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NURSE-PATIENT COMMUNICATION IN ONCOLOGY SETTINGS:

A PHENOMENOLOGICAL STUDY OF TRUST FROM PATIENTS' PERSPECTIVES

By

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A Thesis Presented in Partial Fulfillment
of the Requirements for the Degree
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Interpersonal Communication

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NURSE-PATIENT COMMUNICATION IN ONCOLOGY SETTINGS:

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ABSTRACT

Nurse-Patient Communication in Oncology Settings: A Phenomenological Study from Patients' Perspective

A phenomenological study was performed to explore trust within the contexts of nurse-patient relationships with oncology patients. Specifically, the present study explored trust within these relationships in oncology settings. Former and current patients were interviewed to determine their experiences of being trusted (or distrusted) by nurses. Four themes were derived from interviews: competence, personal attention, comfort and communication. Communication and competence were themes that were shown to most increase trust. Incompetence was shown to decrease trust. Nurses who appeared too busy did not instill trust either. Touch, positive facial expressions, and physical appearance increased trust. Non-verbal communication that decreased trust included being physically rough when administering medications or performing treatments and rushing patients too much.

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Chapter 1

INTRODUCTION

Trust is an important part of any interpersonal relationship (Six, 2005). Whether a friend or co-worker trusts another might determine whether or not that relationship continues. Trust seems to be particularly important within the context of nurse-patient relationships as nurses could be responsible for one's health- even one's life. Communication is also is important in establishing trust within the nurse-patient relationship (Dowling, 2008). The aim of this study is to examine the meaning of trust within nurse-patient communication from patients' perspective within oncology treatment programs.

According to Davis (2005), as professionals, nurses are aware that every action taken in patient care has a consequence and that nurses must understand the patient in context. Trust is essential to the nurse-patient relationship (Erikson & Nilsson, September 2008). "Health care providers are ethically obligated to help patients through distressing human health experiences such as suffering, and it is through [this] relationship that nurses engage patients in this journey" (Sacks & Nelson, 2007, p. 676). It is through this relationship that trust is established through the interaction with a suffering individual (Sacks & Nelson, 2007). "Patients put their trust in nurses' interpersonal skills" (Hem, Heggen & Ruyter, 2008, p. 785).

Six (2005) found that caring and concern for other people was shown to be important in trust building in business organizations. Also, sending unambiguous, positive feedback to colleagues was also found to have helped build trust. Furthermore, if colleagues made themselves dependent upon another person, this helped to build trust. Patients need access to care where nurses act in a manner that instills trust (Miton, 2002; as cited by Berg & Danielson,

2007). Perhaps, patients in oncology settings have different needs than those in other settings as they may be suffering both physically and emotionally.

Statement of the Problem

Cancer patients suffer and experience much pain in their disease, both physically and psychologically. Trust helps those in stressful situations and that nurses interact with patients in a trusting manner. However, how patients experience this trust will be examined in this study.

It is clear that trust is important in relationships with patients; however, little research has been done that explores trust from patients' perspectives. A lack of significant research has been performed on how patients experience trust within oncology settings. Additionally, there has been little investigation into how nurses' communication is seen as either being trustful or distrusting by patients.

Furthermore, phenomenological research exploring trust within nurse-patient relationships in oncology settings is very sparse. More specifically, patients' experiences of communication between nurses and patients in oncology settings has not been well studied. Therefore, the purpose of this study is to research the phenomenon of being trusted by a nurse in oncology settings.

According to Merriam-Webster Online (http://www.merriam-webster.com/dictionary/trust), trust is defined as the assured reliance on the character, ability, strength, or truth of someone or something. A trusted person can be defined as one in which confidence is placed. According to Cambridge Dictionaries Online (http://dictionary.cambridge.org/define.asp?key=85211&dict=CALD), trust can also be defined as having belief or confidence in the honesty, goodness, skill, or safety of a person, organization,

or thing. It seems that patients must have this belief and reliance (Sellman, 2007; de Raeve, 2002) of honesty in nurses for patents to trust them.

Carl Rogers (1961), who developed person-centered therapy, believed that each therapist develops a unique relationship with each of his or her clients and believed it was very important to be present with a client. Perhaps, this is important to do in nurse-patient relationships as well. Since the patient is at the center of all interactions in the health care industry (Kreps & Thornton, 1992), keeping the nurse-patient relationship patient-centered could be very important in increasing patient experience of trust.

Background of the Problem

Dowling (2008) studied how intimacy is formed in nurse-patient relationships in oncology care settings. More specifically, the aim was to explore the meaning of intimacy in nurse-patient relationships from the nurses' and patients' perspectives in oncology settings using a phenomenological research approach. Dowling found that competence of technical skills were important to building trust. When patients trusted a nurses' competence, they wanted that nurse to care for them (2008).

Seetharamu, Iqbal and Weiner (December 2007) discovered four factors that influence patient trust in oncology settings. These include minimizing shame and humiliation, managing the power balance between doctors and patients without abuse or misuse, demonstrating to the patient an appreciation of how he or she is suffering from the experience of having cancer, and demonstrating an appreciation of how the patient is suffering from the treatment provided by the oncologist.

According to Seetharamu, Iqbal and Weiner (December 2007), oncology patients sometimes feel shameful because of embarrassing health concerns or because they may feel

vulnerable. Additionally, patients may not be willing to discuss some aspects of care with their physicians. For example, some patients may not be ready to talk about end-of-life care and therefore, be labeled as “in denial” (p. 406) by the staff. Finally, social context may also make a patient feel shameful. AIDS patients may feel shame because of the social stigma that is associated with having AIDS. A trusting relationship between physician and patient can help to reduce shame (December 2007).

“The patient is vulnerable in emotional and physical intrusion whenever he or she sees a physician” (Seetharamu, Iqbal & Weiner, December 2007, p. 406). Since patients are so vulnerable, managing the power imbalance between physician and patient is key to instilling trust. Seetharamu, Iqbal, and Weiner (December 2007) have discovered that this power imbalance exists because the patients’ life is at stake and that power imbalance increases patients’ distrust in physicians. Such distrust ruptures belief in diagnosis, acceptance of prognosis, and adherence to treatment. Therefore, it is important for nurses and physicians to make patients feel comfortable (Seetharamu, Iqbal & Weiner, December 2007).

The third factor that Seetharamu, Iqbal and Weiner (December 2007) found that impacts patient trust of oncology physicians is the acknowledgement of suffering from cancer. Physicians should acknowledge the integrity of the patient as a human being. For example, the patient does not suffer from the objective terminology used in oncology settings like “tumor pathophysiology” (p. 407), but from the subjective experience of how the tumor affects one’s life. If the patient does not believe that the physician understands how his or her life is being specifically threatened by cancer, he or she may not be able to trust the physician to help.

The final factor that may impact patients’ trust of oncologists is acknowledgement of suffering as a result of the treatment given. Patient distrust can form when physicians do not

understand the subjective nature of suffering from cancer. This follows for the treatment itself. If a physician does not understand how a treatment (or treatments) has caused suffering, both physically and psychologically, in a subjective way, trust in future recommendations for treatments may be shattered (Seetharamu, Iqbal and Weiner, December 2007).

Eggly, *et al.* (2006) studied questions asked during stressful encounters in oncology settings. They found that when trust between patients' companions and physicians increased so did the frequency and quality of questions asked. This could imply that as communication between physicians and patients' families increase, so does trust. However, Eggly, *et al.* (2006) did not find that if trust between physicians and patients increased, so did questions asked by patients. Companions are active participants in oncology situations and thus, this involvement affects the behavior of the patient. Perhaps, patients felt exempt from question-asking because they did not feel that they needed to be involved in the interaction because their companions were so involved, argued Eggly, *et al.* (2006). These findings are relevant to the present research problem in that Eggly *et al.* did not study how trust affected the physician-patient relationship from patients' perspective nor did the researchers study nurse-patient communication. The present study attempts to answer that question hence closing this gap in research.

Kraetschmer, Sharpe, Urowitz, and Deber (2004) found that patients had varying degrees of trust in their physicians. For example, 6.3% of participants had blind trust (those who wished a passive role in decision-making), 36.1% had high trust, 48.6% had moderate trust, and 9.0% had low trust in their doctors. Although the percentage of participants that had blind trust was low, it was seen in females, those with less education and those participants over the age of 65 years of age. Blind trust was never found in those with a post-secondary education and participants under the age of 35 years of age. This could imply that those with less education

may not have known as much about their health condition and wanted to trust someone who did know.

Although most of the participants in this study rejected an idea of being purely passive, they also showed little desire to take full charge (Kraetschmer, Sharpe, Urowitz & Deber, 2004). Kraetschmer, Sharpe, Urowitz and Deber (2004) found that most participants wanted to take a shared approach in making decisions. Most participants in this study trusted their physicians, but 10% of those did not. These findings indicate that trust within a physician-patient relationship is one where decisions are shared and that patients are participants within this dyadic relationships.

Purpose of the Study

There is a need to study trust within the contexts of nurse-patient relationships in oncology settings as little research has been performed within this context. Additionally, not much research has been done from the patients' perspective. Therefore, the purpose of this study is to understand trust in these contexts more fully from the patients' perspective only. Since the patient is at the center of all health care interactions (Kreps & Thornton, 1992), it is imperative that trust is understood from their perspective.

Kreatschmer, Sharpe, Urowitz, and Deber (2004) studied how trust affects one's decision-making ability in oncology settings. A few participants (2.9%) preferred an autonomous role and were willing to make decisions on their own, but most participants wanted a shared role where decisions were made in conjunction with their physician. Those that wanted to be completely autonomous viewed themselves as being more knowledgeable about their particular health conditions than those that were passive (those who did not want to make any decisions at all about their health care.) They indicated that they had less knowledge about their health conditions. Perhaps, when one trusts his or her nurse, he or she can make more informed

decisions. This trust may increase one's overall satisfaction. Therefore, studying trust within nurse-patient communication is important.

The aim of this study is to perform a phenomenological study which explores the meaning of trust within nurse-patient communication in oncology settings from patients' perspective. In addition to attempting to better understand the phenomenon of trust in nurse-patient communication, there are several research questions that are related to how nurses instill (or do not instill) trust by using communication.

These research questions that will be examined are:

1) How do patients experience trust within the nurse-patient relationship in oncology settings?
2) What types of communication are helpful in building a trusting relationship with patients?
3) What types of communication are not helpful in building this type of relationship?
4) What types of non-verbal communication are helpful in building trusting relationships with patients?
5) What types of non-verbal communicating are not helpful in building trusting relationships with patients?
6) What types of communication make patients trusting or distrustful of nurses?
7) What can be said, or communicated that can increase patient trust?
8) Does a dominant or assertive communication style of a nurse lead to greater satisfaction with nursing care?
9) Do patients feel that trust increases their satisfaction of nursing care?
10) Do they feel that being distrusted decreases nursing care?

11) Are there other variables that may be important to increasing patient satisfaction?

Chapter Summary

It is important to study the meaning of trust within nurse-patient relationships because it has not been studied widely. Nurses see patients in their most vulnerable moments (de Raeve, 2002). They may need the trust of nurses more so than in other health care settings because of their tremendous suffering. Additionally, studying how nurses communicate with their patients and how this communication builds trust in oncology settings is also imperative because the literature on this topic is sparse. The aim of the present study is to examine trust in nurse-patient communication from patients' perspectives using a phenomenological research approach. In the next chapter, a review of the literature of trust in nurse-patient in various health-care settings will be examined and discussed.

Chapter 2

REVIEW OF LITERATURE

Although this study is interested in the role of communication in building trust between oncology patients and their nurses, most of the literature that was found that dealt with trust in nurse-patient interactions was not found within the field of communication. Instead, most of the research dealing with this topic has been researched within the fields of nursing, psychology, and sociology. Additionally, most of the research that has been conducted has been performed in palliative care or hospice settings. These studies were important as many cancer patients are given care within these settings (Mok & Chiu, 2004; Bostrom, Sandh, Lundberg & Fridlund, 2004; Hoimberg, Septermber-October 2006; Sacks & Nelson, 2997). All of the other studies took place in oncology settings and other health care settings. Additionally, little research has been performed in this area.

Trust in Interpersonal Relationships

Trust is important in many different types of relationships. These include business and personal relationships (Brunner, 2008; Six, 2005; Guffey, 2004; Hupcy & Miller, 2006). Trust helps to build rapport in business relationships (Brunner, 2008; Six, 2005; Guffey, 2004) and interpersonal relationships (Hupcy & Miller, 2006).

Hupcey and Miller explained that participants felt that trust occurred when a person had confidence or faith in a friend. Participants felt that trusting another included being honest and that there was a sense of confidence in the trusted individual. One would feel comfortable or relaxed at having trusting another (2006).

According to Brunner (2008) listening to others is important in building trusting relationships with business colleagues. “Trust could be redefined as ‘a willingness for both

parties to communicate and listen with an open mind" (p. 80). Business colleagues must be engaged with one another by listening intently with an open mind in order for trust to occur (Brunner, 2006).

Six (2005) argued that trust is difficult to build and maintain in work relationships. He explained that interpersonal trust occurs between colleagues in an organization. It is a two person process that involves learning about each other's trustworthiness. This is because trust requires dependence, vulnerability, and optimism about a positive outcome. According to Six (2005), people may be hesitant to trust because these qualities are difficult to attain in work environments. Six also explained that trust is difficult to build because there is no certainty that trust will be honored. Trust is based on predictability and is perceived on consistency of behavior. Trust needs regular nurturing and will become depleted if it is not nurtured in this way.

Trust in Nurse-Patient Relationships

Trust in nurse-patient relationships includes the following attributes: using moral judgment over technical judgment (de Raeve, 2002), the belief of good will towards another person as being trusting (Sellman, 2007; Hupcy & Miller, 2006), and the intimate nature of nurse-patient relationships almost requires patients to trust nurses (de Raeve, 2002; Sellman, 2007). Additionally, once trust is lost in a nurse-patient relationship, it is difficult to gain the patients' trust back; and that trust is not the same in nurse-patient relationships as in friendships (Hupcy & Miller, 2002).

The implications for Six's (2005) definition of trust to nurse-patient relationships in oncology settings are twofold. Firstly, Six (2005) presented that interpersonal trust is a process of two individuals who learn each other's trustworthiness before trust can be formed. Patients

may be doing this during encounters with nurses. They may be assessing how trustworthy a nurse seems by assessing his or her communication style or non-verbal communication. Nurses may be assessing how trusted a patient feels during a medical encounter by examining their verbal communication and their non-verbal communication as well.

Secondly, Six (2005) explained that when trouble occurs, it can be helpful to the relationship because it can make the trust that is re-built much stronger than it was before. However, previous research with regards to trust in nurse-patient relationships in a general health care setting has found that patients were unwilling to re-build trust with the health care provider who broke their trust (Hupcy & Miller, 2006). This is an interesting finding and different from Six's. Perhaps, this is because work colleagues are forced to spend time together due to the nature of a work relationship whereas patients can choose to see another health care provider if they wish too. In other words, colleagues *have* to work together because they may be assigned to do so by a supervisor or a manager, but patients have the choice to receive care from whomever they wish. Perhaps, since health care situations also involve life or death situations, it is easier for patients to leave interactions with nurses and find other nurses that fit their needs.

Sellman (2007) explained that trust may be part of a family of ideas made up of belief, hope, faith, confidence, and reliance. Each can be seen as separate from one another, but sometimes they are intertwined. Sellman argued that trust involves the belief that one will harbor good will towards another. For example, a solider harbors good will that one of his or her comrades will not shoot him or her during battle. A patient must have the belief that a nurse harbors good will towards that patient. In order for a patient to believe that he or she can trust a nurse, he or she must believe that the nurse will not harm him or her.

However, Sellman explained that this belief could just be reliance upon the nurse. A patient may not truly believe that a nurse will not hurt him or her, but may simply rely upon that nurse to not do so. Patients have to rely upon nurses that they will be competent in their job and not hurt them voluntarily.

Also, because patients reveal themselves emotionally and physically to nurses, they must rely on their trust of them. Nurses often see patients naked or upset. They also may have to bath and dress them. This exposure and loss of privacy drives people into accepting nursing (de Raeve, 2002). Perhaps, this forced exposure to nurses requires patients to trust them.

Additionally, Sellman (2007) argued that past experiences can influence the willingness of a patient to trust a nurse. The criterion with which a nurse uses to determine how trusting a patient is depends upon how the patient judges the trustworthiness of his or her nurse. However, these criterions are hardly ever made explicit. Therefore, there is nothing straightforward about trust in nurse-patient relationships. Some patients may trust out of necessity rather than truly trusting nurses. According to Sellman, it is this willingness to trust that is imperative for the nurse and patient relationship because nurses are charged with caring for the lives of patients which are very important to them. Additionally, it follows that nurses should be trustworthy persons as well.

According to de Raeve (2002), patients trust nurses not only based on technical competence, but also on their moral judgment. For example, a nurse may not insert a catheter based on its technical merit, but rather for moral reasons. Perhaps, it may fit the patients' individual health condition than one that is of high-quality. Patients trust nurses on their moral judgment as well as their technical competence because there is more at stake than fixing a machine such as a broken dishwasher. Additionally, nurses are in their field because they feel

morally obligated to help patients; therefore, patients trust them because of this moral obligation. In other words, nurses treat patients differently than a plumber would treat a broken dishwasher because the human body is much more complex. One catheter may not fit one person, but it may fit another. De Raeve (2002) called this moral judgment or moral obligation.

Furthermore, patients trust nurses on this moral obligation because there is no one way to treat the human body.

> "The 'range' and 'focus', whilst not unlimited, will also be open to individual interpretation and no two nurses may exactly agree on this matter, although one would expect broad general agreement sufficient to warrant comprehension of each other's position. This makes nursing very different from plumbing, where the parameters within which the plumber's judgment may be needed are much more narrowly and tightly defined" (de Raeve, 2002, pp. 155-156).

According to Howard University's College of Medicine, The American Nurses Association Code of Ethics states that "nurses provide services with respect to human dignity and the uniqueness of the client, unrestricted by consideration of social or economic status, personal attributes, or the nature of health problems" (http://www.med.howard.edu/ethics/handouts/american_nurses_association_code.htm). Additionally, this code explains that nurses should safeguard their clients' right to privacy by protecting information that is confidential. Also, the nurse acts as a safeguard to the client and the public when their health care and safety are danger due to the incompetent, unethical or illegal practice of any person. It is clear that professional ethics indicates that nurses must be worthy of the patients' trust.

Patients' trust in nurses is based on reliance and confidence. Patients have confidence that nurses will perform their job to the best of their professional ability. They have confidence that nurses will not hurt them (de Raeve, 2002). This follows Sellman's (2007) argument that people have a belief that another will not disrupt one's good will. Patients may have the belief or confidence that nurses will not hurt them (Sellman, 2007; de Raeve, 2002).

Hupcey and Miller (2006) studied the difference between interpersonal trust and trust in a health care provider. Here, health care providers were defined as any health care worker that cares for a patient, including nurses. Semi-structured interviews were conducted with patients to determine this difference mentioned above.

Participants had trouble actually defining trust. However, the definitions that were found had a theme of having confidence or faith in the trusted individual. Participants trusted individuals when they felt that the trusted person was honest; one would feel relaxed and have no concern about trusting that person. This was defined by Hupcey and Miller as interpersonal trust (2006). Perhaps, this confidence is similar to Sellman's (2007) good will and de Raeve's (2002) reliance.

There was little consensus about whether or not this interpersonal trust that was defined was the same or different for health care providers than in relationships with friends. Some participants felt that interpersonal trust was the same and others felt that trust needed to be higher. However, some said that trust in health care providers was not there. These participants felt that the deep-seated trust one feels with an interpersonal friend is not there with health care providers (Hupcey & Miller, 2006).

According to Hupcy and Miller (2006), there was also disparity about how trust was built. Some participants felt that once one met a health care provider trust was established

(Hupcy & Miller, 2002). Perhaps, this is because of the reliance patients have on nursing care (de Raeve, 2002; Sellman, 2007). Additionally, patients may have confidence in nurses' ability to perform their jobs with high-technical competence (de Raeve, 2002).

However, most participants felt that the building or the testing phase was the same for friends and health care providers. These participants felt that they inherently trusted nurses based on their profession (Hupcey & Miller, 2006). This supports de Raeve's (2002) argument that as patients lose privacy and are very much exposed they are forced to accept nursing. Therefore, they rely on nurses and have to trust them.

Hupcy and Miller (2006) found several attributes that nurses have that can help to build trust. These were strongly tied to participants' descriptions and definitions of interpersonal trust. These attributes included: being caring, personable, truthful or honest, and respectful. Additionally, having a professional demeanor, being sincere, compassionate and being good listeners were also found to be attributes of health care providers that helped to build trust. However, when a health care provider did not act in a professional manner and made mistakes, trust was lost.

Sellman (2007) argued that trust is dependent upon patients' belief that nurses will not harm them and that good will and trust are inherently tied. Additionally, patients must have the willingness to trust a nurse in order for that trust to be built. According to de Raeve (2002), patients must have confidence in the nurses' professional ability and that patients are forced to rely on them, and therefore, trust nurses because patients lose so much privacy. Hupcy and Miller (2006) found that interpersonal trust and trust in health care providers are strongly linked and that trust was defined as a comfort level that the trusted individual is trustful and honest; one

would not have any problems trusting that person. According to Hupcy and Miller (2006) patients inherently trusted health care providers because of their profession.

History of Nursing Practice

In a literature review conducted by Chaitin *et al.* (2003), Chaitin *et al.* found that since World War II, the relationship between patients and primary physicians changed from a long-term relationship to one that is more of a fluid transfer of care from the primary physician to that of a specialized one, like oncologists. During this time, patients began developing relationships with nurses where patient-centeredness evolved from a multitude of interlocking interactions (Miles, Koepp, Weber, 1996; as cited by Chaitin *et al.*, 2003). Historically, the women of the family did the nursing of the patient and rarely were patients moved from their home to receive care (Katz, 2002; as cited by Chaitin *et al.*, 2003). During the twentieth century, nurses took the place of mothers at the bedside of the sick and the sick began to receive treatment outside of the home (Reverby, 1987; as cited by Chaitin *et al.*, 2003). Once this transition was made, modern medicine replaced the complete patient interview by the physician with tests such as radiographs, blood testing or other forms of diagnostic testing (Katz, 2002; Starr, 1949; as cited by Chaitin, *et al.*, 2003). It seems that the focus of medicine changed from being patient-centered to more technically-centered. Chaitin *et al.* (2003) discussed that nurses were not a part of this technically-centered dialogue until after World War II. Perhaps, this is why studying communication in nurse-patient interactions is so crucial because nurses may need to return to the patient-centered way of practicing medicine.

Nurses are much more intimate with patients than one sees in most other work environments and thus, this patient-centered way of communicating with patients may be very important. Communication techniques that nurses use that others may not use include being

calm, courteous, attentive, and comforting (Davis, 2005). Participants felt that these types of communication were helpful in building trusting relationships (Davis, 2005). It could be that communication is much more needed in patient-centered relationships than in technically-centered ones because patients are the focal point of the interaction. In the technically-centered relationship tests such as those for diagnostic purposes could be the center of the interaction.

According to Winstead *et al.* (April 1992), having a friend can reduce one's stress level when engaging in a stressful event such as public speaking. Eye contact, humor, and friendly communication were used with friendship pairs and these pairs decreased anxiety about public speaking than did those of stranger pairs. Perhaps, cancer patients who are going through stressful situations require more social support from nurses. Nurses who behave in a friendly way (i.e. display humor, friendly communication, and eye contact) may instill more trust in oncology patients than nurses who do not engage in this type of communication.

According to Merriam-Webster Online (http://www.merriam-webster.com/dictionary/trust), trust is defined as the assured reliance on the character, ability, strength, or truth of someone or something. A trusting person can be defined as one in which confidence is placed. According to Cambridge Dictionaries Online (http://dictionary.cambridge.org/define.asp?key=85211&dict=CALD), trust can also be defined as in having belief or confidence in the honesty, goodness, skill, or safety of a person, organization, or thing. It seems that patients must have this belief and reliance (Sellman, 2007; de Raeve, 2002) of honesty in nurses for patents to trust them.

Now that a general definition of trust, trust in nurse-patient relationships, and a brief history of nursing practice have been provided, themes within the literature will be discussed. These themes include: being there, competence, time, and communication.

Themes in Nurse-Patient Relationships

Being There

Being there was a consistent them throughout the literature (Davis, 2005; Hem, Heggens & Ruyter, 2006; McCabe, 2004; O'Brien, 2004; Sacks & Nelson, 2007; Mok & Chiu, 2004). Another factor that was found within the theme related to being there was continuity of care (Thompson, Hupcey & Clark, 2003: Hoimberg, September-October 2006).

Davis (2005) performed a phenomenological study to determine the expectations patients have of nurses, and how patients describe good nursing care. "Presence (being there and being with) was the most pervasive thread running through stories of good nursing care" (p. 129). Presence was absent in stories of bad nursing care. Presence (being with) was described in the demeanor of good nurses. Being gentle, calm, courteous, kind, attentive, comforting, sincere, available, empathetic, and reassuring were attributes described in nurses who provided good nursing care. According to the participants in this study, good nurses seemed to make patients feel special. This was supported by Eriksson and Nilsson (September 2008) who found that making patients feel special when trying to educate patients on how to change their lifestyle habits was to be helpful in facilitating this dialogue. Nurses must make the patient feel welcome during these encounters.

Thompson, Hupcey and Clark (2003) studied the development of trust in parents of hospitalized children and found that continuity of care was important in how much a parent trusted a nurse. The parents in this study felt that the staff, which included nurses, came and went during their shifts and did not stay in the child's room for very long. This coming and going did not instill much trust with the parents. When parents asked their children to be cared

for by a specific nurse, rather than the several who did not create a sense of continuity of care, trust in the health care team as a whole increased.

Hoimberg (September-October 2006) discussed that having a small number of nurses and one physician involved in the care of the patient were important in building trust. The frequency and the continuity of contact between these health care providers were key to building trust. This frequency and continuity of care included frequent visits by the physician and more importantly, much talk with the patient's family on the part of the nurses. Everyday, small talk was made over coffee and this helped to build trust so that when difficult issues came about, the family felt comfortable communicating their concerns with the home care team.

McCabe (2004) attempted to explore patients' experiences of how nurses communicate with them. McCabe found that the theme of attending to patients was a theme that increased patients' experience of trust. Attending meant giving time and being there for patients. According to Benner (1994; as cited by McCabe, 2004) expert or senior nurses have the experience and self-confidence to recognize the value of patients' time and be truly present for their patients. However, in McCabe's study, patients felt that senior nurses did not do this, but that student nurses did. This could be because student nurses have not been socialized into a more task-oriented way of communication that senior nurses were found to engage in, explained McCabe. McCabe found that task-oriented communication focused on performing tasks and did not focus on attending to the patient.

Open and honest communication was found to be important to patients' views of how nurses attended to them. Nurses that used language that patients could understand were seen by patients as being there and were seen as better at attending to them. McCabe explained that this

open and honest communication could be considered patient-centered and that not using patient-centered communication can have a negative effect on patients' sense of self-worth (2004).

Additionally, nurses who appeared to be genuine in their communication were seen as being much more attending than those who did not appear genuine. The type of communication that patients viewed important was that of non-verbal communication. Participants felt that the tone and pitch of nurses' voice was a non-verbal indicator of being genuine. A nurse whose tone was that of "I like to be the boss" (p. 45) were seen as unhelpful and as not being very genuine. This type of communication demonstrated emotional support, understanding and respect for the patients. These characteristics of genuineness as seen in nurses' non-verbal communication increased patients' perspectives of trust (McCabe, 2004).

O'Brien (2000) found that being there was a pervasive theme when patients were interviewed to determine what the experience of what a nurse-patient relationship is like. Self-disclosure of nurses was important to patients in building trust. Nurses used their self-disclosure of being an ordinary person as a credible way to help patients. Self-disclosure of nurses and patients helped to build a relationship which was shown to establish trust.

Additionally, patients felt that when nurses were "totally reliable- regular and predictable" (p. 188) the establishment of trust increased. The establishment of trust was believed to be the test that would determine the quality of the rest of relationship. Establishing trust was often discussed by the nurses as being related to a specific event such as expressing understanding about an experience. Acknowledging patients' positive or negative feelings was seen as an important step in consolidating trust in the relationship (O'Brien, 2000).

However, O'Brien also found that nurses believed that being there was draining even though it was shown to help patients and to help establish trust. Nurses reported that it took a lot

of emotional energy to go and be the person that patients wanted to see. Nurses said that sometimes they did not want to be that person. Nurses felt that there was little acknowledgment or confirmation that being there was a valuable part of treatment and at times there was pressure to reduce the time spent with patients (2000). Perhaps, this was due to nursing shortages or these participants were not as easy to care for as others.

According to Sacks and Nelson (2007) being there increased trust in hospice patients. Being there consisted of keeping promises, answering questions, following-up and checking-up on patients, and setting expectations. All of these behaviors were associated with building relationships built on trust.

Also, patients wanted to trust nurses when they felt vulnerable. In these cases nurses provided patients with comfort and care. When patients did trust nurses, they shared very private information. However, some patients felt a loss of trust when they felt vulnerable. For example, if medication was changed, patients felt vulnerable and distrustful of nurses. Patients often turned to others whom they trusted that were not part of the nursing staff (i.e. family members or chaplains.)

Mok and Chiu (2004) discovered that responding to patients' needs increased trustworthiness. They listed four attributes that occurred when nurses responded to patients' needs. These attributes were: (1) understanding the patients' needs; (2) displaying caring actions and caring attitudes; (3) promoting holistic care; and (4) acting as patient advocates. When patients felt like nurses listened to them, they trusted them more. However, Shattell (2004) found that nurses often distanced themselves from "bad" or "difficult" (p. 720) patients indicating that not all nurses listen and therefore, not all nurses develop trust with patients.

Competence

Patients are forced to rely on nurses for their basic needs (Shattell, 2004); therefore, competence was cited throughout the literature with regards to establishing or losing trust (Shattell, 2004; O'Brien, 2000; Thompson, Hupcey & Clark, 2003; Hupcey & Miller, 2006; Berg & Danielson, 2006; Davis, 2005; Eriksson & Nilsson, September 2008). These studies' results and possible implications will be discussed in detail below.

O'Brien (2000) found that being totally reliable and predictable increased the establishment of trust. While O'Brien (2000) did not explicitly explain that being totally reliable and predictable was associated with competence, perhaps it is. Nurses who are reliable and predictable may be seen as competent in their jobs and therefore, may be instilling trust in their patients.

In a study conducted by Thompson, Hupcey, and Clark (October-December 2003), parents of hospitalized children reported that they trusted the hospital staff, but they would not leave their child alone with any of them. Thompson, Hupcey, and Clark noted in their discussion that this was due to parents' vigilance and that vigilance is inherent in parents. The parents' vigilance was not an indicator of mistrust or a lack of competence on the part of the hospital staff members. It is possible that adults may feel differently about how competence affects trust as they do not have to be as vigilant of another person such as a child. Additionally, parents may have simply wanted to support their children as a parental duty.

Hupcey and Miller (2006) found that patients' loss of trust had to do with competence mistakes. Nurses who were not aware of what was going on, providers who did not answer important questions, nurses (and other health care providers) who made premature judgments, who lied to cover up mistakes, or who had a care-free attitude were attributes that were

associated with patients' loss of trust. Few patients said that trust could be re-built after these mistakes were made and that the loss of trust was an acute event. Additionally, most patients in this study said that they would not see a provider again even if he or she apologized.

When compared to the loss of trust in interpersonal relationships, Hupcey and Miller found that patients believed that loss of trust of a friend or co-worker was a slow process and that it could be re-built. Patients also expressed the importance of re-building of trust, but did not express interest in re-building trust with a health care provider (2006). Perhaps, this is because patients have the ability to walk away from a relationship with a nurse because they have not put much time and energy into establishing a strong relationship like they may have with a friend or co-worker. Patients may have felt that healthcare is a market place and they can easily change to another nurse just as someone would buy a better television.

According to Berg and Danielson (2006), using one's own competence was a theme associated with nurses' view of a caring relationship. Berg and Danielson did not find that competence was associated with trust; however, it could be the case since others like Hupcey and Miller (2006), Davis (2005), Eriksson and Nilsson (September 2008), and O'Brien (2000) found that being competent is important in establishing trust. Nurses in Berg and Danielson's study reported that they tried to create an atmosphere in which patients felt confident. This attribute was seen as important when being competent; however, it did not result in patients' view of trust. Specific use of competence only pleased patients, but it did not give feelings of trust, according to the participants in this study.

According to Davis (2005), patients expected nurses to be technically competent. Patients also expected nurses to have a good knowledge base and to contact physicians in a timely manner. Additionally, patients wanted nurses to use critical thinking skills. While this

study mainly studied patient expectations of nursing care, it is possible that if a patient views a nurse as being competent in the areas mentioned above, that patient will be more likely to trust that nurse. This follows Hupcey and Miller's (2006) findings in that nurses who had a care-free attitude were less likely to be trusted by patients. Perhaps, this care-free attitude was one where nurses did not use critical thinking skills and did not contact physicians in a timely manner.

Benkert, Peters, Tate and Dinardo (2008) found that provider competency increased patient trust. Competence does not only include technical competence, but also cultural competence. Nurses must know how to relate appropriately with people from other cultures, such as people who are from the African-American cultures.

Eriksson and Nilsson (September 2008) also found that competence was important in establishing trust. Pedagogical competence was important in their study. This was defined as the way information was provided during medical interviews. Eriksson and Nilsson found that nurses who balanced giving patients too much information and giving them too little information were better at establishing trust. Nurses who were professionally mature by not giving too much information were seen as more trusting. Additionally, for a patient to trust a nurse, the nurse had to have knowledge and experience of the patient. This was considered to be a trait of competence (Eriksson & Nilsson, September 2008).

Time

Time was a pervasive theme within the literature. Patients needed more time than nurses could provide (Berg & Danielson, 2007; Sacks & Nelson, 2007). Nurses did not have enough time (Davis, 2005). Establishing trust also involved communication between patients, nurses, and physicians in a timely manner; patients wanted information to be provided quickly, with little delay (Mok & Chiu, 2004; Thompson & Hupcey, October-December 2003).

Davis (2005) conducted a humanistic phenomenological study to determine patients' expectations of nursing care. Specifically, expectation of spiritual care was emphasized. Seven men and four women participated in the study and all participants were white. This lack of external validity is concerning; however, the results are important to note because they emphasize the importance of time since it was a major theme in this study.

Davis (2005) found that patients felt that the lack of time that nurses had decreased nursing care. Nurses were too busy and that affected their ability to provide quality care. Participants felt that patients should only make requests of nursing with good cause, protecting nurses' time. They felt that since nurses did not have much time, they should be respectful of it.

One participant indicated that a nurse was too engaged with what she was doing, rather than paying attention to the patient's basic needs (Davis, 2005). This follows findings by McCabe (2004) in that nurse who were more focused on tasks, were seen as being less trustful. Nurses did not want to talk with patients, but wanted to complete tasks. McCabe also found that nurses did not have enough time to provide enough information.

Another participant felt grateful when nurses took the time to speak with her and to treat her as a "real person" (p. 130). Using time as a way to show interest was also found by Mok and Chiu (2004) and Benkert, Peters, Tate, and Dinardo (2008). It is possible that when a person is dying or facing a possible end of their life, the interactions with others becomes even more significant than they are for people in general. Perhaps, the need to be seen as a real person is greater at this stage of life than in other stages.

Berg and Danielson (2007) studied long-term patients' experience of a caring relationship with nurses. Seven patients and six Registered Nurses participated in this study. Four participants were women and three were men. Participants ranged from ages 51 to 75 years.

This sample appeared to be very general and the results seemed to be sound. The results included the theme of time which has been discussed by others (Davis, 2005; Benkert, Peters, Tate & Dinardo, 2008; Mok and Chiu, 2004; Sacks and Nelson, 2007).

According to Berg and Danielson (2007), patients needed more time than nurses had opportunities to give which decreased patients' feelings of trust. Even though the entire nursing staff attempted to form caring relationships by listening and being there, feelings of trust were not felt among patients. Patients also needed more trust than nurses could provide and this was due to time limitations.

Benkert, Peters, Tate, and Dinardo (2008) studied African-Americans levels of trust, mistrust and satisfaction in healthcare providers. These healthcare providers included nurses and physicians. For the purpose of the current study, only results with regards to trust levels of nurses will be discussed.

Within the sample that Benkert, Peters, Tate and Dinardo (2008) studied there were high levels of trust and satisfaction with levels of mistrust that were in the neutral range. No participant reported a high level of mistrust. Trust and mistrust were inversely related and there was a strong positive relationship between trust and satisfaction (Benkert, Peters, Tate & Dinardo, 2008). It appears that when patients trusted either nurses or physicians, satisfaction increased; however, this correlation between trust and satisfaction cannot provide a causational relationship.

Most importantly, patients who were seen by nurses reported a significantly higher level of trust than those seen by physicians. It was found that nurses emphasized allowing time to build trusting one-to-one relationships (Benkert, Peters, Tate & Dinardo, 2008). One possible implication of this research is that nurses should spend as much time as possible with patients

and spend time learning about their culture. According to Benkert, Peters, Tate and Dinardo (2004), patients can form a cultural mistrust of providers due to previous discrimination and past (and present) negative experiences which can negatively affect trust of the provider. Providers can overcome this by building trusting relationships by using time effectively. Perhaps, physicians feel that their job is more diagnostic than nurses' jobs which could result in less trust by patients.

While this study produced results that were relevant to the present study, the sample included only women. Perhaps, if men participated in this study, external validity would have increased, thus improving the overall implications of this study.

Mok and Chiu (2004) attempted to explore the nurse-patient relationship in palliative care using a phenomenological research design. There were 15 nurses working in palliative care settings and 66% of these nurses participated in this study. There were 110 patients receiving palliative care and 9% of these patients made up the participant sample. This appeared to be a representative sample as the sample size was small which is appropriate for a phenomenological study (Leedy & Ormrod, 2005).

According to Mok and Chiu (2004), in the process of entering into a relationship with a patient, nurses took the initiative. Taking initiative was described by giving time to patients when they were not ready to disclose their deeper feelings. On the other hand, nurses responded to patients' needs in a timely and quick manner. Both of these qualities were important in building a trusting relationship which in itself was pivotal in providing optimal palliative care.

Finally, Sacks and Nelson (2007) studied nonphysical suffering and trust in hospice patients. Many of these patients were cancer patients and nonphysical suffering included suffering of social, spiritual and emotional types. Eighteen participants (10 women and 8 men)

engaged in 22 interviews. It was unclear, but perhaps since there were only 18 participants and 22 interviews were conducted, repeat interviews may have been conducted. These could have been conducted as member checks, thus increasing validity.

For these participants talking about their nonphysical suffering helped to build and maintain trust. Participants felt that when nurses gave the time to listen to their concerns, trust was instilled; however, many felt that nurses did not have the time to talk or that they did not want to talk with them. It was not clear why this happened, but one reason could have been due to staff turnover (Sacks and Nelson, 2007). Again, this supports previous research that nurses lack the time necessary to properly instill trust (Davis, 2005; Berg & Danielson, 2006; Sacks & Nelson, 2007) and that allowing for time to listen and interact with patients helps to build and maintain trust (Benkert, Peters, Tate & Dinardo, 2008; Mok & Chiu, 2004).

Communication

Communication between nurses and patients seems to be an important factor in building and maintaining trust. This was by far the most pervasive theme found in the literature. It is important to discuss because the present study attempts to explore communication in nurse-patient relationships from patients' perspectives. Aspects of effective communication include: timely and accurate communication (Hoimberg, September-October, 2006; Mok & Chiu, 2004; Thompson, Hupcey & Clark, October-December 2003) and open and honest communication (McCabe, 2004; Eriksson & Nilsson, September 2008; Berg & Danielson, 2007; Bostrom, Sandh, Lundberg & Fridlund, 2004; Hoimberg, September-October 2006; Hem, Heggens & Ruyter, 2008; O'Brien, 2000). These studies will be discussed below. Others that do not mention these two aspects will be discussed also because they do emphasize how important communication is.

When determining what aspects of communication can establish a trusting relationship during health counseling sessions with patients who had hypertension, Eriksson and Nilsson (September 2008) explained that when a nurse listened to the patient and met him or her on his or her level, trust increased. This involved respectful communication. While Eriksson and Nilsson (September 2006) did not explicitly state that respectful communication included that of open and honest communication it could be implied. For instance, nurses in this study listened to their patients in a respectful way which may have in turn allowed patients to speak in an open and honest manner.

Additionally, Eriksson and Nilsson (September 2006) stated that dialogue and conversation were used to create a closeness between nurse and patient and to ensure patient participation. Patients were listened to and they were not judged which helped to create a trusting relationship. Nurses tried hard not to be perceived as judgmental or critical as these aspects of communication do not help to build and maintain trust.

When stressful or difficult news had to be given to oncology patients, Chaitin *et al* found that nurses were the best people to give bad news to patients. Chaitin *et a* also found that clear communication between parties is key and that it should not lie with one person but should occur between many health care professionals, including nurses (2003).

Thompson, Hupcey and Clark (October-December 2003) studied the development of trust in parents with hospitalized children. They found that timely and accurate communication between hospital staff members was important in developing trust. All of the participants mentioned the need for timely and accurate information about their child's condition and affirmed that was absolutely essential to the formation of trust.

Shattell (2004) studied communication in nurse-patient relationships using Goffman's theory of face work (1955; as cited by Shattell, 2004). According to Shattell (2004), Goffman's theory describes a theory of interaction whereby both individuals interpret and act in order to appear more positive to others' perspective. Individuals interpret the environment they are in based on symbols and meaning. Then, they act accordingly. The purpose of this face work is to manage the impression, or face, of both parties involved. Shattell (2004) explained that patients' compliments of nurses could be considered face work because patients strive for favorable impressions by nurses to maintain their own self-esteem and autonomy. Patients compliment nurses in hopes that nurses will view patients in a more favorable or positive way.

After reviewing Goffman's theory of face work (1955; as cited by Shattell, 2004), Shattell hypothesized that threats to face work may be greater in situations where patients and nurses interact and where vulnerability is threatened. For instance, nurses often ask very probing questions of an intimate nature. Patients in highly vulnerable health crises are forced to rely on nurses for their basic needs; therefore, they may lose face because they may lose their self-esteem and autonomy. Nurses were forced to exert power over patients in these situations as well. Shattell explained that nurses may need to communicate in such a manner that allows for the saving of face; however, nurses who received communication training of this sort did not improve their communication skills. Nor did their communication improve with work experience.

McCabe (2004) studied nurse-patient communication from patient's perspectives. While this study did not explore nurse-patient communication in oncology settings, it did explore themes associated with communication in these types of relationships. This study is particularly important to the present one since it studied communication from patients' perspective; however,

it did not study trust in nurse-patient communication which is what the present study attempts to do. It also used a phenomenological research approach. Purposeful sampling was done to pick participants, but this type of sampling could have been biased as the researcher may have picked these patients based upon her own biases.

One of the themes associated with nurse-patient communication was “lack of communication” (p. 43). This theme was seen most frequently. Patients felt that nurses did not provide enough information and were more concerned with completing tasks than with communicating with patients. Nurses were too busy to talk. This task-oriented communication and lack of time combined made it difficult for nurses to communicate effectively with nurses (McCabe, 2004).

Patients were re-assured when nurses used a personal approach when caring for them. Those that did not communicate in this way made assumptions about patients’ concerns and needs; they did not communicate in an honest way. Those who communicated in a task-oriented way were more concerned with performing their work than communicating with patients; however, patients did not want to bother the busy nurses, but they also did not blame them for the lack of communication that occurred due to being more task-oriented (McCabe, 2004).

Attending was another theme that was associated with effective communication by nurses. Here, nurses who took the time to listen to patients were seen as better nurses than those who did not. Additionally, using open and honest communication was associated with better nursing care. Patients wanted nurses to communicate with them in an open and honest way by using language that they could understand (McCabe, 2004).

Also, using patient-centered communication was crucial within this theme. All of the patients attributed poor communication skills with task-oriented nursing care. Student nurses

were much better at being more patient-centered. McCabe (2004) explained that perhaps this was because student nurses have not been socialized into the task-oriented way of communicating that senior nurses were. Additionally, maybe the student nurses did not have as many demands placed upon them as senior nurses did. When nurses did not use patient-centered communication, it may have had a negative effect on a patients' sense of well-being and worth.

Nurses who were seen as being empathetic were also seen as being better nurses than those who were not empathetic. This was a huge factor in how patients viewed nursing care; empathetic communication was seen as an essential part of quality nursing care. Sympathetic nurses acknowledged and justified patients' feelings and cared for patients as people, explained the patients in this study. It was important to patients that nurses communicate their recognition and understanding of patients' situations; however, patients did not expect nurses to "fix" (p. 45) everything, but they did appreciate recognition and understanding. McCabe's most important finding that relates to the present study was that patients trusted nurses who emphasized with them and who communicated in an empathetic way. This follows O'Brien's (2000) findings in that when nurses talked to their clients, they spoke with compassion, sympathy, and empathy.

Berg and Danielson (2007) found that it was of great importance to patients that nurses listen to them and that they felt validated. Perhaps, this was done by using empathetic communication that McCabe (2004) explained to be important to the patients in her study. This listening and empathetic communication could have been a way of trust building even though that was not found in Berg and Danielson's study.

Nurses in this study tried to create an atmosphere of trust, but patients still felt mistrusted. Perhaps, this was because these nurses were too busy or that they were focused on tasks rather than patients which McCabe (2004) discussed as being at issue with patients. It was confusing

for patients to know who to talk to; there were too many nurses in the nursing care team and not enough time to speak with each patient (Berg & Danielson, 2007).

Communication was also seen as an important theme in Bostrom, Sandh, Lundberg, and Fridlund's (2004) study about patients' perspective of pain management in palliative care. Patients felt that there was a need for open and honest communication between patients and health care professionals about all of the patients' pain-related problems. "A need to improve verbal communication and understanding of the patients' non-verbal communication was apparent" (p. 414). Patients felt that it was important to discuss their pain as early as possible as there were some participants who engaged in this type of communication, but it was too late in the course of their disease to have much impact on the understanding of their pain.

Lack of communication prevented patients from talking with the palliative team about their dreams, previous experiences, their knowledge, fears and, learned behavior about pain. When communication between patients and health care professionals improved, patients had a better understanding of their pain. Some of these health care professionals included nurses so it is important that nurse-patient communication be strengthened and be used effectively (Bostrom, Sandh, Lundberg & Fridlund, 2004).

Hoimberg (September-October 2006) found that effective communication between the palliative care team and the patient's family was imperative in building trust. This effective communication included regular conversations on a daily basis between nurses and family members. This frequent communication was as informal as talking over a cup of coffee. The nurses were not limited by time (Hoimberg September-October 2006); however, many studies have found that nurses are limited by time and that this affects communication in a negative way (McCabe, 2004; Davis, 2005; Berg & Danielson, 2007; Sacks & Nelson, 2007). Additionally,

information was shared freely between nurses and family members (Hoimberg, September-October 2006). However, conflict of interest may have occurred in this study which may have decreased how valid the results were. The researcher conducted this research with her own family.

Chapter Summary

During this chapter, a review of relevant literature was presented. Here, literature which pertains to trust in nurse-patient relationships in various health care settings was discussed. First, some definitions of trust in general and trust in nurse-patient interactions were offered. Next, a brief history of how nursing care has changed since World War II was discussed. Then, themes that help to build or destroy trust within the literature that have been found were presented. These themes included: being there, competence, time, and communication. Now, a discussion of what methodology will be used in this study will be presented.

Chapter 3

METHODOLGY

The purpose of the present study was to explore trust within nurse-patient interactions from patients' perspectives. More specifically, nurses' communication was examined as to whether or not this communication instills trust in patients. The patients that were studied were Oncology patients because there has been little research conducted with this population and trust could be an important factor in oncology nurse-patient relationships. These patients included those who were cancer survivors. The methodology that was used will be discussed below.

Participants

Participants were recruited from a local gynecological clinic. Many patients at this clinic have been diagnosed with either breast, ovarian, or uterine cancer, therefore, these participants were appropriate for the present study. Additionally, participants were recruited through a co-worker of the researcher, who works at a local publishing company. The researcher felt it was necessary to recruit participants in this manner because of the difficult nature of the research topic. Participants, who were asked by someone they knew, could have been more likely to participate in a study such as this one. Participants were also recruited through participants who completed the study and expressed interest in helping the researcher recruit more participants. Participants' names, specific medical conditions or hospitals they were affiliated with were not released to be in accordance with anonymity protocols. None of the participants were known to the researcher.

There were seven participants who participated in the present study. All of the participants were women. Four were between the ages of 50 and 60, one was between the ages of 40 and 50, one was between the ages of 30 and 40, and one was between the ages of 20 and

30. Additionally, all seven participants were former cancer patients. This was defined by the researcher as having been in remission for more than six months.

Participants signed consent forms that outlined the purpose, the benefits and the potential risks associated with participating in the present study (see Appendix A). Participation was completely voluntary and any participant could have withdrawn at any time with no consequences. However, none of the participants withdrew.

Risks to participants included: confidentiality of their answers to interview questions and possible negative emotional reaction due to the sensitive nature of material discussed during interviews. Only the researcher, the researcher's professor, and the participants saw the answers to interview questions and only the researcher had access to the names of the participants. Any publication of the results of the present study did not include participants' names but coded responses. Each participant was coded to a specific number (i.e. P1, P2, or P3). Additionally, none of the patients' specific medical conditions or hospital affiliations were discussed in the present study nor were they published.

To control for the possible risk of negative emotional reaction during interviews, the researcher clearly stated at the beginning of each interview that participation in this study was completely voluntary and that it would be all right if participants chose to leave during the interview. Additionally, the researcher attempted to create a safe environment for participants. To accomplish this, the researcher practiced role playing mock interviews with her professor who is a licensed counselor before beginning the interviewing process. This assisted the researcher in anticipating what emotions participants experienced during interviews. This was also accomplished by getting to know participants on a more personal level by using small talk at the beginning of the interview. This was done to make participants feel comfortable. Also, the

researcher asked participants from time to time if the interview could be continued if participants appeared to feel uncomfortable. The researcher also tried to convey a sense of comfort by making the interview more of a discussion. This was accomplished by empathizing with the patient when he or she is explaining a difficult situation. The participants were given the opportunity to choose to conduct the interviews in their own home to create a safe and comforting environment as well.

Additionally, the researcher paid very close attention to participants' non-verbal behavior as non-verbal communication can give clues about one's emotional state (Cormier & Nurius, 2003). For example, Cormier and Nurius explained that tight lips can be a sign of frustration, hostility, or anger. Sadness is expressed through the eyes and the lower face and the brows express anger. Additionally, arms folded across the chest can indicate an avoidance of interpersonal interaction (Cormier & Nurius, 2003). If participants expressed any of these non-verbal behaviors or others that may have indicated an unwillingness to continue, the researcher simply asked, "Is it all right to continue?" If any participant wished to stop, he or she did so. However, none of the participants who were recruited wished to discontinue any of the interviews.

Measurement

A phenomenological approach was taken to explore this phenomenon. According to Leedy and Ormrod (2005), a phenomenological study is a study that attempts to understand people's perceptions, perspectives, and understanding of a situation. Performing a phenomenological study that explores trust was important here because it helped the researcher better understand what it is truly like to have a trusting relationship with a nurse.

Merriam and Associates (2002) explained that a phenomenological study focuses on the subjective experience of the individual and seeks to understand the essence or structure of a phenomenon.

> "Phenomenological research addresses questions about common, everyday human experiences (for example, love), experiences believed to be important sociological or psychological phenomena of our time or typical of a group of people (for example, being a cancer patient), and transitions that are common or of contemporary interest (such as becoming a parent or changing gender roles)" (p. 93).

The phenomenological interview is the primary method of data collection wherein the researchers attempt to uncover the essence or the meaning of the experience (Merriam & Associates, 2002). Interviews were conducted which lasted approximately one or one and a-half hours. Interviews began with a general question asking participants to think about a time when they have either been trusted or not trusted by a nurse and how that felt. Then, participants were asked a series of questions that are designed to explore trust within nurse-patient relationships. Questions regarding verbal communication of nurses were asked and how this relates to patients' feelings of trust or distrust were also asked.

Procedures

Once participants were recruited, interviews were conducted with participants who were former cancer patients. Each interview began with a brief explanation of the present study and participants were asked to read and sign an informed consent form. Interviews were recorded using a standard tape recorder which was mentioned in the informed consent form. Interviews were transcribed verbatim with the consent of the participants.

Interviews were conducted in the participants' home. This was done to reduce bias of participant answers during interviews. Questions that were asked during interviews included:

1. How do you define trust?
2. What is the difference between interpersonal trust (i.e. trust with a friend or co-worker) and nurse-patient trust? What are the similarities?
3. Can you explain why it is important to be trusted by a nurse?
4. Why might it be important to be trusted by a nurse in this setting?
5. Why would it not be important to be trusted by a nurse in this setting?
6. What specific words or phrases have nurses used that have helped you to trust them?
7. What specific words or phrases have nurses used that have destroyed your trust of them?
8. What can be said, or communicated by a nurse, that can help to increase your trust in them?
9. What can be said, or communicated by a nurse, that can help to decrease your trust in them?
10. How does trust affect your satisfaction of nursing care?
11. Does a more dominant, assertive way of communicating help to increase your satisfaction of nursing care? If so, how so?
12. Does a more dominant, assertive way of communicating help to decrease your satisfaction of nursing care? If so, how so?
13. What types of non-verbal communication (i.e. eye movement, dress, facial expressions, ect) can increase (or decrease) your trust in a nurse?

14. What might make oncology settings different than those of other healthcare settings with regards to trust? What makes these settings similar?

Participation in this study was completely voluntary. Participants could withdraw from the present study at any time. However, all participants recruited completed the study. Participants who wished to withdraw from the study after the interview has begun could have done so if they wished. Participants' names, specific medical conditions, or any hospitals associated with the participants were not released to minimize anonymity concerns.

Member checks were also done to raise reliability as the researcher may have misinterpreted what participants said during interviews. This was accomplished by paraphrasing what patients said during the interviews and sending out transcriptions of the interviews after the study was conducted. Additionally, thank you notes were sent out with the results of the study to participants who had indicated an interest in receiving them to ensure reliability. Any changes that participants wished to have made were made accordingly.

Software

Once the interviews were transcribed verbatim, themes were drawn using NVivo Software. This program allowed the researcher to organize and code participants' interviews. It also assisted n the quantification process of subjective responses from participants; thus, increasing validity and reliability of the study.

Possible bias on the part of the researcher may have included setting themes that participants may have not seen as being either trusting or distrusting. This was minimized by asking participants to think of some words that they associated with being trusting and distrusting within the context of nurse-patient relationships in oncology settings. Additionally,

paraphrasing what participants said during interviews also assisted in minimizing this bias by making sure that the researcher did not misinterpret what participants mean.

Chapter Summary

Interviews were conducted with former oncology patients to explore the nature of trust within the nurse-patient relationship. More specifically, the exploration of nurses' communication was examined and how that impacted patients' perspective of trust was also studied. Possible risks included the confidentiality of participants' answers as well as possible negative emotional reactions during interviews by participants. This was minimized by coding participants' names and specific medical conditions and by creating a safe environment. Analysis of data was done using NVivo Software and member checks were done to increase reliability of the study. Participation in this study was voluntary and participants' names, specific medical conditions or any hospital affiliations remained anonymous.

Chapter 4

RESULTS

Results were interpreted using NVivo Software. After reading and coding each participant's transcription, the researcher used the software to calculate how often a particular theme was referenced among all seven participants, or sources. Additionally, it allowed the research to interpret which themes within nurse-patient trust and non-verbal communication either increased or decreased trust with oncology nurses. More, the software was able to tabulate relationships between various themes within nurse-patient communication to better understand how participants experienced trust with their oncology nurses. These relationships will be discussed in the Discussion section of this study; however, this chapter will be devoted to presenting the results of the present study.

Participants defined general trust (i.e. not specific to nurse-patient trust) as confidence that a task will be performed, privacy will be upheld, or that dependence can be relied upon. Most participants expressed positive and negative feelings about how trust is experienced within oncology settings.

Participants generally felt that it was important to hold trust with a nurse in an oncology setting because having cancer is a life-threatening illness. However, one participant did not feel it was important to hold trust in an oncology nurse because it was more important for her to hold trust in her Oncologist. She felt this because he was the one making all of the medical decisions relating to her treatment.

Generally, participants felt that the similarities between oncology settings and general health settings were in nurses' ability to perform their tasks competently. However, the most striking difference between the two was in regards to whether or not it is important to hold trust

in nurses of both settings. In general health settings, all of the participants explained that one does not need to hold trust in a nurse because one does not go to a general health care setting (i.e. a general practitioner's office) for a life-threatening illness. Whereas, when one is a cancer patient, one does not know whether he or she will live; thus, trust is imperative.

There were four themes that were most commonly associated with nurse-patient trust in oncology settings that were derived from interviews with participants. Table 1 (see Appendix B) represents all the themes coded for by each participant. The four most common themes included: competence, personal attention, comfort, and communication. The researcher determined how common a theme was by counting how many times it had been referenced by participants during interviews. These four themes will be discussed in detail below.

Competence

Competence was a theme that increased trust. All seven participants felt that when nurses acted competently, trust increased. However, all seven participants also felt that when nurses acted incompetently, trust decreased. The findings that Hupcey and Miller (2006) found were consistent with the findings in the present study. They found that patients' loss of trust had to do with competence mistakes. Additionally, Davis (2005) found that patients expected nurses to be technically competent. This finding held true in this study as many participants stressed the importance of nurses' competence in managing the side effects of particular medications or procedures.

Competence (88 references) was also by far the most common theme that was found during data analysis. All 7 participants felt that this was an important factor in building trust with an oncology nurse. Participants felt that when an oncology nurse was competent in his or her ability to perform tasks, trust was much more likely to occur.

Many participants said that trust increased when nurses appeared to be knowledgeable about what specific medications would do or how to administer medications. For example, one participant said:

> "I wanted them to tell me how to deal with the physical aspects because that's what they knew. That's what I trusted them to know about."

Incompetence destroyed trust for many participants. For example, one participant told of an experience of when a nurse hung her IV on a nail on a wall. That struck her as very incompetent and destroyed her trust immediately.

Another participant told of a time when her arm became infected and the nurses on her case didn't know what to do.

> "My arm had swelled up. It was like a log and when I went in the doctor was not there. I did not feel comfortable. They just stood there and looked at me. They didn't know what to do and that destroyed all...if there was any trust that destroyed [the] little bit that was left."

Experience was also very important with regards to whether or not participants held trust with their oncology nurses. For example, one participant had a negative experience when a nurse explained that she had never performed a particular procedure. After the nurse explained this, the participant told her that she would rather have the procedure done by another nurse.

Personal Attention

Personal attention (51 references) was the second most common theme that occurred in interviews with participants. Personal attention was defined by the researcher as any situation when participants received one-on-one care from a particular nurse or when participants indicated that they felt they received exceptional care from a nurse. While only 6 out of 7

participants mentioned personal attention was important to them with regards to how they hold trust with oncology nurses, it was referenced several times during the interviews.

It was important to many participants that they felt they were the center of all nursing care while they were in cancer treatment. For example, one participant felt that the nurses who always took the time to give her personal attention were the ones that she preferred.

> "For me, the nurses that always took their time regardless of what my situation was or what my appointment was for, were always nurses that I trust[ed]. [They] always were ones that I always said "hi" to when I saw them again. I enjoyed seeing them. I preferred to have them as my nurse and if I could request [them], I usually requested them."

Another participant left one cancer center because she felt like she did not receive much personal attention. When she first began her treatment, she watched a video about what potential side effects there are to treatment. She explained that after she watched the video, she did not have the opportunity to ask any questions or speak with any one nurse; she simply began her treatment.

Participant number four mentioned that she did trust her nurses who were busy and did not pay attention to her. However, another participant felt that she could develop stronger relationships with her nurses because they were not rushing around as much as another cancer center that she was in which she left.

Comfort

While only six of seven participants explained that being comfortable and receiving comfort was important in holding trust in an oncology nurse, it was referenced 47 times throughout the interviews. Comfort included aspects of confidence and making the surroundings more comfortable for those receiving treatment. Additionally, explanations of treatment

procedures made participants feel more comfortable.

Comfort included being able to have the confidence to speak about difficult physical and mental issues with one's nurse. For instance, P3 mentioned that she had to have trust in her nurses because she had to tell them things that made her uncomfortable. She trusted nurses who made her feel commutable when telling them difficult mental or physical aspects of her health. P1 felt the same way.

> "You're kind of putting yourself out there because you may share things with them you just feel very uncomfortable doing and you're baring your soul where you normally wouldn't do that because you are in a very emotional state."

Any explanation of treatment procedures also helped participants to feel comfortable and that helped them to trust their nurses. For instance, P5 felt that the nurses she trusted more were the ones who made her feel comfortable by telling her exactly what he or she was going to do and how he or she was going to do it.

> "The Nurses that I trusted always made me feel relaxed right up front by saying, 'I need you to just relax. Here's what I'm going to do.' and explained to me what they were going to do. If they explained to me exactly what they were [going] do, then I could relax. I could look away or whatever, but I think the words, 'Just relax," "I need you to just relax," and "Here's what I'm gonna do," helped me to trust them because they did-they told me in detail exactly what they were going to do to me and that made me feel more comfortable."

Communication

The theme of communication most increased trust. All seven participants felt that when nurses communicated with them in a timely and accurate manner, trust increased. This finding is consistent with previous research conducted by Mok and Chiu (2004), Thompson and Hupcey (October-December, 2003), and Hoimberg (September-October, 2006). Additionally, according to Sacks and Nelson (2007), answering questions increased patients' trust.

Additionally, communication (37 references) was the fourth most common theme within nurse-patient trust. When nurses clearly communicated how procedures were done and why they were done, trust was established. This was the case for all seven participants. Additionally, when questions were asked and nurses who communicated the answers in a timely manner helped to establish and increase trust.

There seemed to be a relationship between the theme of personal attention and communication as well. P5 indicated that one of the reasons she left a cancer center and went to another one was because of the lack of information and personal attention she received. She explained that the first time she went to this particular cancer center she was shown a video about the potential adverse effects of Chemotherapy, but was not given the opportunity to ask questions or speak one-on-one with any particular nurse. It was because of this lack of personal attention and communication that she chose a different center for treatment.

Honest communication was also important. Honesty was also important to one participant. This participant wanted honest communication during her cancer treatment. This participant said:

> "I think most cancer patients are probably first time cancer patients and when you've never gone through it- when you've never had the specific procedures or specific

medication, you really want information and you want someone to be honest with you. So that's important."

Non-Verbal Communication

Appendix D represents the findings with regards to which types of non-verbal communication increased trust and which types of non-verbal communication decreased trust. Table 3 in Appendix D represents how many sources were coded for each aspect of non-verbal communication that was spoken about in each interview. Chart 2 is simply a visual representation of that table.

When participants were asked what types of non-verbal communication can increase their trust in a nurse, physical appearance, facial expressions, and touch were shown to increase trust. Participants felt that when nurses appeared clean and tidy, used expressive and positive facial expressions (i.e. smiling), and touched them appropriately, participants were much more likely to hold trust in a nurse.

Aspects of non-verbal communication that decreased trust included: time, physical gentleness, and eye contact. Three participants reported that when nurses rushed them or when they were not physically gentle with them, their trust in these nurses decreased. Two participants felt that when nurses did not look them in the eye, trust decreased. However, it should be noted that eye contact was also an important factor in increasing trust for these two participants. When these participants felt that nurses looked them in the eye, trust increased.

Time decreased participants' ability to hold trust in their oncology nurses. Participants felt that if nurses made them feel rushed or made them feel like the nurse's priority was to keep the schedule, trust decreased which is consistent with previous research. Davis (2005) found that

lack of time decreased nursing care. Additionally, Berg and Danielson (2007) found that patients needed more time than nurses were able to provide, which decreased trust.

Chapter Summary

The results of this study indicate that participants experienced trust through four themes – competence, personal attention, comfort, and communication. When nurses were competent, trust seemed to increase and when nurses were incompetent, their experience of holding trust decreased. Also, when participants felt that they had received much personal attention, were comfortable, and received timely, honest, and accurate answers to their questions, trust seemed to improve. Eye contact increased and decreased trust; when nurses did not give participants direct eye contact, trust decreased and when nurses looked participants in the eyes, trust increased. Additionally, when nurses appeared clean, touched participants appropriately, and showed expressive and positive facial expressions, trust increased. When nurses were not physically gentle with participants, trust decreased and when nurses rushed participants, trust decreased.

Chapter 5

DISCUSSION

The present study examined whether or not trust is important in nurse-patient relationships and found that trust is very important in oncology settings because being a cancer patient is a very stressful and emotional event. Overall, most participants felt that they needed someone to depend on, or trust, to make them well again. As was presented in Chapter 4, the most common themes that came up the most frequently were: competence, personal attention, comfort, and communication. Of these themes communication and competence were shown to increase trust the most. These could be aspects of nurse-patient communication that nurses may wish to think about when communicating with patients to help increase patient trust.

Communication that increased participant trust included communication that was seen as encouraging and comforting. Negative words or phrases that decreased participant trust were associated with the themes of being uncompassionate, being too busy, and controlling patients. Non-verbal communication that was shown to help increase trust included: positive facial expressions, touching, and physical appearance. Non-verbal communication that was shown to decrease trust in nurses was associated with being too busy, not making eye contact with patients, and being physically rough when administering medications or treatments.

Relationships between Nurse-Patient Trust Themes

Appendix E shows a comparison of nurse-patient trust themes by nurse-patient themes. This table was derived in order for the researcher to see the relationships between these themes. It was necessary to do this to better understand how participants experienced trust within oncology settings.

There seemed to be a strong relationship between the themes of competence and confidence. All seven participants felt that in order to hold trust in an oncology nurse one must have the confidence that he or she will have the competence to make the patient better, or to at least treat them to the best of their ability. This competence included knowledge of treatment and procedures. One participant indicated that it was essential for a nurse to have much education in order for trust to occur. According to the Oncology Nursing Certification Corporation (http://www.oncc.org/getcertified/TestInformation/ocn/eligibility.shtml), the minimum requirement for an oncology nurse is to have obtained a Registered Nurse degree and to have received the OCN Certification. It seems that nurses who are more educated are more trusted. Perhaps, if nurses were given the opportunity to further their education, patient trust would increase and maybe patient outcomes would increase.

There were also relationships between the themes of personal attention and competence and competence and communication. Six out of seven participants felt that when they received the most personal attention, nurses appeared their most competent. This relationship seemed to be related to how busy nurses were; when nurses were busy, their competence seemed to decrease. Davis (2005) found that nurses were too busy and that affected the quality of care they gave to patients. When nurses paid close attention to patients' needs, participants felt that nurses appeared more competent.

Competence and communication were two thematic themes that were related to one another. All but one participant said that when nurses communicated in a timely or accurate manner, they appeared more competent and that trust increased. Simply answering patient questions was also shown to be helpful to five participants. One participant mentioned that this was helpful not in oncology settings, but in another situation when her son was born. Perhaps,

this participant felt it more important to have her questions answered as a parent. This finding follows Thompson, Hupcey & Clark (October-December, 2003) study that found when parents' children were hospitalized their trust increased when timely and accurate communication between hospital staff occurred.

Interpersonal Trust and Nurse-Patient Trust

Appendix F represents a table that shows all of the interpersonal communication themes by nurse-patient communication. Some of the aspects of interpersonal trust included: implicit trust, honesty, privacy, comfort, superficial trust, and confidence. Participants felt that within interpersonal trust, one must hold confidence, that a person can be trusted. This is consistent with Sellman's (2007) study that found that participants needed to have a belief of good will towards another persona as being trusting before trust can be built. This seemed to hold true for participants in the present study with regards to nurse-patient trust. Participants felt that within nurse-patient relationships, one needed to have a confidence that nurses were competent and could be trusted.

However one participant felt that there is a baseline trust with friends and that trust with nurses has to be earned. Additionally, some participants felt that with nursing care came an implicit trust while others felt that trust needed to be earned in the nurse-patient relationship. Perhaps, this confidence came naturally to participants because of the positive image that may be associated with nurses; nurses are important, therefore, they should automatically be trusted.

Within the theme of confidence, one participant also felt that it was important to confide in nurses when having a bad day. According to Saks and Nelson, hospice patients felt that when nurses took the time to listen to their concerns, trust was instilled (2007). However, the participant in the present study who mentioned that it was important to confide in a nurse when

having a bad day could have been referring to a bad day medically; it is unclear as the participant did not explicitly state what her definition of a bad day was.

Comfort was also a common theme in both interpersonal and nurse-patient trust. Participants felt that nurses, friends, co-workers, and family members should make them feel comfortable and comfort also increases trust within the nurse-patient relationship. The implication of this finding is that nurses may want to make patients feel as comfortable as possible in order to increase the quality of the nurse-patient relationship. Creating comfort could include making the chemotherapy room more comfortable[,] as one participant suggested. This could be done by playing soft music, creating soothing lighting, and keeping the place warm. This participant also indicated that cancer patients want to feel comfortable because they are receiving chemotherapy treatment for at least three hours. She said that if people felt comfortable, the whole experience could be more positive.

It seems that some of the differences between these two types of relationships was in how trust was earned and how confidence was felt. Two participants felt that trust within interpersonal relationships was to be earned and four thought that trust within nurse-patient relationships was to be earned. Perhaps, this is because when one is an oncology patient, one's life is at stake; therefore, trust is placed at a higher-level and nurses must be held to a higher standard. One participant, in particular, stressed that trust within nurse-patient relationships must be earned. She mentioned that this belief stems from how she was raised. This participant appeared to be of Hispanic origins so perhaps, it was also due to her cultural upbringing that she held this belief. However, it is unclear as the researcher did not ask for participants' ethnicity at the start of the study.

Dominance and Assertiveness

When participants were asked whether or not a more dominant, or assertive, way of communicating helped to increase trust, most participants said that it did. However, it depended on how a nurse communicated. If a nurse was dominant, or assertive, to accomplish a task, then trust increased. However, if nurses become dominant, or assertive, in a bossy way, trust decreased.

One participant said that neither type of communication increased her trust. She explained that she had been in an abusive, dominant relationship, so she generally tried to not interact with people who communicated in this manner. It is interesting that this interpersonal relationship also affected her judgment of other situations like nurse-patient communication. It is possible that the reason for this is because many aspects of interpersonal communication are also common in nurse-patient communication.

Satisfaction and Trust

Six out of seven participants felt that it was important that one hold trust in an oncology nurse. Many participants indicated that it was important because one has to put one's life in another's hands. All six participants felt that having a nurse who is competent is necessary and that one must have confidence that nurses will give them the best possible care and treat them to the best of their ability. The implications of these finding[s] are twofold: 1) Nurses should be well educated, either by receiving a Master's of Science in Nursing or by continually performing research, and 2) Those credentials should be clearly stated so as to increase patients' confidence.

One participant felt that it was not important to hold trust in an oncology nurse because one must hold trust in his or her Oncologist. According to this participant, a person's Oncologist makes all of the medical decisions-- what medicine to diagnose, how much to diagnose, or what

surgeries should be performed. However, many other participants felt that if nurses made mistakes with the Oncologist's direction, their trust greatly decreased as potential mistakes could be fatal. Therefore, it seems that it is very important to trust one's oncology nurse.

Study Limitations

Potential bias of the researcher may have included coding responses where participants may not have explicitly stated which theme the response should have been coded to. Additionally, a confound could have included bias of the participants. Participants may have responded to questions in such a way that made the researcher believe was not the way the participant wanted to answer the question. Participants may have answered questions in such a way because that is the way they thought was the "right" answer.

Another potential bias of the researcher could have included the way in which sampling was done. Although the researcher did not know any of the participants, the researcher did know the people that found the participants for this study. Participants could have been willing to participate in the present study only because they were asked to by a friend or co-worker.

The largest limitation of the present study was the sample size. There were only seven participants in this study. Additionally, all seven participants were women. Further research will need to be conducted with a larger and more generalizable sample size in order to confirm conclusions drawn in this study.

Further Research

In addition to replicating this study with a larger and more random and generalized sample size in order to confirm conclusions drawn from this study, additional further research could be performed to better understand the nature of trust in nurse-patient relationships. A study could be conducted using a different methodology such as using surveys to collect data.

For instance, participants could be asked to describe how much trust they hold for their nurses on a Likert scale. Using surveys to collect data would provide more concrete results as to whether or not patients hold trust with their oncology nurses and how that trust affects patient satisfaction.

Additionally, the present study could be replicated in two phases. The first phase could use phenomenology to further explore trust within the oncology nurse-patient relationship. The second phase could use the same methodology to explore how trust with Oncologists is experienced by oncology patients.

Further research could also be done to determine which patients trust more - orthodox health care professionals or alternative medicine practitioners. Phenomenology could be the best suited methodology for this type of study. However, surveys could be used to quantify whether or not patients hold more or less trust in alternative medicine practitioners.

Chapter Summary

This chapter presented a discussion about the results presented in this study. This included a discussion of how themes within nurse-patient trust related to one another, what similarities and differences existed between interpersonal and nurse-patient trust, and how trust affected patient satisfaction. Study limitations included small sample size and an all female population. Additionally, potential confounds in how participants answered research questions and how the researcher coded data were limitations to the present study. Further research should be conducted with a larger sample size using either phenomenology or surveys to confirm conclusions drawn in this study.

In conclusion, as Kreps and Thornton explain, the health care industry is like a wheel where the hub of the wheel is the client, or the patient (1992); patients should be at the center of

nurse-patient communication. According to this study, trust is extremely important in oncology nurse-patient communication which included the themes of personal attention, competence, comfort, and timely and accurate communication. Trust appears to be a fundamental piece of the oncology nurse-patient relationship and nurses should strive to build and maintain that trust with their patients to create a more positive experience.

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APPENDIX A

Informed Consent Form

Nurse-Patient Communication in Oncology Settings: A Phenomenological Study of Trust from Patients' Perspective

Dear Participant,

You are asked to participate in a research study conducted by Julia Havelick from Regis University under the supervision of Juanita Ratner, Facilitator of course MAPC 697A and MAPC 697B.

Purpose of research: The purpose of this study is to determine how communication of nurses can either instill or destroy trust of patients.

Time spent: The time you will spend in this project will be about 1-1 ½ hours.

Costs associated with study: There is no additional cost associated with participation in this study.

Procedures involved: The procedures involved will be face-to-face interviews with the researcher and review of your answers once transcribed by the researcher. Interviews will be tape-recorded using a standard tape-recorder.

There are no experimental procedures involved.

Risks or discomforts to the subjects: Risks that are involved with participating in this study include possible negative emotional reaction due to the sensitive nature of topics discussed during the interview. If any topics discussed during the interview make you uncomfortable, you are allowed to stop participating at any time.

Participants' names, specific medical conditions and any hospitals mentioned during the study will not be released. Participants will be assigned a number during the interview and transcription process. Any publication of the results of this study will not mention individual participants by name, specific medical conditions or hospital affiliation but contain coded responses.

Benefits: Individual participants in this study will not receive tangible benefit for the study other than to discuss the research topic. The results of this study may, however, be used to promote a better understanding of trust in nurse-patient relationships in oncology settings. Results of the study will be made available to participants who indicate an interest in receiving them.

Confidentiality: Any information that is obtained during interviews will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of coded responses.

Participation is voluntary: Your participation in this project is voluntary. You can decide not to participate at any time even after the interview has begun if you wish.

If you have questions: You may contact Julia Havelick at havel504@regis.edu or 303-321-3453 for additional information about the research project. Contact Juanita Ratner at jratner@regis.edu or 303-433-5006 for information concerning the class and the assignment. For additional information about your rights as a research subject contact the Regis Institutional Review Board at 303-458-4206 or 447 Main Hall, Regis University, Denver, Colorado 80401.

____

Printed Name of Subject

______________________________ ____________________________ _______________

(Signature of subject) (Phone number of subject) (Date)

____

(Address of subject)

____

In my judgment the subject is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

____

Printed Name of Researcher

____

(Signature of Researcher)

APPENDIX B

Table 1

Themes Represented within Nurse-Patient Trust

	P1	P2	P3	P4	P5	P6	P7
1 : Comfort	1	1	1	1	1	1	0
2 : Communication	1	1	1	1	1	1	1
3 : Compassionate	1	1	1	1	1	1	1
4 : Competence	1	1	1	1	1	1	1
5 : Confidence	1	1	1	1	1	1	1
6 : Consistency	0	1	0	1	1	0	0
7 : Control	1	1	1	1	1	0	1
8 : Dependence	0	1	0	0	0	0	1
9 : Encouragement	0	1	1	1	1	1	1
10 : Honesty	0	0	1	1	0	0	0
11 : Humor	1	0	0	0	1	1	1
12 : Implicit trust	0	1	1	0	1	0	1
13 : Personal attention	0	1	1	1	1	1	1
14 : Privacy	1	1	0	0	0	0	1
15 : Relaxation	0	0	0	0	0	1	0
16 : Time	1	1	1	1	1	1	1

APPENDIX C

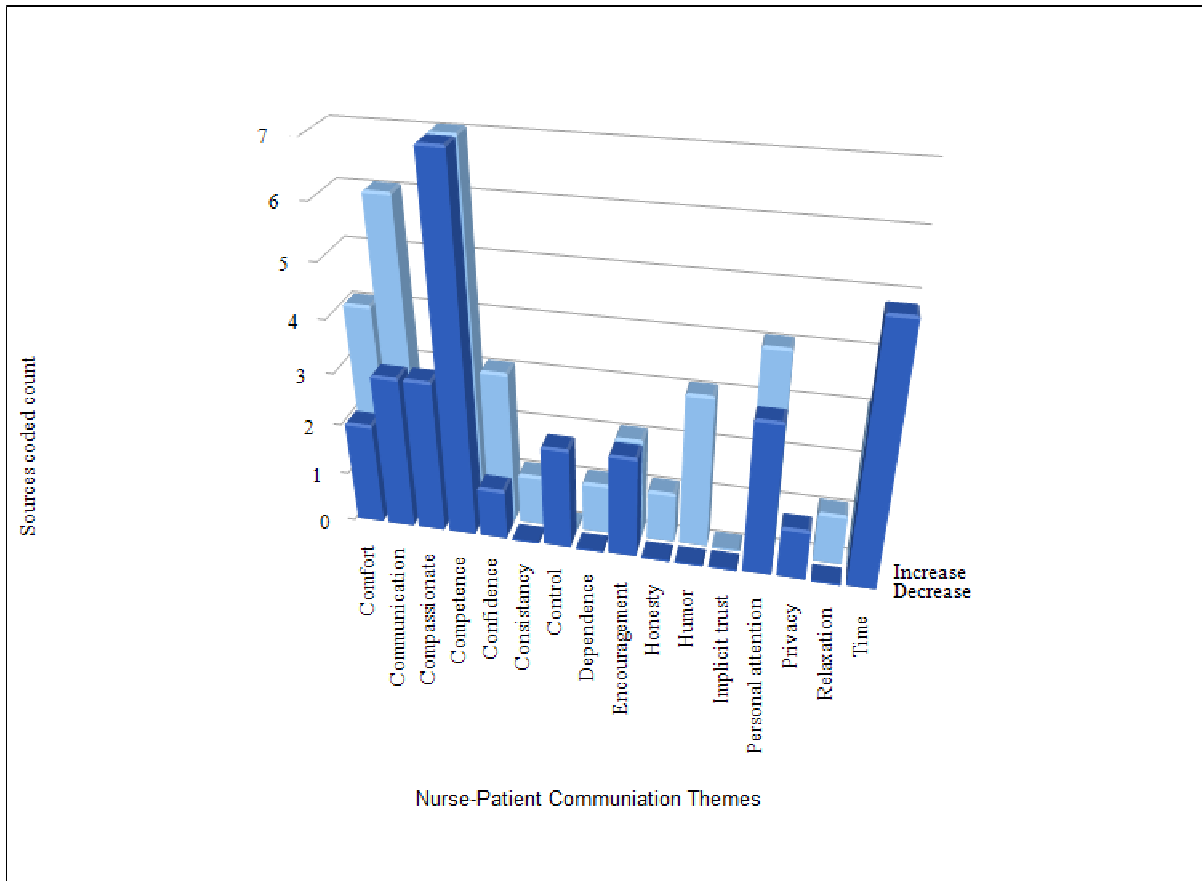
Table 2

Nurse-Patient Communication by Increase or Decrease

	Decrease	Increase
1 : Comfort	2	4
2 : Communication	3	6
3 : Compassionate	3	1
4 : Competence	7	7
5 : Confidence	1	3
6 : Consistency	0	1
7 : Control	2	0
8 : Dependence	0	1
9 : Encouragement	2	2
10 : Honesty	0	1
11 : Humor	0	3
12 : Implicit trust	0	0
13 : Personal attention	3	4
14 : Privacy	1	0
15 : Relaxation	0	1
16 : Time	5	3

Chart 1

Nurse-Patient Communication by Increase or Decrease



APPENDIX D

Table 2

Non-Verbal Communication by Increase or Decrease

	Decrease	Increase
1 : Eye contact	2	2
2 : Facial expressions	1	3
3 : Physical appearance	2	3
4 : Physical gentleness	3	2
5 : Physical proximity	1	1
6 : Time	3	1
7 : Touch	2	3

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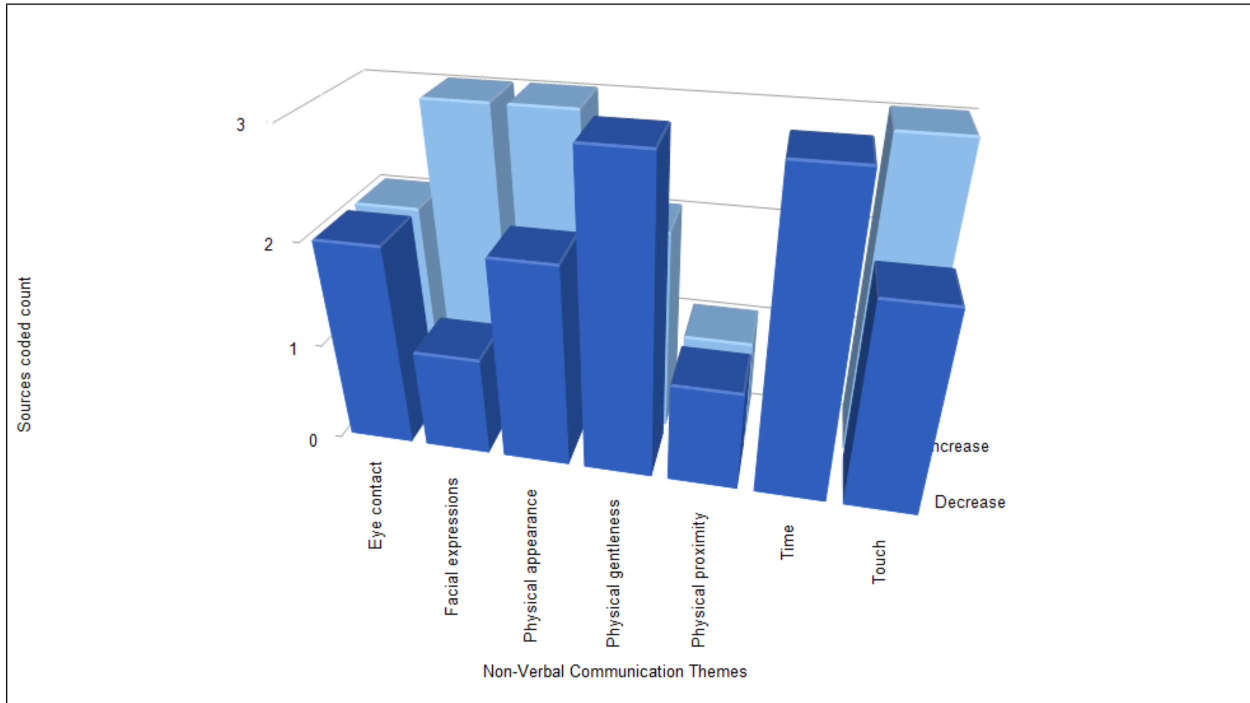
Chart 2

Non-Verbal Communication by Increase or Decrease



APPENDIX E

Table 3

Nurse-Patient Trust Themes by Nurse-Patient Trust Themes

	Comfort	Communication	Compassionate	Competence	Confidence
1 : Comfort	6	2	3	5	4
2 : Communication	2	7	2	6	2
3 : Compassionate	3	2	7	4	0
4 : Competence	5	6	4	7	7
5 : Confidence	4	2	0	7	7
6 : Consistency	0	0	0	3	0
7 : Control	2	0	1	4	2
8 : Dependence	1	1	0	2	2
9 : Encouragement	2	2	1	2	0
10 : Honesty	0	1	1	1	0
11 : Humor	1	0	0	0	0
12 : Implicit trust	1	0	0	3	4
13 : Importance	4	2	0	6	6
14 : Personal attention	4	5	3	5	1
15 : Privacy	0	0	0	0	2
16 : Relaxation	1	1	0	0	0
17 : Time	2	4	2	5	2

(

Table 3 (continued)

	Consistency	Control	Dependence	Encouragement	Honesty	Humor
1 : Comfort	0	2	1	2	0	1
2 : Communication	0	0	1	2	1	0
3 : Compassionate	0	1	0	1	1	0
4 : Competence	3	4	2	2	1	0
5 : Confidence	0	2	2	0	0	0
6 : Consistancy	3	1	0	0	0	0
7 : Control	1	6	0	1	1	0
8 : Dependence	0	0	2	0	0	0
9 : Encouragement	0	1	0	6	0	2
10 : Honesty	0	1	0	0	2	0
11 : Humor	0	0	0	2	0	4
12 : Implicit trust	0	1	1	0	0	0
13 : Importance	1	3	2	0	2	0
14 : Personal attention	1	3	0	1	1	2
15 : Privacy	0	0	0	0	0	0
16 : Relaxation	0	0	0	0	0	0
17 : Time	1	2	0	0	1	0

Table 3 (continued)

	Implicit trust	Importance	Personal attention	Privacy	Relaxation	Time
1 : Comfort	1	4	4	0	1	2
2 : Communication	0	2	5	0	1	4
3 : Compassionate	0	0	3	0	0	2
4 : Competence	3	6	5	0	0	5
5 : Confidence	4	6	1	2	0	2
6 : Consistancy	0	1	1	0	0	1
7 : Control	1	3	3	0	0	2
8 : Dependence	1	2	0	0	0	0
9 : Encouragement	0	0	1	0	0	0
10 : Honesty	0	2	1	0	0	1
11 : Humor	0	0	2	0	0	0
12 : Implicit trust	4	2	0	1	0	0
13 : Importance	2	7	2	0	0	1
14 : Personal attention	0	2	6	0	1	5
15 : Privacy	1	0	0	3	0	0
16 : Relaxation	0	0	1	0	1	0
17 : Time	0	1	5	0	0	7

APPENDIX F

Table 4

Interpersonal Themes by Nurse-Patient Communication

	Comfort	Confidence	Honesty	Implicit trust
1 : Comfort	1	1	0	1
2 : Communication	0	0	1	0
3 : Compassionate	0	0	0	0
4 : Competence	0	1	1	1
5 : Confidence	2	3	1	2
6 : Consistency	0	0	0	0
7 : Control	1	0	1	1
8 : Dependence	0	0	0	0
9 : Encouragement	0	0	0	0
10 : Honesty	0	0	1	0
11 : Humor	0	0	0	0
12 : Implicit trust	2	2	0	3
13 : Personal attention	0	0	0	0
14 : Privacy	0	1	0	1
15 : Relaxation	0	0	0	0
16 : Time	0	0	0	0

	Privacy	Superficial trust
1 : Comfort	0	0
2 : Communication	0	0
3 : Compassionate	0	0
4 : Competence	0	1
5 : Confidence	0	1
6 : Consistency	0	0
7 : Control	0	0
8 : Dependence	0	0
9 : Encouragement	0	0
10 : Honesty	0	0
11 : Humor	0	0
12 : Implicit trust	0	0
13 : Personal attention	0	0
14 : Privacy	1	0
15 : Relaxation	0	0
6 : Time	0	0