Origins of Difficulty in the Nurse–Patient Encounter

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Key words: difficult encounters; difficult patient; knowing the patient; nurse–patient relationship; time

The purpose of this study was to look beyond the patient as the source of difficulty and to examine the context of care encounters for factors that contributed to the construction of difficulty in the nurse–patient encounter. The study explains the origins of difficulty in the nurse–patient encounter. This explanation broadens the thinking limits previously imposed by locating difficulty within the individual. Key elements of this explanation are: knowing the patient minimizes the likelihood of difficulty in the encounter; and families, availability of supplies and equipment, who is working, and care space changes are contextual factors that contribute to the construction of difficulty in the nurse–patient encounter. Awareness of these findings has implications for the strategies nurses employ in difficult encounters.

Introduction

During many years of working as a clinical nurse specialist I listened to nurses describing patients as 'difficult' and was complicit in this process. This experience led to the desire to understand the origins of the phenomenon of the difficult patient. 'Difficult' for the purposes of this study refers to descriptors of patient behavior such as 'demanding, complaining, frustrating, time-consuming, requesting often, calling frequently, manipulative, female, impolite, unreasonable and unco-operative'.[1]

Background

The nursing literature is replete with anecdotal articles about difficult patients and how nurses can get difficult patients to alter their behavior.[2–13] Nursing research on difficult patients has reported: (1) a list of interventions for nurses to use with difficult patients;[14] (2) that nurses distance themselves from patients with own-fault diagnoses, leading to patients being more difficult;[15] (3) difficult patients received the least supportive care;[16] (4) descriptions of difficult patients, how nurses felt about these

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patients, that nurses coped poorly with these patients and patients reported a lack of control;[1,17] and (5) high stress levels in nurses led them to enforce control over patients and patients acted in a difficult manner. A significant correlation was found between nurse personality profiles and stress levels.[18,19]

What is noteworthy in this work is the acceptance of the phenomenon of the difficult patient and generally locating difficulty in the patient. It is interesting that, in studies where researchers looked beyond the patient to consider other factors when difficulty arose, it was reported that, when patients felt controlled, this led to difficult behaviors, and when patients felt they were listened to and respected, they were less difficult.[20] Similarly, Laskowski[21] found that the degree of meaning established in the nurse–patient relationship mediated the level of difficult behavior expressed.

Johnson and Webb[22] explored the moral climate in which nurses worked and found that the labelling of patients as good or bad was socially constructed and varied with what was going on with the nurses' day and the ward in general, and with forces external to the ward. Becker's[23,24] work on labelling and deviance found that the interaction and the context of the interaction determined the extent to which the individual was deemed deviant. There is a gap in the literature about difficult patients and of studies that look beyond the patient to examine the nurse–patient encounter and the context of the encounter for the origins of difficulty. The purpose of this study was to generate a substantive explanation of the origins of difficulty in the nurse–patient encounter. The specific aims of the research were to answer the following questions: (1) How do nurses describe the origins of difficulty in the nurse–patient encounter? (2) What are patients' perceptions of recent care encounters? (3) How does the context of care influence the nurse–patient encounter? and (4) What are the consequences of difficult nurse–patient encounters for patients and nurses?

This study is relevant for three reasons: nurse and patient satisfaction, nurse stress, and nursing knowledge. The phenomenon of the difficult patient is known to cause dissatisfaction for both patients and nurses.[1,18,20] A known relationship exists between patient satisfaction with nursing care and overall patient satisfaction.[25,26] The present world-wide shortage of registered nurses (RNs) is the subject of numerous studies to determine strategies to retain nurses and recruit more into the profession.[27–35] These studies found that the variable with the highest predictor of nurse dissatisfaction was stress. The presence of the phenomenon of the difficult patient is known to leave nurses feeling stressed, frustrated, angry and helpless.[1,19]

Little is known about the origins of difficulty in the nurse–patient encounter. In fact, difficulty has been located primarily within the patient, obviating the need to examine the encounter or the context within which the encounter has occurred. This grounded theory study moved away from a focus on the patient as the source of difficulty to a focus on the context of the nurse–patient encounter.

Study design and methods

A constructivist approach to grounded theory informed this study. Data and the analysis were co-created by the researcher, the participants, the context and the literature. Central to this approach is finding out how phenomena are constructed through participants' meanings and actions in the context of their work. This approach offers a guideline rather than a stepwise process. Research strategies included:

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simultaneous data collection and analysis, line by line coding, development of categories, constantly comparing new data with existing data, memo writing to articulate emerging concepts, theoretical sampling to verify emerging concepts, and the integration of concepts into a framework[36] to explain how difficulty originated in these nurse–patient encounters. Grounded theory is an appropriate method for the study of phenomena that are imperfectly formed or partly in existence. There is a need to generate some initial concepts about the origins of difficulty in the nurse–patient encounter, and to link these concepts in such a way as to explain the phenomenon.

Qualitative data were obtained through 120 hours of participant observation on a family medicine nursing unit, in-depth interviews with 12 former patients on the unit and 10 nursing staff from this unit in a hospital in Atlantic Canada. Institutional review board approval was obtained, as well as informed consent from both patients and nursing staff.

Setting

In-hospital, family medicine units are not common settings for research in Atlantic Canada. These units support all specialty services. When patients exceed their expected length of specialty service stay and are not ready for discharge, family medicine units bridge the gap. Patients and families on these units often face a variety of challenges surrounding discharge and, as a researcher, I wanted the opportunity to conduct this study in such a setting. The unit chosen had a reputation for strong nursing leadership and stable staffing.

Sample

The nursing staff who participated in the study were recruited by posting fliers on the nursing unit inviting those interested to contact the researcher by e-mail or in person during participant observation sessions. Those interested were contacted and a date, time and place were set for an interview. The nurses were female, white, English speaking, ranging in age from 28 to 60 years (average 41). The majority were diploma prepared, and their experience ranged from 6 to 20 years (average 12.8). Experience in the study setting ranged from 1 to 15 years (average 8). The patients were white, English speaking, cognitively alert, and ranged in age from 39 to 93 years (average 62). They came from various socioeconomic backgrounds. Six were men and six were women. Prior to discharge, the discharge co-ordinator explained the study to the patients and asked if they were interested in participating. If a patient indicated interest, contact was made within 7–10 days to confirm continued interest and, if still interested, a date, time and place convenient to the patient were arranged for an interview.

Data collection and analysis

Data collection and analysis was a simultaneous process. Participant observation and interviews with staff and patients took place over a 10-month time frame. Written notes were made during participant observations and later developed into narratives. Interviews with staff and patients were tape-recorded and transcribed verbatim. Each observation session's data were coded and compared with each interview and vice

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versa. This constant comparison led to the development of categories that were common in the data and made subsequent data collection more focused, allowing for the emergence of a core category. This was achieved through the practice of reflexivity. 'Reflexivity can be defined as thoughtful, conscious self-awareness.'[37] No qualitative researcher would argue that a researcher enters the field without bias. Every researcher comes from a context, and has a degree of knowledge and a set of values and attitudes.[38] Researchers using a constructivist approach recognize that data are co-created by the researcher and the participants.[36] Theoretical sampling was used to confirm the categories. An example of this was 'availability of supplies and equipment'. This category was identified in the first nurse participant interview and seemed to cause considerable frustration. In subsequent interviews, if participants did not talk about this they were asked if they could think of examples of situations when they could not obtain supplies and equipment in a timely fashion. Every participant could easily give an example of this (e.g. obtaining medications from the pharmacy, vital signs machine not working). Each interview confirmed the fit and relevance of this category in the study.

Findings

Reconciling temporalities (time) was the core category that emerged in this study and was the main concern for both nursing staff and patients. This was the process that patients and nurses experienced in obtaining and delivering care. When nurses had time to get to know patients, little difficulty occurred in encounters and little reconciliation was necessary. Conversely, when nurses did not have the time to get to know patients and to be with them, difficulty necessitating reconciliation arose in encounters. The degree of reconciliation required determined the degree of difficulty present in the nurse–patient encounter. What emerged as the most problematic issue for nurses was not having time to get to know patients; for patients it was feeling that nurses did not have the time for them that the patients believed they needed. 'The only time I think may be, um, it wouldn't go so well is if you don't have the time to give to somebody that clearly requires a lot of time.' Patients also participated in the process of reconciling temporalities (time). They could see that nursing staff were busy and some patients would bundle their requests to try to save the nurse some time. Others insisted they wanted more of the nurses' time whether the nurse had time or not. This would necessitate considerable reconciliation on the part of the nurse. 'I mean, when you're sick, you just need a little bit of attention. Most times they're so busy that you don't get that attention.'

Knowing the patient

This factor was a prerequisite to harmonious nurse–patient encounters and its discovery came as no surprise. Nursing staff spoke with feelings of pride and satisfaction in describing encounters that went well. They not only spoke about knowing the patient but also the family. For some staff, positive feelings resulted from one encounter within a shift; for others this meant the course of a shift or several shifts with a patient and family. Nursing staff reported that they made a difference in the lives of patients and families by knowing them. 'They knew I knew how to treat him,

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and just the whole interaction, you were able to not only nurse him but the family as well.'

Factors influencing the nurse–patient encounter

The factors that limited the time that nurses had for patients were: families, availability of supplies and equipment, who is working, and care space changes. The process employed by nurses and patients when faced with time constraints was reconciling temporalities (time). The strategies that nurses used were: controlling, working together, managing families, and employing geographies of place and bodies (persons). Contextual conditions that influenced the process of reconciliation were unit reputation and labor market structure changes. The factors that contributed to the construction of difficulty in the nurse–patient encounter are shown in Figure 1 and explained in more detail in the following sections.

Families

During participant observation sessions, most patients had at least one or two family members visiting at varying times; some had many family members present, who were often in search of the nurses for varying types of information. In the course of the nurse participant interviews families were identified as needing a lot of nursing time. Some nurses readily incorporated family time into patient care: 'I've learned how to nurse those families rather than the patient – because the patients get all they need.' Others

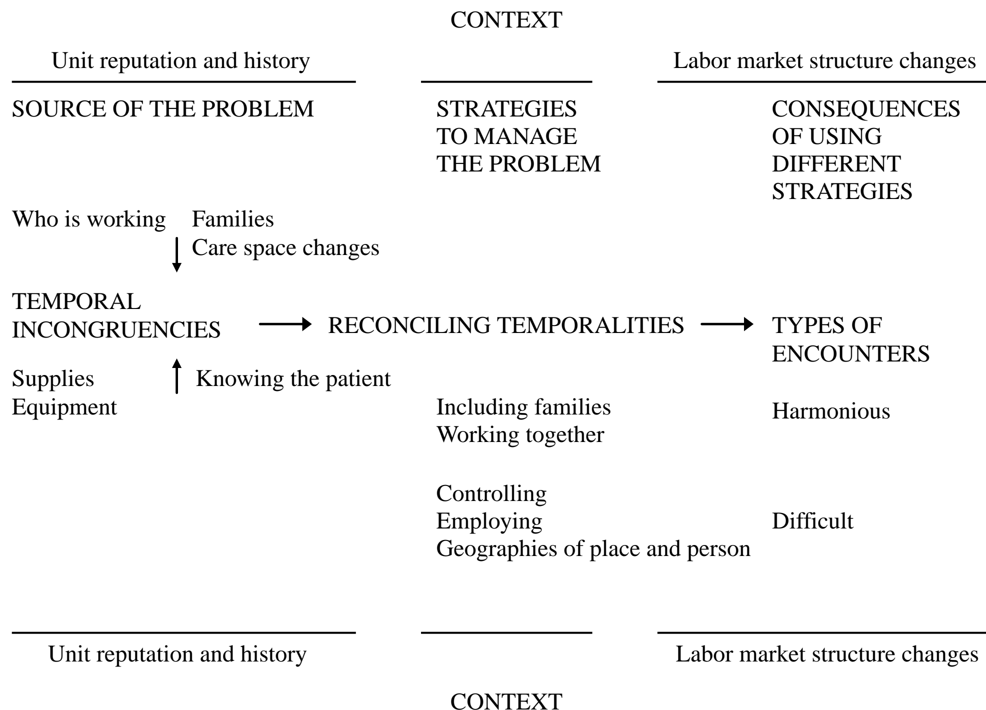

Figure 1 Factors contributing to the construction of difficulty in the nurse–patient encounter

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were quite burdened by it. It was clear that families needed time from the nurses but what was less clear was whether the time families needed was adequately compensated for in the nursing workload.

Availability of supplies and equipment

A second factor that emerged from the data and which consumed considerable nursing time was the availability of supplies and equipment. The pharmacy department at the study site embarked on a computer system upgrade during the course of data collection for this research. The purpose of the upgrade was to make dispensing more efficient, but the opposite happened. This left nursing staff frustrated, looking for medications and making trips to the pharmacy for much needed medications. The efficiency of departments ancillary to the nursing unit is a key factor. Nurses lost hours of precious patient care time in trying to procure medications.

Who is working

A third factor that made a difference in how much time nurses had for patients was who is working. Nurses have said for years that getting the work done is easier with some coworkers than others. Most nurse participants eloquently described that, when they were working with certain staff, even if time was at a premium, the most was made of every available minute; even though patients did not get all the care they wanted to give them, the nurses knew that the patients received all the care there was to be had for that shift. 'So, you know, we work really well together that way and nobody is hung out to dry, nobody is in a situation by themselves, and everybody gets looked after.' They also described working with other staff who did not help one another, did not work as a team, and how hard it was to work under these circumstances.

Patients noticed how well staff got along with each other and if they helped one another. They said the atmosphere was more relaxed and comfortable on some shifts than on others.

Care space changes

A further factor that emerged was care space changes. This meant changes in the patient care environment, including shortened lengths of stay, patients receiving multiple medications, and patients with multiple co-morbid conditions. Nurses described how sick their patients were, that they had multiple medical conditions, that only the most urgent condition was treated and the patient was discharged as soon as possible.

> Most of our patients are in their eighties and nineties. We're seeing people with more numerous problems, multi-diseases, you're patching them up basically, you know, you're putting a band-aid on the biggest problem and maybe sending them home. And I mean, obviously in family medicine, there is nobody who's on one or two medications. They're all on 15 at least.

Nurses felt they needed a lot of time with these patients to prepare them for discharge. As soon as a patient stabilized, a discharge report was written and the nurses had frantically to prepare the patient knowing that once again they did not have enough time with them.

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Patients also believed that they were discharged too quickly. They described feeling very weak, not really able to understand all about their condition and their medications. They often had the sense that their condition was not being completely assessed, but rather the most pressing aspect was addressed in the hope that everything else would be all right.

Controlling

Faced with severe time constraints, nursing staff engaged in strategies to manage time. Some of these strategies led to almost immediate reconciliation while others necessitated considerable reconciliation.

The nurses reported resorting to controlling behaviors when they felt really pressed for time. They would enforce rules, such as visiting hours, so that they would not have to deal with families outside certain hours. They would attempt to rush patients through their care and generally limited patient choice. 'I remember washing her and she was okay with all of that, and then I was getting her into the chair and just all of a sudden she said, 'You're hurrying me', and it really kind of made me feel awful and guilty, and I thought, 'Yes I am.' This strategy often set up an adversarial situation between nurse and patient or family. Once this happened, difficulty arose in the encounter and a great deal of reconciliation was needed to restore harmony; sometimes these attempts failed, resulting in difficult encounters. Hospitals are known for their hierarchies and nurses have been socialized to a model that perpetuates behaviors such as controlling to preserve domination. Roberts[39] described nurses as an oppressed group, and as such they often take on the characteristics of oppressors.

Patients also engaged in controlling behaviors. Once patients felt that their choices were being limited or that they were not being listened to they would begin to make demands. Nurses were aware that controlling strategies may backfire; however, these strategies worked well enough so that nurses continued to employ them when they felt they had no time to initiate alternative strategies to ensure care delivery.

Working together

A second strategy was working together, which, unlike the strategy of controlling, had positive results.

The known effect of team work is ubiquitous.[40–43] Nurses described that when they were working with one group of individuals they just knew that, no matter what, the shift would go well. Everyone would check regularly with one another to make sure that each and every one was coping at the moment. Under these circumstances, staff worked shifts where they felt extreme time constraints; however, they were able to finish the shift with the sense that they had done the best they could. If staff did not work well together and some finished on time and left, but others were there well beyond the end of their shift, the nurses described a general feeling of dissatisfaction and frustration.

Including families

When nurses included families in the care of patients, considerable harmony was achieved and little reconciliation was needed. Nurses reported that this strategy took time up front but saved nursing time in the long run. They kept families up to date on what was going on and they also found that some families wanted to participate in the care of their loved ones once they felt comfortable in the situation. Nurses today learn

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that patients and families or significant others are a unit and they care for them as such. This was not the case for all participant nursing staff, but nursing leadership on this unit was very supportive and inclusive of families.

Nurses who included families and worked as a team to provide the best care possible were actually neutralizing factors that contribute to the construction of difficult encounters. Over the course of the study these nurses changed the terminology they used, from referring to patients as difficult to discussing the encounters that were difficult. This was a defining moment in the research when staff moved away from a language of locating difficulty in the patient to talking about the difficulty they experienced in the encounter.

Geographies of place and bodies

The last strategy employed by nurses to mitigate time compression was the imposition of geographies of place and bodies (persons).

This term was used by Holloway and Hubbard.[44] They described how places have a certain social order and that we have expectations about how places should be and what people should do. A classic example is that inner cities are places of crime and criminals, and that suburbs are places of families and people with family values. In this study nurses described having patients they were ill equipped to deal with and how these patients needed to be cared for elsewhere (e.g. requiring palliative care), yet this same unit successfully delivered palliative care in numerous situations. Patients also had definite expectations about who should be a patient on the unit. They were particularly disturbed and sometimes afraid if they encountered patients with dementia or who were substance abusers. 'I had a room-mate who was drug crazed and who was tied down. People in such a state should not be mixed in with people like me. They should be on a locked ward.'

They believed these patients needed care, but not on the same unit. Nurses need to know that this is happening and that it contributes to the construction of difficulty in the nurse–patient encounter.

Unit reputation

The factors in the context of care that contributed to the construction of difficulty in the nurse–patient encounter and the strategies used by nurses under these circumstances were influenced by factors in the wider context.

The unit where this study was conducted had a reputation for effective leadership, low attrition and thus an experienced staff. Reports of nursing and patient dissatisfaction are commonly linked to the absence of leadership and high staff turnover.[25,26,28,29] Conducting this research on this unit was important because the study findings would not suffer from these features. There was a choice of two family medicine units: the one eventually used, and one that was in transition with a new leader and inexperienced staff. Knowing that nurse and patient dissatisfaction are linked to the absence of leadership and high staff turnover, the decision was made to conduct the study where leadership and low staff attrition were present. It was believed that a clearer understanding of the origins of difficulty in the nurse–patient encounter could be obtained in a setting where high levels of dissatisfaction would not cloud the emergent process. If nurses and patients were experiencing difficulty in their encounters in this setting, then factors other than lack of leadership and staff dissatisfaction could emerge. Staff readily described their unit as one of the best in

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the hospital and that there was no recruitment problem; on the contrary, there was a waiting list of applicants.

The nurse manager on this unit considered families to be integral to patient care. When the nurses spoke about difficulties with families, the manager would arrange to meet with the family to listen to their concerns; she acted as a mediator between staff and families in some situations where staff were unable to find common ground. The mediator role played by the manager no doubt contributed to fewer difficult encounters. Despite this, difficulty did arise and was explained by: not knowing the patient, supplies and equipment challenges, not including families, not working together as a team, and changes in the care space, such as shortened lengths of patient stay and the number of complex conditions suffered by patients. Nurses and patients also spoke regularly about the RN shortage.

Labor market structure change

This factor preoccupied nurses and patients. Nurses spoke constantly about the nurse shortage, that when an RN was sick he or she was commonly replaced with a licensed practical nurse, and that there was a proliferation of assistive care personnel. Nurses feared the loss of RN positions and patients worried about not having a nurse when they needed one. Nurses and patients worry about the here and now, and they also experience anxiety about the future. Nurses worry about the present nurse shortage, knowing they cannot give patients the time they need now and they believe that this will become worse. Patients can see how busy nurses are now and worry about a day when there may be even fewer nurses, and also wonder if there will be time for nurses to get to know them and to give them the care they believe they need. This concern by both nurses and patients regarding time for patient care in future is informed by what both groups currently experience.

Discussion

The findings explain how difficulty was constructed in the nurse–patient encounter and represent a contribution to narrowing the identified gap. These findings can assist nurses who encounter difficulty to take a step back and examine the context of care for factors that may have contributed to them facing this problem. This examination and reflection on contextual factors can lead to identification of what constructs as well as what mediates difficulty, leading to possible solutions.

These study findings support the work of Becker,[24] who maintained that social interaction is a dynamic process that is socially constructed by the individuals involved and by the context, and will vary based on who the actors are and what is at stake. Who is working and families emerged as factors in this study and are central to social interaction. The remainder of the factors were contextual. All of these could vary in a given setting. What is important to understand is the social constructedness of encounters and that knowing this will enable nurses to deconstruct what is happening in an encounter. This can be done with harmonious or difficult encounters, although it is usually at the point of difficulty that action is triggered.

The core category in this study was reconciling temporalities (time). Nurses were constantly trying to find time to do the things they wanted to do for patients, and patients were longing for the nurses to find more time to be with them. All of this

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transpires within an organization that heavily invests in the timing of all activities and the scheduling of staff accordingly. The concept of time permeated every session of participant observation as well as the participant interview data. Health care organizations operate on a linear concept of time.[45–48] This creates the perception that events will happen in an orderly fashion, easily quantifiable. In the daily work of nurses on a unit, several patients may want a particular nurse at the same moment. Adam[45] explained that, before the industrial age, the activity determined the time needed. The industrial age made time a commodity and focused on minimizing the time needed for all activities. This philosophy may work reasonably well in the production of inanimate objects. The application of this same philosophy of time to the care of people needs to be examined for appropriateness of fit.

Nurses need to be aware of the tensions that can arise when organizational philosophies do not match situations. Nurses who do not complete their work within a shift are often seen as disorganized when perhaps the system that is measuring the work needs redefinition. As nurses described how time-bound their work can be, they spoke about families and how much time families required and how patients were not necessarily difficult, but that families were.

The inseparability of patient and family is well known.[49] The nurses in this study felt torn between patients and families. This can mean two things: nurses were ill-equipped in knowing how to include families in the care of patients, or nursing workloads were not structured to accommodate time for families. Amelioration of these two factors can impede the construction of difficulty in nurse–patient encounters. One intriguing strategy used by nurses was the employment of geographies of place and of person.

Clinical implications

This study was considered to be relevant for three reasons: nurse and patient satisfaction, nurse stress, and nursing knowledge. Study findings make an important contribution to nursing knowledge. Nursing faculty members need to know about these findings to assist students to recognize how difficulties are constructed, enabling them to break the cycle. Nurses' awareness of the factors that contribute to the construction of difficulty can prepare them to recognize what is happening and also to prevent or ameliorate difficulties. Nurse managers and administrators are ideally situated to work towards improving factors in the context of care that contribute to the construction of difficulty. This knowledge can be disseminated and taken up by nurses and can contribute to improved nurse and patient satisfaction and reduced stress for nurses.

Suggestions for further research

These findings emerged from a grounded theory study conducted with nursing staff and former patients on a family medicine nursing unit known for effective leadership and low attrition. It would be instructive to conduct this same study on a similar unit under less ideal conditions and on other nursing units to uncover what similarities and variabilities may exist between contexts. The most exciting finding of this study was an

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explanation of how difficulty was constructed in a nurse–patient encounter, and, in providing this explanation, the possibility for relocating difficulty from the person to the encounter was created.

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