interchangeability of nurses, which may be a result of patients not feeling that one particular nurse is responsible for their care which limits the potential for partnership development between patients and staff nurses (McQueen, 2000).

Partnership in health care settings is a contentious issue and empirical evidence related to its prevalence is limited in acute care settings and non-existent in relation to ACNP-patient relationships. Documented outcomes of practitioner-patient partnerships include improved nurse-patient communication, diminished patient dependency and apathy and reductions in patient’s perceptions of powerlessness (Cahill, 1996). These outcomes are likely the result of narrowing the competence gap between patient and nurse which ultimately improves patients’ understanding of their illnesses, allowing them to better cope on their own (Cahill, 1996).
Implementing a partnership approach requires time and funding (McQueen, 2000). The inherent nature and relational intensity of ACNP’s connected relationships, educational preparation, socialization and role expectations may offer fertile conditions for partnerships with patients to evolve. While previous studies suggest that all health professionals should be able to develop partnerships with patients, in the current study, ACNPs appear to be the ones successfully demonstrating this ability. The uniqueness of this product in the ACNP-patient relationship sub-theory suggests that it may be a significant contributor to the unique nature of ACNP practice.

**Complementary Practice of Acute Care Health Professionals**

Nurse practitioner roles were established based on the “nursing profession’s values, knowledge, theories and practice and is a role that complements, rather than replaces, other health care providers” (Canadian Association of Schools of Nursing, 2004, p. 1) and as discussed earlier, NPs have long been described as offering “something special” (Sullivan, 1982) and “value-added” components in the care they provide (Courtney & Rice, 1997; Williams, A. & Jones, 2006). However, this component has not been quantified or explained and researchers have not made clear links between unique aspects of NP practice and patient outcomes. Unique features and practices likely contribute to the complementarity of various health professions and these has been discussed in relation to nursing role expansion and the introduction of NPs (Davidson & Lauver, 1984). Complementary practices are purported to be important because they contribute something new, expanding the services offered to patients rather than simply substituting services traditionally provided by other professionals. While the constituent elements of the ACNP-patient relationship sub-theory are supported empirically (see Appendix L), they are configured and relate differently to one another than previously described and explain the relational practice of a relatively new health professional in the acute health care system. This offers an opportunity to identify potentially unique elements of ACNP practice that complement what already exists in the acute care system.

**Unique Features**

While connection is well described in nursing studies, ‘making a connection’ emerged as as a driving force in ACNP relational practice. Making a connection is a motivating factor, a central purpose of the relationship, as well as a behavioural approach used by ACNPs when they meet patients who require their care. In the current study, the expressive nature of making a connection is unique and contrasts the more instrumental nature of physicians managing diseases
and staff nurses meeting patients’ needs. As discussed earlier, connectedness has been associated with staff nurse-patient relationships but given the evolution of health care reform, staff nurse ability to achieve connection may be an inadvertent casualty of staff nurse relationships as a result of health care reform (Ramos, 1992; Rankin & Campbell, 2006).

Patient participants describe a hierarchy in acute care with physicians as at the top, ACNPs in the middle and staff nurses at the bottom. A health professional’s position in the hierarchy influences how he is seen with respect to autonomy, power and influence. It has been suggested that nurses’ position in the hierarchy may be beneficial with respect to relationship development. The social distance between patients and nurses is often less than that between physicians and patients (Seale et al., 2006). However, given the difficulties staff nurses are reported to be having related to relationship development and because ACNPs are nurses, they may be uniquely positioned to establish relationships with increased relational intensity. In addition, some of their knowledge and ability overlaps with that of medicine and they are endowed with enhanced decision-making authority and autonomy but are still perceived as nurses. Therefore the social distance between them may be perceived as less which may allow for increased relational intensity and intimacy to develop (Seale et al., 2006).

Relational competence has not been previously discussed in nursing relationship studies and it may be a second unique and complementary aspect of ACNP practice. As already discussed, ACNPs’ central focus is expressive and relational in nature. ACNPs describe achieving moderate levels of relational intensity with most patients, with a span of intensity that is the largest of the three types of relationships. The relational intensity that is achieved by ACNPs may be explained by their relational competence (Jordan, 2004) that is developed as a result of socialization and education related to relationship development (National Organization of Nurse Practitioner Faculties, 1995).

Using time as a resource features prominently as a strategy used by ACNPs in their relational work with patients. Establishing significant relational intensity requires time (Ramos, 1992) and ACNP roles have been developed to foster ACNP autonomy, particularly in relation to time management. In particular, ACNPs are able to provide care over time to the same patients (continuity), they are able to budget time throughout the day to optimize their time spent with patients (making time) and they make choices as to who they spend time with and when (allocating time) and they are more able to respond to patients’ requests for their time (accessibility). Continuity, in particular, has been found to promote patient satisfaction (Langner & Hutelmyer, 1995) and caring for patients over time allows ACNPs to get to know patients
well, leading to effective individualization of care to meet patients’ unique needs. The models of care provision used by physicians and staff nurses in this study may negatively impact the continuity of care they can provide, at least when patients are hospitalized. This suggests that continuity may be yet another unique and complementary feature of ACNP practice.

How time is used by ACNPs within their relationships with patients may also be a unique feature of ACNP practice that has been identified by other investigators (Hogan & Hogan, 1982; Pediani, 1998; Seale et al., 2006; Summers, 2002; West et al., 2005). The amount of time spent by health professionals with patients has also been shown to influence relationship development (Drury et al., 1988; Williams, A. & Jones, 2006), a finding that is corroborated in the current study. Gathering detailed descriptions of the content of discussions between health care professionals and patients was not the focus of the current study. However, patient participants express satisfaction with ACNPs ability to answer their questions, anticipate their information needs and make things happen. Patients’ ability to differentiate the role of ACNPs from physicians and staff nurses suggests that something different happens between them. While this might be a unique element of ACNP practice in the current study, it may not always be this way. In fact, it is proposed in some medical literature that physicians need not spend more time with patients, but, instead can spend time differently, focusing on humanistic strategies in order to enhance effectiveness and patient satisfaction with care (Snyderman & Weil, 2002; Stewart, M. et al., 1995). Therefore, given their intention to make a connection and the importance of making time count as a strategy in that process, ACNPs are uniquely positioned in the acute care environment to establish levels of relational intensity that reflects connectivity, complementing those of physician-patient and staff nurse-patient relationships.

Attention to social and biographical issues during patient encounters has been suggested as a unique feature in PCNP practice (Fisher, 1995). ACNPs’ initial intent to know the patient as a person and the impact that the “patient/person orientation” has on relational intensity reflects a similar emphasis in their practice. Orientation towards the person allows them to gain a broad understanding of the patient which they use to anticipate their unique needs and ultimately make the connection. Gathering this information and using it in this way is unique to ACNP practice in the current study.

A final element of ACNP practice that may be unique is the relational product of partnership. While the desirability of partnerships is described extensively in relation to nurse-patient and physician-patient relationships, in the current study partnership is most explicitly addressed in the ACNP-patient relationship. This may be a result of the time ACNPs spend with
patients, their professional inclination to get to know them as people and engage them in the
process of care and their exposure to the principles relevant to partnership negotiation in their
graduate education programs.

Gaining insight into the unique nature of ACNP practice allows for the identification of
unique elements of practice used by them when working with acutely ill patients. While
proponents of NP roles have long subscribed to the importance of the substitutive functions (i.e.,
those offered by other professionals such as physicians) they have placed significant emphasis on
those services that complement what is already offered to patients. Within an ACNP-patient
relationship, these unique practices and approaches complement the care and services provided
by staff nurses and physicians.

Complementary Practices

The expressive nature of ACNPs’ relational focus has been discussed as a unique feature
but can also be viewed as complementary to the approaches used by staff nurses and physicians.
Meeting the here-and-now needs as well as disease management are important priorities and
contribute to patients being able to move on with life as soon as possible. The addition of an
ACNP offers another approach to patients, that of getting to know patients in a different way and
over time. ACNPs’ focus on “making a connection” results in the gathering and contribution of
different information as well as a patient-centred perspective to the patient care equation that can
be used to address patient’s issues effectively and efficiently. Patients see ACNPs making things
happen on their behalf, a goal that is more instrumental than expressive in nature and not
consistent with some literature that suggests that what a patient seeks is a close relationship with
a nurse (Fosbinder, 1994). However, patient participants describe a number of expressive
elements of their relationships with ACNPs including ACNPs knowing them well and spending
time with them, lending support for their complementary role and function. The findings of the
current study suggest that the ACNP approach to patient care is complementary particularly
when caring for patients with multiple, complex and/or long term issues. Conversely, patients
who have uncomplicated, straightforward issues requiring limited engagement with the acute
care health system may not require the complementary approach offered by ACNPs. Morse’s
(1991a) findings suggest that the nature of patient’s health needs and the amount of time required
to meet them are two factors that influence the intensity of the relationship developed between
nurses and patients. In the current study, ACNP participants described caring for patients who
have multiple and complex problems over long periods of time and the majority of their
relationships were professionally or personally connected. This is likely related to the nature of the needs typical of the patient populations with which ACNPs in this study worked. Clearly this has implications for future research.

A second complementary aspect of ACNP practice inherent in the ACHPPR theory is the role ACNPs play as a hybrid of nursing and medical practice. This complementarity is evident in patients’ comments about hierarchy involving nurses, ACNPs and physicians as well as their views of ACNPs’ abilities to address their needs. For example, when asked if there are questions that they would ask only of a physician or only of an ACNP, most patients said that they didn’t need to differentiate because they saw each professional as able to help them. However, as patients perceive that ACNPs spend more time with them, there are more opportunities to discuss issues about their care, which is directly related to the deployment of ACNPs to work exclusively with patients with specific kinds of needs and the overall stability of ACNPs’ caseloads. Unlike their physician colleagues, they are not required to rotate into other areas of the hospital and are not trying to balance their own education with service demands (Daly & Genet, 1997). Historically, when the ACNP role was first established in the 1990s, it was in response to unmet patient needs that had become increasingly complex, specialized and costly (Daly & Genet, 1997; Simpson, 1997). The introduction of this ‘alternative’ provider was seen as logical, adding a health focus to the existing disease orientation of medicine, and more comprehensively meeting the changing demands of society (Daly & Genet, 1997). Thus the ACNP role rapidly developed and has been met with support from patients and professionals alike (Daly, 1994; Daly & Genet, 1997). The findings of the current study are in keeping with the original intentions of the ACNP role, to deploy practitioners who provide quality substitutive as well as complementary care to acutely ill patients.

A final complementary feature of the ACNP role with patients is what they identify as ‘making things happen’. ACNPs are viewed as complementing physicians’ disease management role, dividing the plan into manageable components, discussing them with patients, individualizing them to fit their needs and then following through, ensuring each piece is accomplished by appropriate members of the health care team, such as staff nurses. This complementary feature of their relationships with patients referred to as the “shepherd role” (Daly & Genet, 1997), can be viewed as instrumental, but is in keeping with the original impetus and philosophical tenets for ACNP role development (Daly, 1994). By virtue of their continuous involvement with the same patients over time, ACNPs get to know patients well, are able to negotiate and establish mutual goals with them in collaboration with more transient health
professionals and offer continuity in terms of their approach to their complex issues, overall planning and monitoring of outcomes. Their focus on the person who is the patient positions them to effectively coordinate patients’ care, focusing on tailoring it to achieve patients’ overall goal of moving on with life. This feature of their relationship with patients has been shown to positively influence patient outcomes (Daly & Genet, 1997).

**Part III: Limitations**

Recruitment of participants depended upon interest expressed by ACNPs who practised at the research site. While a number of strategies were used to cultivate wide interest (e.g., study presented at ACNP meeting, electronic distribution of brief slide presentation explaining study to all ACNPs), not all ACNPs expressed interest in participating. Though not all those who volunteered were interviewed, their interest in the study could have led them to present their perspectives in a particular light, wishing to provide me, the researcher, with the “right stories”. However, having access to more volunteers than I needed allowed theoretical sampling procedures to be used and reduced the influence of selection bias.

The social desirability of being involved in the study may have been influenced by ACNP participant knowledge of my background as an established practising ACNP who had developed an ACNP education program and had continuing teaching responsibilities within the program. However, the phenomena of interest ultimately guided decisions about who among those who volunteered would be interviewed and all participants met the inclusion criteria for the study.

The gender distribution of health professional study participants, who were predominantly female, was reviewed to detect atypical distributions. Health professional participants in this study were predominantly female (4/5 staff nurses, 3/6 physicians and 6/6 ACNPs). However, since 96% of Canadian nurses and a similar proportion of ACNPs are female (Health Canada, 2005; Kleinpell & Hayden, 1999), and 50% of physicians are female (Burton & Wong, 2004), the proportional representation among participants in the current study is consistent with health professional gender distribution. However, as females are believed to engage in relationships differently than males (Jordan & Walker, 2004; Jourard, 1971b), gender will be an important factor to consider in future research.

Using a quartet sample recruitment strategy, only five of the six quartets yielded all four participant interviews which may have had implications for saturation of central concepts and theory development. In one quartet, the staff nurse consented to participate, but despite numerous efforts to arrange a convenient time for the interview, it was never completed.
However, during the study the staff RN sub-theory concepts were saturated, and thus the missing staff nurse participant did not influence the end results.

None of the patients interviewed in this study was part of a “clinical relationship” with any of the health professionals interviewed so this study lacks a first person account of this type of relationship from the patient perspective. Relationships between patients and health professionals in this study reflected levels of relational intensity consistent with “professional” or “personal” relationships. This is, no doubt, because this type of relationship is rare, as reported by health professional participants. As a result, health professional perspectives provide the only perspectives used to establish this type of relationship in the theory. Future research should seek patients’ perspectives on this rare but important type of relationship that may negatively influence their health outcomes.

This study was completed in a large urban academic health sciences centre. The site was chosen because it employs many ACNPs who practise with a wide variety of patient populations. Therefore, it is possible that the ACHPPR Theory suggests processes that are reflective of the academic and teaching nature of the research site. For example, the concept of team that emerged from patient participants may be defined differently or with different emphasis if the theory is tested in an acute care community hospital. But while the site has certain characteristics, it is but one influence on how patients and health care professionals conceptualize their relationships. For example, other personal and professional factors such as educational curriculum and socialization contribute to how ACNPs work with patients. Therefore, this limitation is a stimulus for testing of this theory in other acute care settings.

While this study explored the perspectives of patients as well as health professionals, it did not include family members who may be very involved with acutely ill patients during their care. All patient participants discussed their family members’ involvement in their care. So, while it was a conscious decision to interview patients only in order to streamline the study design, exploring family perspectives on health professional-patient/family relationships may expand our understanding of how specific relationships can best address patients’ and family members’ needs (Morse et al., 1997).

In the literature, studies of interactions with patients are distinct from those exploring relationships between health professionals and patients. Studies of interactions have a prospective component and address what occurs between two people during one or numerous encounters. Studies of relationships tend to have a retrospective component, asking participants to recall what has occurred between them. This study focused on building an understanding of
the processes used by acute care health professionals to develop relationships (and not on their specific interactions) with patients by exploring individual participants’ perspectives on specific dyadic relationships as well as health professional-patient relationships in general. Studies of interaction necessitate the inclusion of participant observation allowing the researcher to observe the interactions between patients and health professionals. Morse and her colleagues (1997) suggest that since there are several studies of one or the other, future studies should be designed to include exploration of both interactions and relationships in order to correlate and validate what participants think is happening with what actually does occur in context. This perspective offers opportunities for future research.
CHAPTER 9: IMPLICATIONS, RECOMMENDATIONS AND CONCLUSIONS

Implications and Recommendations

This is the first study to address ACNP-patient relationships, offering a middle-range theory that describes ACNP-patient relationships and how they compare with those established between physicians and patients and staff nurses and patients. A strength of this study is the inclusion of the patient perspective. Exploration of both health professional and patient perspectives in a single study is rare and offers opportunities to corroborate the perspectives of each member of the relational dyad with the other. While the ACHPPR Theory describes how all three health professionals establish relationships with patients, the primary focus of this study was to understand the nature of the ACNP-patient relationship. Thus, the implications for research, education, theory and practice will predominantly focus on this relationship.

Implications for Research and Theory Development

The findings from this study provide us with an understanding of how relationships are developed and experienced by health professionals as well as patients in acute care settings. Each health professional is identified as having a distinct focus or purpose when establishing relationships with patients. While the underlying structure of relationship development (readiness conditions, use of relational strategies, and the resultant relational products) is similar, the approach used within the structure is unique to each health professional. As ACNPs focus on making a connection with patients, they do so in order to get to know the person who is the patient. While the nature of ACNP-patient relationships appears to be a unique element of their practice, it is unclear if a relationship focused on making a connection makes a difference when it comes to patient outcomes. The relationship between relational intensity and patient outcomes, such as length of stay, would be worth exploring.

The ACHPPR Theory has been developed from the analysis of data collected in an academic health sciences centre responsible for caring for patients who require acute care services. As there was no measure of patients’ severity of illness (a proxy measure for acuity) in this study, it is unclear if there is a relationship between patient acuity and the relational intensity that evolves between patients and health professionals. Further study will be required to expand our understanding of relationship development and relational intensity and resultant outcomes to allow the theory to be further refined and tested. Applicability of this theory to a variety of other populations and acute care settings in important to study in the future including patients:

- in community acute care hospital setting
o who spend extended periods engaged in care and with acute care health professionals, e.g., palliative care, dialysis
o with highly intense disease-related needs, e.g., intensive care
o whose disease-related needs are low intensity and routine e.g., same-day surgery
o whose developmental stage and acuity may precipitate higher baseline relational intensity, e.g., paediatrics

Of course, opportunities to explore the credibility of the theory will be dependent upon the deployment of ACNPs in relevant patient care areas. The findings of subsequent studies could further inform decisions regarding patient populations who might benefit most from the involvement of an ACNP.

The ACHPPR Theory describes health professionals’ relationship development with patients but the role patients play in this process is not well addressed. In particular, the clinical relationship with patients is not well understood especially in terms of the control patients exert over development of relational intensity. There is little written about relationships characterized by this minimal level of relational intensity. Further exploration of the nature of such relationships would contribute to our understanding of minimally intense relationships and perhaps stimulate further study on how to prepare health professionals to optimize those relationships if that is feasible.

While this study was designed to focus on relationships, it has been suggested that investigating interactions simultaneously with relationships may contribute to our understanding of nurse-patient relationships. The ACHPPR theory can also be developed further by including triangulation of data collection methods, such as participant observation. This approach would afford the researcher opportunities to witness specific interactions which would provide specific examples for later exploration during interviews, adding to our clarity of understanding as to how relationships develop and what levels of relational intensity look like in vivo.

As discussed earlier, a quartet sampling strategy was used to recruit and interview study participants. The purpose of this strategy was to gain an understanding of specific relationships from patients’ perspectives as well as explore patient-health professional relationships in general. In the interest of maintaining a reasonable scope for the current study and ensure full elaboration on the particulars of each health professional-patient relationship, analyzing the data by role was deemed advantageous. Future studies might employ case study methodology, to explore dyadic
relationships (patient-health professional) with the intent of legitimizing processes described in the ACHPPR Theory.

Another middle range theory, proposed by Morse (1991a), presents a typology intended to describe the nature of nurse-patient relationships. This conceptualization of relationships, while not born out in staff nurse-patient relationships in the current study, garners some support from the ACNP-patient relationship sub-theory. So, while some of the themes included in Morse’s theory are consistent with the parts of the ACHPPR theory developed in the current study, their relevance to current practice realities may now be in question. For example, typical staff nurse relationships with patients appear similar to Morse’s therapeutic relationship, reflecting characteristics such as a professional tone to their interactions and seeing the patient as a patient first and secondly as a person. These relationships offer no evidence that connection is achieved.

Now that making a connection has been identified as unique and central to ACNP relationship development, the ACHPPR theory can be used in conjunction with other related theories, like negotiating commitment and involvement in the nurse-patient relationship (Morse, 1991a), interpersonal competence (Fosbinder, 1994), attachment and involvement in the nurse-patient relationship (Ramos, 1992) and human relatedness (Hagerty et al., 1993; Hagerty & Patusky, 2003), with the goal of expanding our understanding of how ACNP-patient relationships complement and contribute ‘something different’ to patient care. One example of this application might be the exploration of what is responsible for ACNPs’ lack of identification of a less intense ‘therapeutic’ relationship and a high intensity ‘over-involved’ relationship as described by Morse. The impact that health professional-patient relationships have on patient outcomes is another area of study that can be guided by a synergistic use of available theories and will solidify the importance of these theories in health care practice.

*Implications for Education*

The educational implications of this research can be classified as those addressing nursing in general, those related to educating ACNPs and those related to physician and interprofessional education. One global educational recommendation is that a commitment to the “clinical encounter” be reaffirmed and acknowledged as essential to all health professional practice (Dieppe et al., 2002).

In broad terms, the importance of nurse-patient relationships is emphasized in nursing education programs and is highlighted in professional regulatory standards and best practice
Empirical evidence verifies that an effective relationship between a nurse and a patient is essential and has implications for the quality of patient outcomes. However, research exploring the nature of nurse-patient relationships and interactions has yielded conflicting results. The variability in the findings is largely related to study design (choice of informants, data collection strategies) and timing (health care reforms). Some studies indicate that nurse-patient relationships are not a priority in current nursing practice and this may be due, at least in part, to a dissonance between the philosophical tenets espoused by schools of nursing and the organizational culture and values of those who subsequently employ them. One strategy for basic nursing education programs is to instill an awareness of this potential dissonance in students and prepare them to detect it and make positive change. Providing students with experiential learning opportunities that allow them to develop self awareness and openness to others as well as practice in getting to know patients will help them experience how this approach helps them more effectively meet patients’ needs.

Another recommendation that may be effective in reducing dissonance between the values inherent in nursing education and the sites where nursing is practised is to collaborate with organizations to develop clinical teaching units. Educators and employers of nurses working together may foster a joint commitment to quality in education as well as practice and offer opportunities to develop a common philosophy and practice model that encourages nurse-patient relationships.

The relational intensity evident in ACNP-patient relationships requires that graduate curricula preparing these practitioners emphasize theoretical perspectives on interpersonal relationships and development of the associated humanistic skills. ACNP students may benefit from learning opportunities that allow them to participate in simulated interactions with patients followed up with a debriefing session that reviews strengths and areas for development (Summers, 2002). Such a strategy would provide opportunities for the integration of theory as well as practical skill development in interpersonal relationship development for beginning ACNPs.

Traditional medical education has focused primarily on the development of superb diagnostic and technical skills and while this concentration does not preclude the development of humanistic values and skills, the lack of explicit attention to them in medical education tends to devalue them (Markakis, Beckman, Suchman, & Frankel, 2000). While patient-centredness is claimed by many physicians as a core value (Stewart et al., 2000), the learning environments to which medical students and trainees are exposed may present inconsistent examples of this
humanistic approach (Markakis et al.). It has been suggested that medical curricula and practice be revised to centrally position patient-physician relationships to enhance effectiveness as well as patient and practitioner satisfaction (Markakis et al.; Snyderman & Weil, 2002).

Given that more formal, low intensity relationships do occur in clinical practice, it would be advantageous to address this practice reality formally in nursing education. McQueen (2000) suggests that these relationships are emotionally exhausting. Attending to skill development with respect to such relationships may allow nurses to salvage the relationship, allowing it to develop to a higher level of intensity or, at the very least, reduce the feelings of frustration experienced by nurses.

Humour is a common thread across all three sub-theories, yet it is not well addressed in health professional curricula. In the current study, physicians are most hesitant to use humour, feeling that patients may misinterpret its intention. Staff nurses use humour as a strategy in relationship development but not in a planned way. ACNPs are most strategic in their use of humour but have likely developed this ability informally. Given the usefulness of humour as a strategy with patients and the positive impact it can have on well-being, it would be advantageous to incorporate effective use of humour in formal educational programs (Summers, 2002), possibly using an interprofessional curriculum model. All health professionals will benefit from evidence-based approaches to using humour with acutely ill patients, allowing them to have yet another strategy to enhance their relationships with patients.

**Implications for Practice**

The study findings inspire a number of implications and recommendations related to practice that can be classified as micro (implications for patient care), meso (implications for professional nursing practice) and macro (implications for the health care organizations) in scope.

**Implications for Patient Care**

The complexity and multiplicity of patients’ needs in acute care settings are realities that must be addressed and patients’ identification of ACNPs ‘making things happen’ confirms the value patients place on ACNPs’ abilities in coordinating and managing the system to meet their complex needs. Patients have a sense of the busyness of all health professionals but especially physicians and staff nurses. The additive effect of patients’ complex needs and the length of time patients require acute care attention culminates in busy health professionals and creates a
potential gap in care provision, one that is filled by ACNPs. Given this study’s findings, comprehensive care that meets patient expectations may not be provided without the inclusion of the ACNP role.

The foci of each health professional-patient relationship described in the ACHPPR theory are complementary. ACNPs focus on relationships as an end in themselves in contrast to physicians who view their relationships with patients as necessary in order for them to manage disease effectively. Staff nurses espouse a desire for relationally intense involvement with patients but are rarely able to achieve this in the current acute care environment. So, when acutely ill patients require attention to multiple and complex needs over time in environments that are busy, introduction of an ACNP may complement existing roles and resources to optimize patient care.

Implications for Professional Practice

Despite the emphasis placed upon health professional-patient relationships, the findings of this and other studies suggest that staff nurses are unable or choose not to focus on their relationships with patients. Nurses may feel comfortable making this choice because they are aware of the complementary nature of each profession’s relational focus and are confident that if an ACNP is involved with a patient, a connected relationship is possible. It has also been suggested that less than ideal staff nurse-patient relationships may be related to changes in how health care systems are organized, how priorities are established and what is valued at the health professional-patient interface. ACNPs, whose practice demonstrates the positive effects of their relational focus and who may be seen as clinical leaders, can role model relational competence and strategies that foster connected nurse-patient relationships. With their nursing background and in the context of a supportive practice environment, ACNPs are well positioned to influence the relational practices of their nursing colleagues in particular, helping them to achieve or exceed their relational intensity aspirations with patients. Strong collegial relationships among all nurses, including ACNPs, are necessary for role modeling to be effective. If staff nurses see ACNPs as ‘mini-doctors’ or as unapproachable and no longer affiliated with nursing, they will not look to ACNPs as role models. Enhancing staff nurse relational competence may also reduce the dissonance that exists between what educators teach nursing students about relationships and what nurses find is feasible in their work environments, addressed earlier in relation to educational implications.
Another implication for the profession is related to nursing recruitment and retention. Studies report that nurse practitioners are highly satisfied despite some reported challenges and barriers inherent in their roles. They continue to be drawn to NP roles, likely in part, because of their desire to be involved directly with patients (Mundinger, 2002). Their high levels of satisfaction are important to consider in relation to the impending nursing shortage. There is a need to reverse the trend of nurses leaving the profession and creating roles like the ACNP, with its highly satisfying relational focus and enhanced professional autonomy, may offer an important incentive for recruitment as well as provide a viable retention strategy (Canadian Nurses Association, 2006).

Implications for Health Care Organizations

The introduction of ACNPs into acute care settings offers opportunities for system enhancements. ACNP role descriptions consistently include leadership and change agency responsibilities. ACNPs are viewed as clinical experts in their specialty and findings from this study promote their strong relational focus and abilities. They are well prepared to work with like-minded organizational executives and leaders to establish a philosophy of care that promotes not only nurse-patient relationships but all health professional-patient relationships and develop practical approaches to operationalizing that philosophy.

To reap this benefit of ACNP practice, organizations must first commit to promoting an environment that reflects a value for all relationships, including those between professionals and patients. Secondly, the organizational context must be analysed to determine what interferes with achievement of good health professional-patient relationships. Thirdly, interprofessional leaders, including ACNPs, can work together with staff to establish practical processes (e.g., an interdisciplinary practice model where patients are the central focus), supports (e.g., professional development and educational experiences related to relational competence) and strategies (approaches to achieving continuity of nursing care) to foster establishment of optimal health professional-patient relationships.

Partnership is seen as a product of a connected relationship in the ACNP-patient relationship sub-theory. As discussed earlier, many patients are expecting to be involved in their treatment planning and establishing partnerships with them is becoming an essential element of practice. Some suggest that evolving a model that values professional-patient partnerships will require time and funding (McQueen, 2000) so health executives and leaders must see this as
important and make organizational changes, such as alterations to nursing unit staffing, to accommodate relation-based care.

Conclusions

This exploration began with a hypothesis that relationships that ACNPs establish with acutely ill patients may include practice elements that are unique and culminated in the development of a middle range theory. The Acute Care Health Professional Relationship Theory offers an understanding of how physicians, staff nurses and ACNPs develop relationships with patients in acute care settings. As Brykczyński said “relationships cannot be reduced to formulas” (1989, p. 101), but this theory offers a first glimpse at how these three types of relationships compare and ultimately complement one another. The broad process of achieving readiness conditions, using strategies to establish a level of relational intensity and the resulting products of the relationship is common across the three types of relationships but many of the specifics of the process are different allowing each type of professional to establish a relationship with a unique nature.

Even though the current study shares concepts from earlier investigations, it does contribute a new way of viewing the relationships that three different acute care health professionals establish with patients. It is significant that this is the only known study to investigate three relationships prospectively from the perspective of each participant; ACNP, physician, staff nurse and patient; and it is the first study to explore this aspect of ACNP practice.

ACNP-patient relationships are uniquely focused on making connections with patients, with ACNPs using their relationships as vehicles for the work they do with and for patients to address their health/illness needs. While connectivity has been associated empirically with staff nurse-patient relationships this was not the case in the current study. Making a connection is highly expressive and contrasts with the more instrumental, task-oriented focus of physicians’ and staff nurses’ relationships with patients.

The intensity of each type of health professional-patient relationship is modulated by relational dimensions. There is variability across the three relationship types in terms of readiness conditions that must be met before relationship establishment, relational strategies used and the products that result when a relationship is established.

When viewing health professional-patient relationships through the adopted philosophical lens, it seemed reasonable that qualities of “I-Thou” relationships might emerge during this
exploration. However, earlier discussions about the unlikelihood of achieving authentic “I-Thou” relationships between health professionals and patients were realized. Some “I-Thou” qualities did emerge, especially in the relationships ACNPs had with patients (e.g., being authentically present, mutuality, self-disclosure). In fact, some elements of health professional-patient relationships reflect characteristics that Buber would likely associate with “I-It” relationships (e.g., imposing boundaries, multi-tasking, busyness). This is likely due, in part, to the purposeful nature of health professional-patient relationships. This functionality is also reflected in the central themes of each type of relationship from patients’ perspectives.

The majority of the ACNP-patient relationship sub-theory is distinct from the other two, but there are elements that are common to them all. One example is humour, which, while used differently by the three health professionals, is evident in all three health professional-patient sub-theories. Most of the other common elements, not surprisingly, are common to the staff nurse-patient and ACNP-patient relationship sub-theories, e.g., the relational product of making a difference.

A feature of this study that has proven invaluable is the presence of patients’ voices. The congruence of patients’ views with those of health professionals enhances the validity and relevance of each sub theory and the ACHPPR theory in total. Since patients are the reason health professional roles are required, it is essential to understand their perspectives and preferences. Patients’ expectations of each type of health professional vary and are functional in nature. The relationship was not of primary importance yet clearly had an impact on their feelings of satisfaction and comfort.

ACNP-patient relationships have been shown to be a unique feature of their practice in acute care, offering something different to the patient care equation than is otherwise unavailable in the settings in which they practice. Relationships they develop with patients, with a broader span of relational intensity than their staff nurse and physician colleagues, may contribute to overall patient satisfaction with care and enhance patient outcomes in an interprofessional team environment that is the current reality in acute care settings. Clearly their unique contribution can be “a focus on person-centred care that supports people in health and illness, to live intact, meaningful lives” (Pogue, 2007, p. 36), a position that Pogue suggests is a ‘way of the future’. The theory developed in this study offers a beginning understanding of how this can be operationalized with acutely ill patients and provides a basis for future exploration of how ACNPs can use their relationships with patients to achieve mutually acceptable outcomes.
REFERENCES


Curry, R. W., Jr. (2006). Second opinion. It's about time! *Patient Care, 40*(8).


APPENDICES
## APPENDIX A - Review Of Nurse Practitioner Research

<table>
<thead>
<tr>
<th>Author/Title</th>
<th>Design</th>
<th>Sample/Participants</th>
<th>Theoretical Perspective</th>
<th>Findings</th>
<th>Strengths</th>
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<td><strong>Primary Care</strong></td>
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<tr>
<td>Allen, M.J. (1993), Sociolinguistic dimensions of nurse practitioner practice: a question of power</td>
<td>Qualitative, Ethnographic study</td>
<td>9 PCNPs, all female, 3 encounters each, (except for one who had 2) – 26 pts all female</td>
<td>Ethnography, Sociolinguistic inquiry (structural, organizational and interactional aspects of language in social situations), Power</td>
<td>Central themes • Language as a process • Patterns of language • Two themes converged in relation to power • 5 language steps; openings, transitions to business, business at hand, transitions to closure, closures • Linguistic patterns: supporting, informing, controlling and professional jargon • Power used to control pace and direction of visit, controlling language and professional jargon also e.g.s of power influence</td>
<td>• Declared biases • Strong method with methodological triangulation • Ethical considerations well addressed • Processes for trustworthiness described (some member checking)</td>
<td>• Patients and NPs all female introducing gender bias, reduced generalizability • Observer during visit may have influenced NP and pt behaviour</td>
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<tr>
<td>Brykczynski, K.A. (1989). An interpretive study describing the clinical judgment of nurse practitioners</td>
<td>Qualitative, interpretive pair NP interview x2, participant observation individual NP interview audiotaped</td>
<td>22 experienced NPs practicing in 4 different hospital ambulatory settings minimum 3 yrs experience</td>
<td>• Phenomenological and existential perspectives • Intent to describe the knowledge embedded in clinical practice of NPs</td>
<td>Identified the following, described extensively and interpreted in relation to Benner’s (1984) aspects of practice: • Practical Knowledge: discretionary judgement, background knowledge and practical skills are experience-based • Domains and Competencies 4 of previously established headings to categorize competencies were deemed valid in NP practice and one new addition that consolidated two of Benner’s (management of patient health/illness status in ambulatory settings) • Several new competencies established</td>
<td>• Methods well described • extensive interviewing process, using semistructured approach, yielding 66 hours of interview transcripts • used participant observation to observe real-time NP practice, able to ask for clarification in second NP pair interviews</td>
<td>• no discussion of relationships between researcher and participants • no mention of credibility of findings • acknowledged that not an exhaustive list of competencies • ambulatory care setting considered primary care (reduced acuity) but is part of larger</td>
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<td>Findings</td>
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• videotaped NP – pt encounters  
• single rater | 2 NPs (master’s)  
20 patients  
- visits videotaped over a 2 mth period | None  
Intent to test NP rating form as a tool to evaluate NP – patient interaction in ambulatory setting |  
• NPs use a holistic, personalized approach and continue to practice nursing  
• NP’s practice in hospital ambulatory care complements physician’s  
• one of the first studies to attempt to describe what NPs do |  
(triangulation of methods)  
• Reliability addressed  
• Patients randomly chosen  
• Single rater using instrument to assess NP behaviours (good inter-rater reliability r >0.8)  
• Consent issues addressed  
• Comparison of findings to previous studies using instrument  
• Author reports on deficits of tool  
• lacking detailed evaluation of interpersonal dimensions, eg. Comforting, empathy |  
• Very small sample  
• Validity not addressed  
• Focus on primary care  
• Only 2 NPs limits generalizability because findings may reflect only their practice patterns  
• Limited detail re: communication scales included in instrument  
• No comparison cohort |
| Covington (2005). Caring presence: Providing a safe space for patients.     | Exploratory, qualitative                                                | 5 NPs (1 male)  
9 female, 1 male patients with chronic illness who saw NP at least 3x/year | Caring (Watson) Phenomenology  
Intent to examine the experience of caring presence from the perspective of NPs and pts in the relationships | Caring presence is:  
• Mutual trust and sharing  
• Transcending connectedness  
• Experience  
Characterized by NP and patient  
• ways of being  
• ways of behaving |  
• Consent issues addressed  
• Confidentiality issues addressed  
• Male NP and male pt included in study |  
• Patients volunteered – potential bias (either positive or negative re: NPs)  
• Focused on patients with chronic illness  
• ? generalizability to all NP-pt relationships  
• Study methods not
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<tr>
<td>Donohue, R.K. (2003). Nurse practitioner-client interaction as resource exchange in a women’s health clinic: An exploratory study</td>
<td>Exloratory descriptive</td>
<td>2 expert NPs, graduate prepared working in women’s health practice</td>
<td>Resource Exchange Theory (Foa &amp; Foa)</td>
<td>• All patients desired similar things, not dependent upon practitioner</td>
<td>• Theoretical perspective well explained and relevant to NP practice</td>
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<td></td>
<td>• audio-taped interviews with patients before and after appt with NP</td>
<td>8 patients</td>
<td>• six resource classes, i.e., information, services, status, love, goods, money</td>
<td>• Patients’ service expectations were similar to services they received from NPs</td>
<td>• Design included the perspectives of both NPs and patients</td>
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<td></td>
<td>• audio-taped interaction between NP and patient during appt.</td>
<td>Intent to determine if this approach will assist in understanding what patients expect from NPs</td>
<td></td>
<td>• Resources expected/ received included combinations of services, information, trust, self-disclosure, support, affirmation, time, acceptance and respect</td>
<td>• Quotations from patients used to illustrate conclusions</td>
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<tr>
<td>Fisher, S. (1995) Nursing Wounds</td>
<td>Qualitative</td>
<td>7 NPs, ? number of encounters</td>
<td>• Feminism</td>
<td>• Both NPs and MDs committed to primary health care</td>
<td>• Methodological triangulation used</td>
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<tr>
<td></td>
<td>• Observation</td>
<td>43 MD-pt encounters</td>
<td>• Sociology</td>
<td>• NP transcript 40 pages vs. MD transcript 8.5 pages</td>
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<td></td>
<td>• Audiotaped interactions</td>
<td></td>
<td>• Critical Theory</td>
<td>• MD approach characterized by pointed ?s, narrow focus, technical fix</td>
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<td></td>
<td>• In-depth interviews with NPs</td>
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<td>• Situated Knowledge</td>
<td>• NP approach characterized by open-</td>
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<td>Discussed 4</td>
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<td>• Clinical</td>
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<td>Horrocks et al (2002). Systematic review of whether nurse practitioners</td>
<td>Systematic Review</td>
<td>11 trials and 23 observational studies</td>
<td>None Intent to determine whether NPs can provide care at first point of contact in primary care settings (including emergency)</td>
<td>• Patients were more satisfied with NP care</td>
<td>• Broad search criteria and sources of studies (UK, North America, South Africa, Australia)</td>
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<td>working in primary care can provide equivalent care to doctors</td>
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<td>Outcomes: Patient satisfaction, health status, costs, process of care</td>
<td>• No differences in health status were identified</td>
<td>• Good analysis of strengths and weaknesses of existing studies used for this review</td>
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<td>• NPs had longer consultations with patients</td>
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<td>• NPs ordered more investigations</td>
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<td>• No differences found in # prescriptions, return consultations or referrals</td>
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<td>• Some aspects of quality of care were better for NPs</td>
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<td>• Introduction of NPs in primary care is likely to positively influence patient satisfaction and quality of care</td>
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<td>Johnson, R. (1993), Nurse practitioner – patient discourse: Uncovering the</td>
<td>Descriptive, qualitative with</td>
<td>3 NPs, all female (2 with master’s)</td>
<td>Ethnography Intent to uncover a process that might contribute to understanding the positive outcomes of NP</td>
<td>NPs interactions can be organized using 4 main activities of the typical visit:</td>
<td>• Good use of quotes to illustrate findings and conclusions</td>
</tr>
<tr>
<td>voice of nursing in primary care practice</td>
<td>inclusion of discourse analysis</td>
<td>22 female pts</td>
<td></td>
<td>• Establishing agenda for encounter</td>
<td>• Purpose of study clearly stated and addresses high priority issue</td>
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<td></td>
<td>participant observation</td>
<td>24 NP-pt conversations</td>
<td></td>
<td>• Eliciting information from patient; being alert to cues, helping to problem solve</td>
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<td>• Conducting the physical exam; attending to comfort level, preparing</td>
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<tbody>
<tr>
<td>Lewis, P.H. &amp; Brykczynski, K.A. (1994). Practical knowledge and competencies of the healing role of the nurse practitioner</td>
<td>Qualitative, Qualitative</td>
<td>10 NPs, all masters prepared, with minimum 5 yrs experience</td>
<td>Hermeneutic phenomenology, Interpretive</td>
<td>Identified two new maxims and two new competencies related to the healing domain of NP New Maxims “little things mean a lot” New Competencies using humour with sensitivity risk taking</td>
<td>• Good beginning study literature rather than studying another cohort (MDs) • Lacks an outcome focus as suggested by purpose statement</td>
<td>• no mention of informed consent • small study with limited generalizability but acknowledged as a beginning exploration</td>
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<tr>
<td>Beal, J. (1999) Responsibilities, roles and staffing patterns of nurse practitioners in the neonatal intensive care unit.</td>
<td>Quantitative, Quantitative, descriptive questionnaire, questionnaire, review of databases re: pts admitted to care of MDs and NPs</td>
<td>22 certified NPs employed in 5 NICUs, their NICU directors Case lists over time (range 9-21 mths)</td>
<td>None</td>
<td>• no differences in infants across sites • All NPs involved in comprehensive care including: assessment, diagnosis and ongoing management of newborns, collaboration with other team members, ordering/performing procedures and therapeutics, providing parent support, educating nurses/medical students, participating in research and administration of pt. care services • Coverage varied with unit size and # of NPs employed • Physician coverage consistent • NPs cared for smaller, sicker infants and those with lower APGAR scores • Demonstrates replacement and enhancement functions of NP role</td>
<td>• questionnaire reliable/valid • followed case loads over prolonged periods of time • prospective nature increases relatedness of findings • IRB approval • Clearly describe methods • Multi-site study</td>
<td>• no pure NP or MD patients because of cross-coverage • all five NICUs in one region of USA potentially limiting generalizability to other regions • well established NP role in all NICUs – role responsibilities may vary in different contexts, e.g., adults • some responsibilities, e.g., attending deliveries, only relevant to NICU</td>
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<tr>
<td>Beal, J. (2000). A nurse practitioner model of practice in the neonatal intensive care unit</td>
<td>Qualitative, ethnographic case study  • audiotaped, semistructured interviews  • participant observation (90 mins each)</td>
<td>7 NPs working in 5 different NICUs  Recruited by letter from a population of 25 practising NPs</td>
<td>Ethnography  • defined culture as NPs who worked full time in an NICU  • Intent to define an advanced practice nursing model unique to NP practice in NICU</td>
<td>Role of NP in NICU  • Clinical management of infants and families (medical management, combination medicine/nursing, coordination of care)  • Leadership  • Role expansion (responsibility, accountability)  • Holistic perspective  • A role of combinations (clinical &amp; professional, medicine &amp; nursing)  • Caring focus  • Concluded model is unique to NICU  • Demonstrated linkages between findings and existing domains of advanced nursing practice  • Concluded practice model was humanistic and caring (as per Watson and Paterson &amp; Zderad)</td>
<td>Commented on relationship researcher had with participants (credibility and trust)  • Informed consent process described  • Method well described, biases declared  • Also interviewed NPs post observation period  • Thematic saturation discussed  • Offered quotations to validate conclusions  • First attempt to describe NICU NP model of practice</td>
<td>• no mention of consent process  • interviewed NPs while practising which may reduce the richness of data because of competing priorities (pt. care vs. interview)  • Taped during practice; ? consent from parents also taped?  • Reported findings by question rather than as they relate to the practice of NPs (similar to content analysis)</td>
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<tr>
<td>Carzoli et al (1994). Comparison of neonatal nurse practitioners, physician assistants and residents in the neonatal intensive care unit</td>
<td>Retrospective chart review  • Patient management  • Outcome  • Costs</td>
<td>Charts for 244 consecutively admitted infants to an urban Florida NICU  Infants cared for by NNP/PA team or pediatric resident team</td>
<td>None  • Intent to compare patient care delivery by neonatal NPs and physician assistants with that of pediatric residents in the ICU setting</td>
<td>Examples of management variables: length of stay (critical care and total hospital, ventilator and O2 use, number of blood transfusions, procedures  • Examples of Outcome variables: air leaks, intraventricular hemorrhage, mortality  • Examples of Cost variables: hospital and physician charges  • No significant differences between patients cared for by one versus the other team  • Neonatal NPs and Physician Assistants can provide effective care and are a reasonable alternative to paediatric residents</td>
<td>Fair sample size (&gt;200 charts)  • Comparison between two provider teams  • Well described patient population allowing reader to decide on representativeness</td>
<td>• No randomization of infants → how were team assignments determined  • No discussion of sample size calculations? sufficient to detect differences  • Mixed care provider team (NP and PA)  • ? 24 hour coverage?  • NPs certificate prepared (no graduate degree)</td>
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<td>Cooper et al (2002). Evaluating emergency nurse practitioner services: A randomized controlled trial</td>
<td>Randomized Control Trial (over 2mths)</td>
<td>199 randomized to receive care from NP or senior house officer (SHO) 8 NPs and 12 SHOs involved</td>
<td>None</td>
<td>Intent to develop tools to use in the evaluation of quality of NP-led care including pt. satisfaction quality of documentation, unplanned follow-up and missed injuries</td>
<td>Wait times significantly longer for SHO vs. NP  No differences in group demographics  No differences in total consultation time  NPs consulted senior medical staff more often but related to requirement to consult re: xray interpretation  No differences in appropriateness of referrals  2 patients were assessed as receiving unsatisfactory care by medical reviewers (both NP patients)  Pt Satisfaction (response rate 84%) – pts satisfied with both NP and SHO but more satisfied with NP (p&lt;0.001), however pts reported that NPs were easier to talk to (NS), they received info on prevention (p=0.001), were given enough info on their injury (p=0.007)  Documentation – NPs better (p&lt;0.001)  1mth questionnaire (response rate=64%) → no differences in recovery time, symptoms, activity or time off work  2 missed injuries (one in each group)</td>
<td>prospective design  Use of existing documentation audit and pt satisfaction tools - reliability for this study not described  Consent issues addressed  Randomization processes described</td>
</tr>
<tr>
<td>Dahle et al (1998). Impact of a nurse practitioner on the cost of managing inpatients with heart failure</td>
<td>Retrospective, chart review, pre-post design</td>
<td>Year 1; Pre NP – 99 pts Year 2; Post NP – 116 pts</td>
<td>None</td>
<td>Intent to examine if there are cost savings with the addition of an NP</td>
<td>No differences in group demographics  During year after addition of NP, NP cared for 70% of pts with CHF  Year 2 costs significantly lower than year 1 (P&lt;0.03) → cost reductions related to total ancillary, lab, respiratory therapy and ECG costs  Year 2 length of stay tended to be shorter (p=0.13)  Readmission rates not significantly</td>
<td>Clearly defined outcome variables used for pre/post evaluation  Early study of ACNP role in acute care with specialty population  Statistical analysis described</td>
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<td>Hoffman et al (2003). Management of patients in the intensive care unit. Comparison via work sampling analysis of an acute care nurse practitioner and physicians in training</td>
<td>Descriptive, prospective</td>
<td>1 ACNP, master degree, in university affiliated hospital&lt;br&gt;6 physicians in training (fellowships)&lt;br&gt;500 observations (5mins each)</td>
<td>Work sampling methodologies&lt;br&gt;• Determine if time spent in work activities differs between ACNPs and MDs-in-training in a medical step-down unit</td>
<td>Evaluated ACNP after 6mths and after 12 mths on unit&lt;br&gt;• NPs and MDs spent ~40% in routine management of patients&lt;br&gt;• NPs spend more time interacting with patients/families, unit staff (MDs, RNs, others), collaborating with health team members&lt;br&gt;• MDs in training spend more time engaged in non-unit activities (e.g., educational sessions, administrative)&lt;br&gt;• No difference in ACNP time spent on varying activities over time&lt;br&gt;• ACNP spent more time coordinating care</td>
<td>• instrument developed using time in motion strategies, Inter-rater reliability 95% suggesting consistency in application of items&lt;br&gt;• comparison made with providers carrying out similar role (ACNP, physician in training)&lt;br&gt;• quantifies activities based on pre-determined listing</td>
<td>• only one NP in practice in a single site (ICU) ↓ing representativeness and generalizability&lt;br&gt;• instrument is likely not exhaustive with respect to activities which may influence consistency when analyzing activities of practitioners (over/under reporting)&lt;br&gt;• no detailed exploration of interpersonal skills</td>
</tr>
<tr>
<td>Knaus et al (1997). The Use of nurse practitioners in the acute care settings</td>
<td>Descriptive, prospective</td>
<td>3 ACNPs practising in one university affiliated teaching hospital&lt;br&gt;All NPs prepared in primary care programs, not ACNP</td>
<td>None</td>
<td>Intent to evaluate an ACNP practice model to determine daily work activities as well as patient and staff satisfaction with&lt;br&gt;• 2 NPs tracked x 4 mths, 1 NP x 5 mths&lt;br&gt;• NPs spent time as follows&lt;br&gt; - Direct Care; 39%&lt;br&gt; - Indirect Care 31%&lt;br&gt; - Administration 13%&lt;br&gt; - Education 12%&lt;br&gt; - Research 5%&lt;br&gt;• Some variation across NPs&lt;br&gt;• Good satisfaction ratings from MDs.&lt;br&gt;Excellent satisfaction ratings from pts,</td>
<td>• Describes role implementation, a typical day, position responsibilities&lt;br&gt;• Some findings presented in pie chart (assists in interpretation)</td>
<td>• Instruments created for study; no indication of reliability/validity&lt;br&gt;• Broad sweeping statements made and difficult to consolidate findings&lt;br&gt;• No ability to...</td>
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<td>Lambing, (2004) Nurse practitioners’ and physicians’ care activities and</td>
<td>Descriptive, comparative</td>
<td>100 patients cared for on two different units</td>
<td>None provided</td>
<td>Pts/day: NP=8, MD=6.7 NP Results • spent more time writing progress notes and care planning • consulted physical/ occupational therapy, nutrition more frequently • discussed advanced directions • cared for sicker and older patients (by CIRS) • higher overall charges (related to professional consultations as above) Physician Results • spend more time completing literature reviews, giving or attending inservices • cared for younger and healthier patients (by CIRS) OVERALL • NPs and physician trainees similar in time spent communicating with patients/families, updating staff • NPs and physician trainees provide similar care • NPs provide effective care to hospitalized geriatric patients, particularly those who are older and sicker</td>
<td>NP managed unit compared to Intern/Resident physician managed unit • Multiple data collection strategies (provider self-report, chart review, patient severity of illness score) • Acute care focus increases relevance to current study • Daily # of patients cared for similar to current study • Chart reviews on randomly selected pts</td>
<td>• 100% of NPs approached agreed to participate, only 33% of physicians approached agreed— selection bias potential • Monitoring readmission rates over time would further address quality of care • Care provider questionnaire developed for this study and not tested/validated • Care provider data required individual recall (bias may result in under or over reporting of specific activities) • NPs had mean of ~8 yrs experience which could be considered more expert than</td>
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| McMullen, M., Alexander, M.K., Bourgeois, A. & Goodman, L. (2001). Evaluating a nurse practitioner service. | Quantitative, descriptive, prospective, cohort study                   | Physician (resident and house physicians – 405 patients with acute medical issues, admitted to hospital) | None provided            | MD team patients were less healthy on admission and one month post discharge (d/c)  
Patient Satisfaction → patients more satisfied with how NP team communicated about the case in front of them and with one another, more satisfied with how MD team discussed test results with them, no differences in perceptions of knowledge, skill and quality of care provided  
Satisfaction of physicians referring to NP team → overwhelmingly satisfied (>80% agree or strongly agree)  
Staff satisfaction with NP very high | Prospective design  
Acute care environment (management of CHF in hospital)  
Used two validated measures → SF-12-physical/mental health, Picker Commonwealth Institute Questionnaire- pt. satisfaction  
Comparison made for three of four variables (referral physicians not surveyed re: satisfaction with MD team)  
Staff satisfaction results (table 5) difficult to interpret and not well discussed in text | While MD team patients less healthy, does not be clinically significant difference in SF-12 scores  
Sicker patients were assigned to MD team to facilitate learning which had potential to influence the similarity of two groups  
Staff satisfaction results (table 5) difficult to interpret and not well discussed in text  
Did not assess referral physician satisfaction with MD team  
No details re: power in relation to sample size and outcome measure (SF-12) |
| Mitchell-Dicenso et al, 1996                                               | Randomized control trial                                               | 821 admitted infants over 1 yr Randomized to receive care from either NP team (day) + pediatric residents (night) | None                     | No statistical differences in outcomes other than two indicator conditions (process of care) → NPs more likely to meet criteria for charting and managing jaundice  
Concluded that NP and resident teams provide similar care  
Interesting to note no difference in | Use of RCT allows rigorous comparison  
Consent obtained  
Explicit description of all measures  
Measure of Parent Satisfaction developed,  
Infants on NP team had a mixture of care which could have influenced outcomes  
Instruments developed for this study, e.g., list of |
<table>
<thead>
<tr>
<th>Author/Title</th>
<th>Design</th>
<th>Sample/Participants</th>
<th>Theoretical Perspective</th>
<th>Findings</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pioro et al (2001) Outcomes-based trial of an inpatient nurse practitioner service for general medical patients</td>
<td>Randomized controlled trial</td>
<td>381 patients randomized (age 18-69yrs) over 1.5 yrs</td>
<td>None</td>
<td>No differences in patient demographics, comorbidity, severity of illness and functional parameters</td>
<td>academic teaching hospital environment similar to current study</td>
<td>complications, process of care, using experts, not validated may reflect local practice patterns, reducing generalizability</td>
</tr>
<tr>
<td></td>
<td>Chart review</td>
<td>2.5 FTEs of NPs and medical director, work 0730-2000hrs</td>
<td>Intent to compare resource use and outcomes of general medical pts receiving NP-based and house staff-based care</td>
<td>47% of patients randomized to NP ward were admitted to house staff ward (e.g., physician request, bed availability) resulting in unbalanced groups</td>
<td>randomization process described</td>
<td>Process of care measures do not seem to reflect clinical significance</td>
</tr>
<tr>
<td></td>
<td>Hospital database</td>
<td>6 teams – one sr. or jr. medical resident &amp; 2 interns, teaching attending physician</td>
<td></td>
<td>No differences in outcomes, e.g., length of stay, costs, consultations, complications, transfer to ICU, 30 day mortality, SF 36 scores, symptom severity (p&gt;0.01)</td>
<td>though randomization overruled, did analyse by ‘intention to treat’</td>
<td>No apparent measure of interpersonal interaction</td>
</tr>
<tr>
<td></td>
<td>Pt Interviews</td>
<td></td>
<td></td>
<td>Concluded that resource use and patient outcomes are similar</td>
<td>Detailed description of outcome variables and associated measures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outcomes at discharge and at 6 weeks post discharge</td>
<td></td>
<td></td>
<td>The practice model evaluated requires the use of house staff to admit and address patient management over night, therefore NP care can complement but not replace house staff</td>
<td>First study of a heterogeneous pt population</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>Institutional expectations of NPs and house staff may be different</td>
<td>One of very few RCTs</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Consideration of NPs’ abilities to</td>
<td></td>
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<tr>
<td>Author/Title</td>
<td>Design</td>
<td>Sample/Participants</td>
<td>Theoretical Perspective</td>
<td>Findings</td>
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<tr>
<td>Rosenfeld et al, (2003). Measuring practice patterns among acute care nurse practitioners</td>
<td>Quantitative, descriptive</td>
<td>All ACNPs practising in 2 large urban academic health sciences centres</td>
<td>None</td>
<td>Response rate = 65% and 55% at the 2 facilities, total n = 61 ACNPs</td>
<td>Clinical feasibility assessed – easy to use tool</td>
<td>Limited number of items and generalized language may reduce generalizability, e.g., paeds settings</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intention to develop a reliable instrument to measure activities of ACNPs and productivity</td>
<td>&gt; 50% of ACNP time spent in direct patient care (6 items) and 33% of time in indirect patient care (6 items)</td>
<td>Confidentiality maintained</td>
<td>No indication of overall usefulness of tool in quantifying role dimensions of ACNP</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Minimal time in administration (2 items), education and research (6 items) and personal time (1 item)</td>
<td>Consent issues addressed</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Most common activities include examining, assessing, admitting pt, doing history and physical</td>
<td>Used expert panels at each organization to develop, refine instrument (content validity?)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Blending of nursing and medical aspects of role evident</td>
<td>Reliability addressed</td>
<td></td>
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</tr>
<tr>
<td>Rudy et al (1998). Care activities and outcomes of patients care for by acute care nurse practitioners, physician assistants and resident physicians: a comparison</td>
<td>Prospective, descriptive, comparative</td>
<td>16 ACNPs and PAs in 2 academic medical centres</td>
<td>None</td>
<td>Resident physicians work longer days, care for more patients, provide more hands on treatment, spend more time writing orders, consulting, doing procedures and talking with patients and spent more time off the unit</td>
<td>Severity of illness and therapeutic illness scoring system reliable for this study</td>
<td>No randomization; patients were assigned to care providers by MD</td>
</tr>
<tr>
<td></td>
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<td>NPs/PAs more likely to discuss patients with RNs and formally present patients on rounds</td>
<td>Offered a forced choice checklist of 23 activities for diary completion which may increase comparability across subjects</td>
<td>Use of log diaries subject to recall bias as they are not usually completed concurrent with pt care processes</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>When data were controlled for length of shift, results were similar except NPs/PAs were more likely to spend time speaking with pt’s family members, reviewing charts/notes, performing hands-on assessment and performing research and administrative duties</td>
<td></td>
<td>Forced choice in diary may not be all inclusive</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>NPs/PAs more often included social history in admission note</td>
<td></td>
<td>Statistical significance demonstrated but questionable clinical significance levels</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>The number of variables and</td>
</tr>
<tr>
<td>Author/Title</td>
<td>Design</td>
<td>Sample/Participants</td>
<td>Theoretical Perspective</td>
<td>Findings</td>
<td>Strengths</td>
<td>Weaknesses</td>
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<tr>
<td>Sidani et al (2000). Practice patterns of acute care nurse practitioners</td>
<td>Descriptive, combined qualitative and quantitative • Structured questionnaire (scope/model of practice) • Unstructured interviews with subgroup of NPs • ACNP diaries</td>
<td>57 ACNPs employed in 11 secondary and tertiary care hospitals, located in two different cities in same region of Ontario (largest employers of ACNPs in province) 10 ACNPs interviewed</td>
<td>None Intent to describe the practice patterns of ACNPs</td>
<td>• Response rate = 85% • 88% ACNPs formal education, 100% master’s degree • 47% previously practised as CNS • Report independent decision-making, making referrals, order investigations, prescribe medications • Described as advanced practice role • Practice Model; 37% nursing, 12% medicine, 63% combination • Clinical Practice includes; medical management, coordination, assessment, planning care, direct pt care • ACNPs report spending &gt;80% in clinical practice</td>
<td>• Excellent response rate • Informed consent addressed • Confidentiality maintained • Participants asked to approximate #mins to perform each activity (diaries) rather than using ranges • First study of non-neonatal ACNPs to describe roles, functions</td>
<td>measures increases the chance of finding significant differences • No focus on interpersonal skills</td>
</tr>
<tr>
<td>Sidani et al (2006) Processes of care: Comparison between nurse practitioners and physician residents (PR) in acute care</td>
<td>Cross-sectional, comparative design • 8 primarily teaching hospitals in 2 different cities • patient interviews • Activity List – 52 items (PR, ACNP)</td>
<td>31 ACNPs (82% response rate) 10 physician residents (42% response rate) 544 patients &gt;21 yrs of age (61% response rate) 320 ACNP, 46 PR</td>
<td>Framework for evaluating the nurse practitioner’s role in acute care settings</td>
<td>• 93.5% ACNPs female, all master’s degree • 60% PRs male, all MDs , 2 in PhDs Patient Care Processes: • ACNPs spent more time in management tasks, informal coordination • ACNPs encouraged pt participation in care (p=0.05) and provided pt. education to a greater extent (p=0.03) • PRs spent more time in formal coordination activities Patients’ Perspectives • Pts receiving care from ACNPs report higher levels of care coordination, participation in care, counseling and • theoretical framework used to guide study design and evaluation of variables • Framework includes a range of structures, processes, outcomes relevant to ACNP practice • Reliability and validity of activity list, patient-centred comprehensive care subscale, coordination of services described</td>
<td>• Consent processes</td>
<td>Low recruitment of physician residents because they believed the ACNP role was different and so should not be compared • Some measures developed for this study → no reliability/validity described</td>
</tr>
<tr>
<td>Author/Title</td>
<td>Design</td>
<td>Sample/Participants</td>
<td>Theoretical Perspective</td>
<td>Findings</td>
<td>Strengths</td>
<td>Weaknesses</td>
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</tr>
<tr>
<td>Weinberg et al (1983) In patient management by a nurse practitioner:</td>
<td>Randomized Controlled Trial</td>
<td>100 stroke patients</td>
<td>None</td>
<td>NP had slightly shorter length of stay, lab costs/day, fewer consultations and slightly higher index of illness score (better than internist) but no statistical significance achieved between NP and each internist or across all providers</td>
<td>NP practice model described (includes physician supervision</td>
<td>• Randomization process not described</td>
</tr>
<tr>
<td>effectiveness in a rehabilitation setting</td>
<td>Chart reviews</td>
<td>(25 from each stroke unit, one of which was managed by NP)</td>
<td>Intent to analyse the use of an NP in the primary medical management of medically stable inpatients in a rehabilitation hospital</td>
<td>• NP demonstrated far fewer documentation defecits</td>
<td>Outcome measures allowed comparison across 3 internists and one NP, finding minimal variation thus indicating comparable care by all</td>
<td>Only one NP ➔↓ generalizability</td>
</tr>
<tr>
<td></td>
<td>Review of index conditions</td>
<td></td>
<td></td>
<td></td>
<td>First study to evaluate NP in inpatient setting</td>
<td>Index condition measure developed for study, no reliability/validity described</td>
</tr>
<tr>
<td></td>
<td>costs</td>
<td></td>
<td></td>
<td></td>
<td>Some acute illness variables addressed</td>
<td>Similarity between NP and supervisor practice ➔? bias inherent in evaluation process</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td># of tests and consultations is not a measure of quality</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rehab hospital is not an acute care setting</td>
</tr>
<tr>
<td>Yeomans Kinney et al (1997). A descriptive study of the role of the</td>
<td>Descriptive Self – Administered Questionnaire (8 pages)</td>
<td>129 NPs employed in</td>
<td>None</td>
<td>Response rate = 59%</td>
<td>Reminders x 2 if questionnaire not returned</td>
<td>Instrument developed for study, reliability/validity not addressed</td>
</tr>
<tr>
<td>oncology nurse practitioner</td>
<td>(8 pages)- fixed choice and open ended items</td>
<td>oncology settings,</td>
<td>Intended to delineate characteristics and practices of NPs specializing in oncology</td>
<td>All NPs prepared in primary care education programs, 62% master’s</td>
<td></td>
<td>Ranges of involvement by domain of practice rather than estimating percentage of time spent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>drawn from</td>
<td></td>
<td>45% working in hospital setting</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>professional</td>
<td></td>
<td>Respondents well distributed throughout USA</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>association</td>
<td></td>
<td>Majority of NPs cared for ambulatory adult patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>members</td>
<td></td>
<td>79% spent &gt;61% in clinical practice</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Listing of specific clinical functions and procedures performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Physicians cited as most helpful in role</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No frequency counts</td>
</tr>
<tr>
<td>Author/Title</td>
<td>Design</td>
<td>Sample/Participants</td>
<td>Theoretical Perspective</td>
<td>Findings</td>
<td>Strengths</td>
<td>Weaknesses</td>
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<td>----------------------------------------------------------------------------</td>
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<td>----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Kleiman, S. (2004). What is the nature of nurse practitioners’ lived experiences interacting with patients | Descriptive unstructured interviews, “Tell me about your experiences interacting with patients” audiotaped | 6 NPs from a variety of primary, acute and long term care settings All masters prepared Purposive (snowball) method to recruit | Phenomenologic inquiry (Giorgi) Intent to illuminate lived experience of NPs interacting with patients, to discover essential meanings | implementation (67%), followed by other nurses (23%), followed by administration (10%)  
  - High levels of acceptance by patients, physicians, other RNs (>4/5) | NP in oncology practice                                                | of procedures, clinical functions  
  - Low response rate despite strategies to enhance this  
  - Findings may no longer be applicable due to age of study |

**Mixed: Primary and Acute Care**
APPENDIX B: Patient Demographic Questionnaire

<table>
<thead>
<tr>
<th>Study ID #: _________</th>
<th>Date: _________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: [Male [Female</td>
<td>[[</td>
</tr>
<tr>
<td>Where do you live? [Greater Toronto Area [Southern Ontario [Northern Ontario [Outside of Ontario</td>
<td>[[</td>
</tr>
</tbody>
</table>

Why were you hospitalized? ____________________________________________

What is the diagnosis responsible for your hospitalization? _____________

Did you have surgery while in hospital? ________________________________

How long were you in hospital for this admission? (days) ________________

Have you ever been hospitalized before? \[Yes \[No \[\[ |

If yes, how many times? ____________________________________________

When was the last time you were in hospital? ________________________

What year were you born? _________
APPENDIX C: ACNP Demographic Questionnaire

Study ID #: ___________ Date: ____________

1. Educational Background (check all that apply and indicate year of graduation):

<table>
<thead>
<tr>
<th>Degree/Diploma</th>
<th>Year</th>
<th>Degree</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Diploma</td>
<td></td>
<td>MHSc</td>
<td></td>
</tr>
<tr>
<td>BScN</td>
<td></td>
<td>MEd</td>
<td></td>
</tr>
<tr>
<td>MN/MScN</td>
<td></td>
<td>PhD</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Specialty Certification: No _____ Yes ____ (please complete below)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Organization</th>
<th>Year Awarded</th>
</tr>
</thead>
</table>

3. Experience (in years):

Nursing: _________
ACNP: _________
ACNP at TGH: _________

4. Present Employment (Check all that apply)

<table>
<thead>
<tr>
<th>Employment: Part time</th>
<th>Full time</th>
<th>Casual</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient medical unit</td>
<td>In-patient surgical unit</td>
<td>Consult Service</td>
</tr>
</tbody>
</table>

Patient Population: ______________________
Average Patient Length of Stay (in days) _________

5. Practice Description:

Approximate number of patients for whom you are responsible/day: _________
Percentage of time spent in:
Patient care – Indirect (orders, consultation, follow-up) _________
Direct (assessment, patient/family communication) _________
Education ________
Leadership ________
Research ________

Other (specify) ___________________________

6. Year of Birth ________
APPENDIX D: Physician Demographic Questionnaire

Study ID #: ___________ Date: ______________

Professional Experience (years):

In Medicine? __________________

At TGH? ______________________

What is your specialty certification?: ________________________________

Please describe your present practice environment (Check all that apply)

In-patient medical unit ☐ In-patient surgical unit ☐ Consult Service ☐

Patient Population focus of practice: ______________

Patient Care:

Approximate number of patients for whom you are responsible/day: __________

Percentage of time spent in:

Patient care –
Indirect (orders, consultation, follow-up) _________
Direct (assessment, patient/family communication) _________

Year of Birth _________
APPENDIX E: Staff Nurse Demographic Questionnaire

Study ID #: ___________ Date: ___________

1. **Educational Background** (check all that apply and indicate year of graduation):

<table>
<thead>
<tr>
<th>Degree/Diploma</th>
<th>Year</th>
<th>Degree</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Diploma</td>
<td></td>
<td>MHSc</td>
<td></td>
</tr>
<tr>
<td>BScN</td>
<td></td>
<td>Med</td>
<td></td>
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<tr>
<td>MN/MScN</td>
<td></td>
<td>PhD</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

2. **Specialty Certification**: No ____ Yes ____ (please complete below)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Organization</th>
<th>Year Awarded</th>
</tr>
</thead>
</table>

3. **Experience** (in years):
   Nursing
   Current unit at [ ]

4. **Present Employment** (Check all that apply)

   In-patient medical unit [ ] In-patient surgical unit [ ]
   Employment: Part time [ ] Full time [ ] Casual [ ]

   If part-time or casual, average number of hours per week: ____________

   Patient Population: ________________
   Average Patient Length of Stay (in days) ________________

5. **Practice Description**:

   Approximate number of patients for whom you are responsible/day: ______________
   Percentage of time spent in:
   Patient care – Indirect (orders, documentation) ________________
   Direct (assessment, patient/family communication, physical care) ________________
   Other (specify) ________________

6. **Year of Birth** ___________
Main Themes for Discussion

Orientation to the Interview Process
- Time frame (30-45 minutes)
- May be a bit complicated. We’ll start by talking a bit about why you are in hospital then move into talking about the relationships you’ve had with the nurses, then change tracks and talk about your relationship with the NP and finally, your relationship with the physician. May take a few notes while we’re talking.

Context setting
- Why have you been in hospital (going to hospital)?

Staff Nurse
- General Relationships
  - Can you tell me about what you think an ideal relationship with a nurse would be like?
  - You’ve had a number of nurses looking after you while you’ve been in hospital no doubt … what kinds of things have the nurses done for you? What was that like for you?
  - Did nurses spend time with you?
    - How did you spend your time together?
    - How long did your spend with nurses each day?
    - Did the time spent together change depending on the nurse? Or the time of day?

- Specific Relationship
  - (Jourard) was one of your nurses during your stay, wasn’t (s)he? [show photo if necessary]. Tell me about the relationship you had with her/him.
  - You must have had some difficult times while in hospital. Was [RN name] looking after you during those times?
    - How was that for you? Was [RN name] able to help? How?
    - Is there anything you wish [RN name] had done or not done during those times?
  - Did [RN name] ever have to share bad news with you?
    - How did that go? How was that for you?
  - Did [RN name] ever share good news with you?
    - How did that go? How was that for you?
  - How did you get to know one another?
    - What did you learn about him/her?
    - What kinds of things did (s)he get to know about you?
  - Was the relationship you had with [RN name] typical of the relationships you have had with nurses?

Physician
- General Relationships
  - Can you tell me what you think an ideal relationship with a physician would be like?
  - About how many physicians do you think you met during this hospitalization?
  - What kinds of things did they do for you? How was that for you?

- Specific Relationship
  - Dr. [Physician name] looked after you [show photo if necessary]. Had you met Dr. [physician name] before this last hospitalization?
If so, how long have you known him/her?
Tell me about the relationship you had with her/him.

- Did Dr. [physician name] spend time with you? How did you spend that time?
- Dr. [physician name] must have had to talk to you about your condition?
  - How did that go? How was that for you?
- Did (s)he ever give you good news?
  - How did that go? How was that for you?
- What about not-so-good news?
  - How was that for you?
  - Is there anything you wish s/he had done during those times
- How did you and Dr. [physician name] get to know one another?
  - What kinds of things did you talk about?
  - Did you get to know him/her? How did that happen?
- Is the relationship with Dr. [physician name] typical of those you have with physicians?

ACNP
- Specific Relationship
  - Can you tell me what you think an ideal relationship with an NP would be like?
  - A nurse practitioner has been caring for you as well during your hospitalization …do you remember [ACNP name]? [show photo if required].
  - Tell me about the relationship you had with her/him.
  - Did the two you spend time together? How did you spend that time?
    - Tell me more about [use an issue/activity identified by patient]? What happened then?
    - How was that for you?
  - During those difficult times while you were in hospital, was [ACNP name] caring for you then?
    - What happened when you spent time together during those times?
    - Was s/he able to help?
    - How was that?
    - Is there anything that you wished s/he had done or not done?
  - Did (s)he ever give you good news?
    - How did that go? How was that for you?
  - What about not-so-good news?
    - How was that for you?
    - Is there anything you wish s/he had done during those times
  - How did you and [ACNP name] get to know each other during your stay?
    - What kinds of things did you talk about?
    - Did you get to know him/her? How did that happen?

Comparison across relationships
- How would you say the relationship you had with [acnp name] and Dr. [physician name] compare? How were they similar? Different?
- And what about your relationship with [acnp name] and [RN name]? How do they compare?
- And what about your relationship with Dr. [physician name] and [RN name]? How do they compare
Closure

• Thank you for sharing your thoughts with me today
• Is there anything else that you’d like to tell me?
• Thank you, again.
**APPENDIX G: Interview Guide Health Care Practitioner (Staff RN/Acute Care Nurse Practitioner/Physician) (March 2004)**

**Main Themes to be discussed**

**Interview Orientation**
- time frame
- purpose
- relationships with patients in general and then the relationship with a particular patient

**General descriptions of relationships with patients**
- You’ve cared for many patients during your professional career; tell me about what makes for a good relationship with patients from your perspective
- Can you tell me about a memorable relationship that you’ve had with a patient
  - What makes it memorable for you?
- Is that relationship typical [of the ones you have with patients]?
- When you have to give bad news, how does that go?
  - How does it feel?
  - How does it affect you as a person?
- When you have good news to give, how does that go?
  - How does that feel?
  - How does it affect you as a person?
- What happens when you feel there is nothing more to say?
  - How does that feel?

**Specific relationship with [patient name]**
- Tell me about your relationship with [patient name]. How did that relationship develop
- You mentioned [specific situation, e.g. answering questions]. Can you recall a time when you answered [patient name]’s questions … how did that go? (relates to the participant response)
- What was [patient name] wanting from the relationship with you, do you think?

**Compare/ Contrast relationships**
- How does your relationship with [patient name] compare with other relationships you have had with other patients?
- What do you want from the relationships with patients?
  - Have any of your relationships with patients changed you? How?
- Can you tell me about a relationship that wasn’t particularly good?
  - How did the relationship develop?
  - What words would you use to describe that relationship?
  - What qualities or characteristics of the relationship indicated that it wasn’t a particularly good relationship?
  - How did it affect you?
  - What do you think are the reasons that a relationship develops in a not-so-good way?
- Can you tell me about a relationship with a patient that was particularly good?
  - How did that relationship develop?
What words would you use to describe that relationship?

What qualities or characteristics of the relationship indicated that it was a good relationship?

How did it affect you?

From your perspective how do those good relationships develop?

When relationships are good, why do you think that is?

**Closure**

- Thank you for sharing your thoughts with me today
- Is there anything else that you’d like to tell me
APPENDIX H: Patient Consent

What is the Nature of the Relationships that Patients have with Acute Care Nurse Practitioners, Physicians and Staff Nurses?

Researcher: Mary McAllister, RN, MHSc, Doctoral Student, University of Toronto
Telephone #: (416) 978-2860  Email: m.mcallister@utoronto.ca

Supervisor: Professor Dorothy Pringle, RN, PhD, Faculty of Nursing, University of Toronto
Telephone #: (416) 978- 2068  Email: dorothy.pringle@utoronto.ca

Invitation to Participate in the Study and Consent

Why are we doing this study?: The reason we are doing this study is to better understand and describe the kinds of relationships patients have with acute care nurse practitioners (ACNP), physicians and staff nurses while they are in hospital.

Why are you being invited to participate in the study?: You are being invited to participate in this study because you were in hospital recently and the people who cared for you included nurses, physicians and ACNPs. Your participation in this study is voluntary. You can choose not to participate or you may withdraw at any time without affecting your medical care.

What will happen during the study?: If you decide to participate in the study you will be interviewed by the researcher. The interview will take about 30 – 45 minutes to complete. The interview will take place at a place and time that is convenient for you. During the interview you will be asked general questions about the relationships you have with health care professionals and what you consider important in those relationships. You will also be asked questions about your relationship with a specific nurse, physician and ACNP who has provided care to you while you have been in hospital. The interview will be tape-recorded. You will also be asked to fill in a short survey about yourself. For your information, an ACNP, a physician and a staff nurse will be interviewed about their relationships with you while you have been hospitalized.

Are there any potential harms or benefits to participating in the study?: There are no known or anticipated harms or discomforts that will happen as a result of you participating in the study. In addition, there are no known benefits to you as a result of participating in this study but your involvement may help us to understand the relationships health care practitioners have with patients in hospitals. At the end of the interview, to thank you for your time you will be offered a $15.00 Starbucks gift certificate.

What happens if you choose not to participate?: If you decide to participate, you may choose not to answer a particular question. If you choose not to participate or choose to withdraw at any time during the research process, that is fine. There will be no consequences for you. All data collected as of that time will be destroyed if you so wish.

Confidentiality: Confidentiality and anonymity will be respected and ensured and no information will be released or published without consent unless required by law. During the
study, an identification number or pseudonym will be used to identify all data including the audio-tapes. All data including the audio-tapes will be kept locked by the researcher for 5 years and then destroyed. Any data used in subsequent publications will not disclose your identity. For your information, a copy of this consent will be given to you. Upon completion of the study, a summary of the results will be provided to you if you wish.

**Sponsorship:** Support for this study has been provided by the Canadian Nurses Foundation and The Hospital for Sick Children Foundation.

**CONSENT**

I have read the description of the study provided and have had an opportunity to ask questions. Those questions have been answered to my satisfaction. I know that I don’t have to answer a question if I so choose and that I may withdraw from the study at any time. I understand that there are no known risks or benefits associated with participating in the study. I know who I can call if I have any other questions about the study at any time. I have been assured that records relating to my participation in the study will be kept confidential and that no information will be released or printed that would disclose my identity without my permission. I know that participation involves an audio-taped interview.

I ___________________________ consent to participate in the study, including audiotaping.

(print name)

_______________________  ____________
(signature)    (date)

_________________________ _________________________
(name of person obtaining consent)  (signature)

I would like a summary of the study results once the study is finished □

Address:  ____________________________________________
____________________________________________
____________________________________________
____________________________________________

For more information before or during the study: Contact: Mary McAllister, or Dorothy Pringle (see above)

If you have any questions about your rights as a research participant, you can call Research Ethics Board. This person is not involved with the research project in any way and calling him will not affect your participation in the study.
APPENDIX I: Acute Care Nurse Practitioner Consent

Patients’ Relationships with Acute Care Nurse Practitioners, Physicians and Staff Nurses: A Descriptive, Comparative Study

Researcher: Mary McAllister, RN, MHSc, Doctoral Student, University of Toronto
Telephone #: (416) 978-2860 Email: m.mcallister@utoronto.ca

Supervisor: Professor Dorothy Pringle, RN, PhD, Faculty of Nursing, University of Toronto
Telephone #: (416) 978-2068 Email: dorothy.pringle@utoronto.ca

Invitation to Participate in the Study and Consent

Why are we doing this study?: The purpose of this study is to understand and describe and compare the relationships that are developed by patients with acute care nurse practitioners (ACNP), physicians and staff nurses in the acute care environment.

Why are you being invited to participate in the study?: You are being asked to participate because you are an ACNP who practises in an in-patient unit at [Name of Institution] and you have been in practise for more than 2 years. In your practice you care for patients who are experiencing acute episodes of illness. Your participation in this study is voluntary. You may choose not to participate or you may withdraw at any time without affecting your employment.

What will happen during the study?: If you decide to participate in the study you will be asked to participate in an interview conducted by the researcher that will be 30 – 45 in length. The interview will take place at a time of your choosing in a private location agreed upon by you and the researcher. The interview will be tape-recorded. During the interview you will be asked general questions about the relationships you have with patients/families and what you consider important in those relationships in your role as an ACNP. You will also be asked questions about your relationship with a specific patient for whom you have recently provided care. Finally, you will be asked to complete a brief demographic questionnaire and a digital photograph will be taken for use as a visual prompt with patient participants in this study. For your information, a staff nurse and physician will also be interviewed about their relationships with a patient for whom each of you has provided care. The patient will also be interviewed about his/her relationships with you, the staff nurse and physician.

Are there any potential harms or benefits to participating in the study?: There are no known or anticipated harms or discomforts that will occur as a result of your participation in this study. In addition, there are no known benefits to you as a result of participating in this study but your involvement may eventually improve our understanding of the relationships health care practitioners have with patients in the acute care environment. At the end of the interview, to thank you for your time you will be offered a $15.00 Starbucks gift certificate.

What happens if you choose not to participate?: If you decide to participate in the study, you may choose not to answer a particular question. If you choose not to participate or choose to...
withdraw at any time during the research process, that is fine. There will be no consequences for you. All data collected as of that time will be destroyed if you so wish.

Confidentiality: Confidentiality and anonymity will be respected and ensured and no information will be released or published without consent unless required by law. The digital photograph will only be seen by the researcher and the specific patient and will be destroyed upon completion of the patient interview. During the study, an identification number or pseudonym will be used to identify all data including the audio-tapes. All data including the audio-tapes will be kept locked by the researcher for 5 years and will then be destroyed. Any data used in subsequent publications will not disclose your identity. For your information, a copy of this consent will be given to you. Upon completion of the study, a summary of the results will be provided to you if you wish.

Sponsorship: Support for this study has been provided by the Canadian Nurses Foundation and The Hospital for Sick Children Foundation.

CONSENT

I have read the description of the study provided and have had an opportunity to ask questions. Those questions have been answered to my satisfaction. I know that I don’t have to answer a question if I so choose and that I may withdraw from the study at any time. I understand that there are no known risks or benefits associated with participating in the study. I know who I can call if I have any other questions about the study at any time. I have been assured that records relating to my participation in the study will be kept confidential and that no information will be released or printed that would disclose my identity without my permission. I know that participation involves an audio-taped interview.

I ___________________________ consent to participate in the study, including audiotaping and photography. (print name)

________________________________________________________
(signature) (date)

________________________________________________________
(name of person obtaining consent) (signature)

I would like a summary of the study results once the study is finished  □

For more information before or during the study: Contact: Mary McAllister, or Dorothy Pringle (see above)

If you have any questions about your rights as a research participant, you can call Research Ethics Board. This person is not involved with the research project in any way and calling him will not affect your participation in the study.
APPENDIX J: Physician Consent

Patients’ Relationships with Acute Care Nurse Practitioners, Physicians and Staff Nurses: A Descriptive, Comparative Study

Researcher: Mary McAllister, RN, MHSc, Doctoral Student, University of Toronto
Telephone #: (416) 978-2860  Email: m.mcallister@utoronto.ca

Supervisor: Professor Dorothy Pringle, RN, PhD, Faculty of Nursing, University of Toronto
Telephone #: (416) 978-2068  Email: dorothy.pringle@utoronto.ca

Invitation to Participate in the Study and Consent

Why are we doing this study?: The purpose of this study is to describe and compare the relationships that are developed by patients with acute care nurse practitioners (ACNP), physicians and staff nurses in the acute care environment.

Why are you being invited to participate in the study?: You are being asked to participate because you are a physician practising at the Toronto General Hospital site of the University Health Network. In your practice you care for patients with acute episodes of illness. Your participation in this study is voluntary. You may choose not to participate or you may withdraw at any time.

What will happen during the study?: If you decide to participate in the study you will be asked to participate in an interview conducted by the researcher that will be approximately 30-45 minutes in length. The interview will take place at a time of your choosing in a private location agreed upon by you and the researcher and will be tape-recorded. During the interview you will be asked general questions about the relationships you have with patients and what you consider important in those relationships in your role as a physician. You will also be asked questions about your relationship with a specific patient for whom you have recently provided care. Finally, you will be asked to complete a brief demographic questionnaire and a digital photograph will be taken for use as a visual prompt with patient participants in this study. For your information, an ACNP and staff nurse will be interviewed about their relationships with a patient for whom each of you has provided care. The patient will also be interviewed about his/her relationships with you, the ACNP and staff nurse.

Are there any potential harms or benefits to participating in the study?: There are no known or anticipated harms or discomforts that will occur as a result of your participation in this study. In addition, there are no known benefits to you as a result of participating in this study but your involvement may improve our understanding of the relationships health care practitioners have with patients in the acute care environment. At the end of the interview, to thank you for your time you will be offered a $15.00 Starbucks gift certificate.

What happens if you choose not to participate?: If you decide to participate in the study, you may choose not to answer a particular question. If you choose not to participate or choose to withdraw at any time during the research process, that is fine. There will be no consequences for you. All data collected as of that time will be destroyed if you so wish.
Confidentiality: Confidentiality and anonymity will be respected and ensured and no information will be released or published without consent unless required by law. The digital photograph will only be seen by the researcher and the specific patient and will be destroyed upon completion of the patient interview. During the study, an identification number or pseudonym will be used to identify all data including the audio-tapes. All data including the audio-tapes will be kept locked by the researcher for 5 years and then will be destroyed. Any data used in subsequent publications will not disclose your identity. For your information, a copy of this consent will be given to you. Upon completion of the study, a summary of the results will be provided to you if you wish.

Sponsorship: Support for this study has been provided by the Canadian Nurses Foundation and The Hospital for Sick Children Foundation.

CONSENT

I have read the description of the study provided and have had an opportunity to ask questions. Those questions have been answered to my satisfaction. I know that I don’t have to answer a question if I so choose and that I may withdraw from the study at any time. I understand that there are no known risks or benefits associated with participating in the study. I know who I can call if I have any other questions about the study at any time. I have been assured that records relating to my participation in the study will be kept confidential and that no information will be released or printed that would disclose my identity without my permission. I know that participation involves an audio-taped interview.

I __________________________ consent to participate in the study, including audiotaping and photography. (print name)

_____________________________ ______
(signature) (date)

_____________________________ _________________________
(name of person obtaining consent) (signature)

I would like a summary of the study results once the study is finished □

For more information before or during the study: Contact: Mary McAllister, or Dorothy Pringle (see above)

If you have any questions about your rights as a research participant, you can call Research Ethics Board. This person is not involved with the research project in any way and calling him will not affect your participation in the study.
APPENDIX K: Staff Nurse Consent

Patients’ Relationships with Acute Care Nurse Practitioners, Physicians and Staff Nurses: A Descriptive, Comparative Study

Researcher: Mary McAllister, RN, MHSc, Doctoral Student, University of Toronto
Telephone #: (416) 978-2860 Email: m.mcallister@utoronto.ca

Supervisor: Professor Dorothy Pringle, RN, PhD, Faculty of Nursing, University of Toronto
Telephone #: (416) 978- 2068 Email: dorothy.pringle@utoronto.ca

Invitation to Participate in the Study and Consent

Why are we doing this study?: The purpose of this study is to understand, describe and compare the relationships that are developed by patients with acute care nurse practitioners (ACNP), physicians and staff nurses in the acute care environment.

Why are you being invited to participate in the study?: You are being asked to participate because you are a nurse practising in an in-patient unit at University Health Network site of the University Health Network and you have been in practice for more than 2 years. In your practice you care for patients who are experiencing acute episodes of illness. Your participation in this study is voluntary. You may choose not to participate or you may withdraw at any time without affecting your employment.

What will happen during the study?: If you decide to participate in the study you will be asked to participate in an interview conducted by the researcher that will be 30-45 minutes in length. The interview will take place at a time of your choosing in a private location agreed upon by you and the researcher and will be tape-recorded. During the interview you will be asked general questions about relationships you have with patients and what you consider important in those relationships in your role as a nurse. You will also be asked questions about your relationship with a specific patient for whom you have recently provided care. Finally, you will be asked to complete a brief demographic questionnaire and a digital photograph will be taken for use as a visual prompt with patient participants in this study. For your information, an ACNP and physician will also be interviewed about their relationships with a patient for whom each of you has provided care. The patient will also be interviewed about his/her relationships with you, the ACNP and physician.

Are there any potential harms or benefits to participating in the study?: There are no known or anticipated harms or discomforts that will occur as a result of your participation in this study. In addition, there are no known benefits to you as a result of participating in this study but your involvement may eventually improve our understanding of the relationships health care practitioners have with patients in the acute care environment. At the end of the interview, to thank you for your time you will be offered a $15.00 Starbucks gift certificate.

What happens if you choose not to participate?: If you decide to participate in the study, you may choose not to answer a particular question. If you choose not to participate or choose to
withdraw at any time during the research process, that is fine. There will be no consequences for you. All data collected as of that time will be destroyed if you so wish.

Confidentiality: Confidentiality and anonymity will be respected and ensured and no information will be released or published without consent unless required by law. The digital photograph will only be seen by the researcher and the specific patient and will be destroyed upon completion of the patient interview. During the study, an identification number or pseudonym will be used to identify all data including the audio-tapes. All data including the audio-tapes will be kept locked by the researcher and will be kept for 5 years and then destroyed. Any data used in subsequent publications will not disclose your identity. For your information, a copy of this consent will be given to you. Upon completion of the study, a summary of the results will be provided to you if you wish.

Sponsorship: Support for this study has been provided by the Canadian Nurses Foundation and The Hospital for Sick Children Foundation.

CONSENT

I have read the description of the study provided and have had an opportunity to ask questions. Those questions have been answered to my satisfaction. I know that I don’t have to answer a question if I so choose and that I may withdraw from the study at any time. I understand that there are no known risks or benefits associated with participating in the study. I know who I can call if I have any other questions about the study at any time. I have been assured that records relating to my participation in the study will be kept confidential and that no information will be released or printed that would disclose my identity without my permission. I know that participation involves an audio-taped interview.

I ___________________________consent to participate in the study, including audiotaping and photography.(print name)

___________________________   _________________________
(signature)                  (date)

___________________________   _________________________
(name of person obtaining consent)   (signature)

I would like a summary of the study results once the study is finished □

For more information before or during the study: Contact:  Mary McAllister, or Dorothy Pringle (see above)

If you have any questions about your rights as a research participant, you can call Research Ethics Board. This person is not involved with the research project in any way and calling him will not affect your participation in the study.
## APPENDIX L: Comparison of ACNP – Patient Relationship Sub-theory Concept with Empirical Literature

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<thead>
<tr>
<th>ACNP-Patient Relationship Sub-theory Concepts</th>
<th>Similar Terms from Literature</th>
<th>Sources</th>
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<td>Making a connection</td>
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<td><strong>Interaction</strong></td>
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<td>Alliex &amp; Irurita (2004)</td>
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