Caring and uncaring encounters in nursing in an emergency department

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Background. Caring is a core characteristic of nursing. Nurses’ caring behaviour has been explored in several studies. When caring for trauma patients, the most important caring behaviour must be the procedures associated with lifesaving. However, it is important not to forget the patient’s psychological needs.

Aim. The aim of this study was to highlight encounters between injured patients and nurses in the trauma team and to explore whether the theory of caring and uncaring encounters in nursing and health care is applicable in emergency care.

Data collection and analysis. Data were collected by videotaping caring episodes between slightly injured patients and nurses in the trauma team. Five episodes involving 10 nurses were studied. The analysis was carried out in four steps. First the videotapes were studied several times and then transcribed into narratives, which were reduced into courses of events. These were subsequently classified according to aspects of caring and uncaring.

Results. The nurses’ verbal and non-verbal communication was poor, and they adopted a wait-and-see policy. A new uncaring aspect, instrumental behaviour, emerged from this poor communication. One of the caring aspects, being dedicated and having courage to be appropriately involved, could not be identified. Most encounters included several aspects of caring and uncaring, but the uncaring aspects predominated. The dominance of uncaring aspects indicates a lack of affective caring behaviour.

Conclusion. The result showed that the theory is partly applicable in emergency care. A new aspect, instrumental behaviour emerged. The nurses’ behaviour in the five episodes was labelled as uncaring. Authentic nurse–patient encounters are essential in nursing.

Relevance to clinical practice. The importance of meeting patients’ psychological needs and nurses’ affective caring behaviour should be emphasized in trauma care, trauma courses and nursing education. It is necessary to measure the caring behaviour of trauma nurses.

Key words: accident and emergency department, caring behaviours, nursing care, nursing theory
Introduction

Most major hospitals in Sweden organize their emergency care in trauma teams that include physicians and trained nurses. Many nurses and physicians in these teams have been given special training in trauma care: the Trauma Nurse Core Course (TNCC) for nurses, and the Advanced Trauma Life Support (ATLS) for physicians. The purpose of the ATLS (1995) is to orient physicians in the initial assessment and management of the trauma patient; the TNCC (1995) is designed to enhance nurses’ ability to assess patients’ responses to the trauma event. The TNCC offers core-level knowledge of trauma and psychomotor skills with the nursing process as a framework. The ATLS emphasizes the first hour of initial assessment and primary management. Both courses consist of trauma lectures and skills training to develop lifesaving skills. The ATLS has pre- and post-course tests, whereas the TNCC concludes with a test. The team is therefore well prepared to take care of patients involved in accidents and with physical injuries. Lifesaving procedures in such situations are, of course, the priority, but it is important not to forget to meet the patients’ psychological needs as well. The nurses in the trauma team meet patients for a short time and in situations where the patient may be terrified after an accident. Meeting the patients’ psychological needs in such situations is an important part of good nursing.

It is known from the medical literature that unmet psychological needs may cause post-traumatic distress syndrome (PTDS) (Van der Kolk, 1996). Research into the psychological effects on slightly injured patients is limited in contrast with the research conducted on seriously injured patients. According to Bergsten et al. (2001) two-thirds of a group of patients involved in accidents were still influenced by residual pain after seven months with symptoms consisting of physical and psychological pain. The data in this study were collected on two separate occasions, 4–6 weeks and seven months after the accident, using interviews and nine validated questionnaires.

Caring encounters in nursing

McCance et al. (1997, 1999) view caring as a central but difficult concept in nursing, and there is no consensus concerning the content of the concept. Morse et al. (1990) identified five epistemological perspectives in nursing: caring as a human state, caring as a moral imperative, caring as an affect, caring as an interpersonal relationship and caring as a nursing intervention. Several nursing theorists stress the interpersonal relationship as fundamental in nursing. In contrast, Travelbee (1971) considered nursing as a process with five phases: the original encounter, emerging, identities, empathy, sympathy and rapport, where rapport is the genuine encounter. Whereas Travelbee (1971) depicts the encounter as a process, Halldorsdottir (1991) depicted five basic modes of being with another. Halldorsdottir (1990) also pointed out the essential structure of caring and uncaring encounters. Later, Halldorsdottir and Hamrin (1997) and Halldorsdottir and Karlsson (1996) identified the concept of professional caring, which they viewed as something that empowers the patient, and contributes to well-being and health. Lack of professional caring results in reduced well-being and health. Paterson and Zderad (1988) emphasized the nurse–patient relationship, viewing nursing as a lived dialogue aimed at nurturing well-being and embracing authenticity rather than a benevolent technical component in nursing. Dialogue is more than sending and receiving messages verbally and non-verbally. It may be understood as seeing the other person as a unique individual. Therefore, an authentic encounter is more than intellectual awareness. If they wish to create an authentic encounter, nurses have to use all their senses.

Several studies have been carried out on the importance of nurses’ caring behaviours. Walsh and Dolan (1999), exploring emergency nurses’ perception of caring, showed that nurses in accident and emergency (A & E) departments scored psychosocial and holistic dimensions in caring lower than general nurses did. Other studies showed differences between nurse and patient perception of good caring (Huggins et al., 1993; Hegedus, 1999; Baldursdottir & Jonsdottir, 2002).

The theory of caring and uncaring encounters in nursing


As we wished to highlight the trauma team nurses’ caring behaviour, the aim of the study was to explore whether the aspects of caring in Halldorsdottir’s theory of, caring and uncaring encounters in nursing and health care are applicable to emergency care (Halldorsdottir, 1990, 1991, 1996; Halldorsdottir & Karlsson, 1996; Halldorsdottir & Hamrin, 1997). The theory consists of two major metaphors: the bridge and the wall (Fig. 1).
The bridge is the metaphor for communication and connectedness with a comfortable distance of respect and compassion, whereas the wall symbolizes negative or non-existing communication, detachment and lack of a caring connection. The theory has been developed from six studies that include the perspectives of patients and nurses.

The competence and caring approach of nurses establish the essential structure of professional caring, which consists of three essential elements: competence, caring and connection. Competence involves empowering, connecting and educating people, making clinical judgements and being able to do tasks and take action on behalf of people.

Caring means being open to and perceptive of others, being genuinely concerned about patients, being morally responsible being truly present for patients and being dedicated and having the courage to be appropriately involved as a professional nurse.

The connection aspects of professional caring involve five phases. To initiate professional connection requires both the patient and nurse to reach out and respond. Mutual acknowledgement of personhood occurs when masks of anonymity are removed. A bridge is built when patients realize the connection and feel free to ask for help. Professional intimacy occurs when patients begin to trust the nurse. As a result of the connection and professional intimacy, nurses work with patients as equals towards their common goal. This last aspect is called negotiation of care.

The essential structure of an encounter perceived as uncaring consists of three basic components: incompetence and indifference, lack of trust, and mutual avoidance and disconnection between the nurse and the patient. Patients perceived nurses as inconsiderate, insensitive, disrespectful and disinterested. Nurses build walls of different sizes and shapes, which symbolize negative or no communication, detachment and lack of a caring connection. Nurses’ indifference can be seen in following stages: first disinterest, where the nurse is inattentive to the patient’s requirements; then insensitivity, which refer to nurses’ indifference to the patient as a person. Coldness is perceived when the patient experiences the nurse almost as an automaton, or a machine. Finally, inhumanity, the most severe form of uncaring, is characterized by several inhumane attitudes.

Method

The research question directed us to design a study that explored caring and uncaring encounters in the A & E department. Observations were conducted by videotaping five caring episodes. The analysis was conducted as a content analysis.

Setting

The trauma team included physicians, nurses and assistant nurses, each with their own specific tasks in the encounter with the patients. The make-up of the trauma team differed on who was on duty. The focus of the study was nurses’ actions and behaviour when they took care of injured patients involved in accidents.

Episode 1: Anne, about 35, came to the A & E by ambulance after a car accident. As this episode involved two nurses, two
encounters were studied. Initially, the nurses were quite anonymous and communicated in a formal manner, sometimes inattentively. When the medical examination was over, they started joking with Anne, who did not mind.

**Episode 2:** Bernhard came to the A & E with his spouse. He had fallen outdoors, injured his face and was bleeding considerably. This episode involved one nurse, who emanated calmness. The nurse took time to listen to the patient and a number of problems arose from the patient’s situation. Blood pressure was measured and the wound was cleaned.

**Episode 3:** This episode involved two nurses, thus there were two encounters. After a car accident, Cecilia, about 20, came to the A & E by ambulance. She had injured her back and had reduced sensibility and mobility in her left arm. She was lying in bed watching the staff closely. Only her feet moved. The encounter took no more than 20 minutes. For 7 minutes she had no verbal or eye contact with anyone in the trauma team. The two nurses were occupied doing tasks such as checking infusion, documentation, taking care of her clothes and talking to other members of the team.

**Episode 4:** Donna reached the A & E after a fall. Her state of consciousness varied during the encounter. A number of procedures were carried out, including collecting blood samples, connecting infusions and catheeterizing. The first procedure occurred when a nurse cut off Donna’s clothes without saying anything to her. As three nurses were involved, three encounters were studied. Many people were moving around the emergency room, and the impression given was rather chaotic. The staff sometimes talked about Donna rather than to Donna.

**Episode 5:** Three nurses and three physicians were involved in this care episode. Erwin came from another hospital within the region where his physical condition had first been examined. Two nurses from A & E were busy with infusions, taking blood samples and documenting what they had done. The nurses informed Erwin about their work. Calmness in performing tasks characterized this encounter.

**Data collection and data analysis**
The data were collected by videotaping the caring episodes. A video camera was installed in the emergency room because the trauma team wanted to study their teamwork. The staff started the camera, and the patients were asked afterwards if the videotape could be used in a scientific study of the nurses’ caring behaviour. Five patients agreed, none refused. We analysed five caring episodes with 10 nurses involved. Accordingly 10 encounters were studied. In two of the episodes, nurses from other departments were involved, but their encounters are not included in this study.

The steps in the process of data analysis can be described in the following way. First, we tried to gain an overview of the videotapes to get an holistic perspective. Then, we repeatedly watched the recordings to catch the nurses’ verbal and non-verbal language and their behaviour towards patients and staff. Courses of events were transcribed verbatim by one of the authors (EW), after which the text was read several times to obtain an overview of the stories. The next step was to identify and mark units with specific meaning and classify the quality of the events in terms of caring and uncaring. The specific utterances were classified individually and subsequently compared. The authors then referred back to videotapes for the final comparison. In order to ensure trustworthiness, the two authors worked together in this step.

**Ethical considerations**
Ethical considerations are very important when collecting research data by videotaping (Latvala et al., 2000). Questions concerning integrity, self-determination and informed consent have to be taken into consideration. The ethics committee at the hospital had given permission to videotape the episodes. The patients were asked whether the authors were permitted to use the videotapes in research. It was not possible to ask the patients in advance because of the acute circumstances. As all patients were adults and four of them were fully conscious, there was no need to ask their relatives for permission. The patient in episode 4, whose state of consciousness fluctuated, was approached when she was fully conscious. The names used in the episodes are fictional.

**Findings**
Nurses acting in the present episodes showed aspects of caring and uncaring. Aspects of uncaring were more common than aspects of caring. In all, 61 aspects of uncaring and 36 aspects of caring could be identified. One encounter did not display any uncaring aspects at all. Being dedicated and having the courage to be appropriately involved was an aspect we could not find in any of the episodes. All aspects of uncaring could be identified. A new uncaring aspect appeared which we called ‘instrumental behaviour.’ This aspect was predominant and appeared in every episode, in total up to 31 accounts.

**Aspects of caring in emergency nursing**

**Being open to and perceptive of others**
Patients in A & E are often affected by the acute event as they have abruptly lost control of their own situation and are in a position of dependence. A caring nurse has to be sensitive to such patients and capable of interpreting or predicting their
needs. The caring nurse needs an open attitude and should communicate openly with the patient. The aspect appeared in three of the episodes and can be partly illustrated in the following way:

A patient frequently asked whether he should have general anaesthesia. The nurse perceived this concern about general anaesthesia, and while the wounds were being cleaned up, she explained the coming procedure concerning anaesthesia and sutures in a calm manner.

Being genuinely concerned for the patient
Nurses with this caring quality displayed genuine feelings of goodwill towards patients and an holistic view of caring. Halldorsdottir (1996) described this aspect as a feeling of compassion from the patient’s point of view. These feelings motivated nurses to provide care for the patient. This aspect appeared in only two of the episodes. Genuine concern was illustrated when the nurses wondered whether relatives had been informed about the accident, and in the following situation:

After 10 minutes the patient suddenly started talking about his retarded daughter. He was worried about the future, and the nurse stopped cleaning his wounds and listened. The nurse affirmed the patient by asking more about his daughter.

Being morally responsible
This aspect is purported to be another essential aspect of the theory and in real situations at the A & E. From the patients’ perspective, visits to the A & E are not planned. They come directly from what they were just doing. They are not prepared for visiting a hospital. Suddenly, they become dependent on others to fulfil their needs. Nurses have to act to maintain and strengthen the patients’ dignity in this serious situation. This aspect appeared in only two episodes. It could be interpreted in situations when the patients were completely naked and the nurses wanted to cover the patient with blankets. Another example was a situation where the patient came directly from gardening:

‘I was digging and… I’m so dirty.’ He raised his head and looked at his clothes. The nurse leaned forward and said: ‘You are allowed to be dirty since you have been gardening.’ Bernhard laughed and glanced at the ceiling and said: ‘Yes, but not in the hospital.’

Being truly present
Being truly present means that nurses have to be attentive to the present moment, and be present in dialogue, in listening and responding. They should be present in the situation, physically and emotionally. In order to be truly present in the dialogue, nurses require good communication skills. This was evident in three of the episodes and especially so in the following account:

The nurse took a chair and sat at the same level as the patient so that they had eye contact. The patient told the nurse that he had forgotten his hearing aid. The nurse answered: ‘Okay, you use two hearing aids?’; and simultaneously pointed at both of her ears.

In another episode a nurse carried out a painful procedure on a patient who was not fully conscious. The nurse was looking at her hands at the same time as she paid considerable attention to the patient’s behaviour.

Aspects of uncaring in emergency nursing

Instrumental behaviour in emergency nursing
Instrumental behaviour is a new aspect, which shows a lack of emotional involvement but not insensitivity. This aspect was identified in 31 accounts and appeared in four of five episodes. It can be illustrated in the following accounts:

The nurse was standing beside the examination table and her attention was on the course of events. Her eyes were wandering from the patient to the monitoring equipment and to the physicians.

Instrumental behaviour was also present in situations where the nurses formally informed patients about practical work such as applying intravenous lines or taking blood samples. This occurred in four of the episodes.

Another typical example of a high degree of concentration on the ongoing procedures surrounding the patient was the following:

Two physicians were examining sensibility and mobility while the others in the team stood around the patient at the bunk. One of the physicians said: ‘Reflex hammer.’ A nurse and two assistant nurses immediately reached for the reflex hammer. The second nurse in the team merely looked in the direction of the hammer.

The caring aspects in the theory of caring and uncaring encounters in nursing and health care can be placed along a continuum with the uncaring aspect, inhumanity, at one end and the unidentified aspects, being dedicated and having the
courage to be involved, at the other. The new aspect, instrumental behaviour, can be placed between disinterest and being open to and perceptive of others. It is considered an uncaring aspect. (Fig. 2).

Disinterest
This aspect refers to inattentiveness to the patient and the patient’s specific needs. The nurses lack a positive approach but are not really destructive. The aspect appeared in four of the five situations as lack of verbal communication. The disinterested nurse paid more attention to physicians and colleagues than to the patient. This could be illustrated in the following account:

A nurse was undressing a patient while talking to another nurse. The physician was simultaneously assessing the patient’s status. None of them spoke to the patient, who was completely conscious. When the patient was undressed, the nurse applied the probe to the pulsoximeter without saying a word to the patient.

Insensitivity
When a nurse acts indifferently, it is destructive for the patient. This aspect appeared in two of the situations and can be illustrated in the following account:

One nurse was busy with technical duties and did not demonstrate any communication skills, neither verbal nor eye contact. The patient said: ‘I want to urinate.’ Neither a verbal nor non-verbal answer could be identified. After a while a nurse appeared with a urinal, which she gave to the patient without saying a word.

Coldness
Coldness is identified when the nurse acts mechanically and the patient perceives the nurse as cold and unkind. The encounters lack kindness and are business-like. If there is verbal communication, the intonation lacks kindness. This aspect could be identified in three of the five episodes and was illustrated as follows:

One nurse, who was responsible for the patient, suddenly appeared close to the patient, looked at her and said: ‘When were you born?’ Then her eyes fell on the identification strip and she said: ‘I’ll put a strip on your arm.’ She put the strip on the patient’s arm and then placed herself at the end of the examination table. This was the first verbal contact she had had with this patient.

In the same episode the patient is lying on the examination table, the nurses are discussing drug prescriptions, and the physicians are discussing alternative X-rays. The patient’s eyes wandered from one...
to the other. None of the staff cared about the patient. Suddenly, one nurse came into the field of vision and told the patient: ‘You are leaving for an X-ray.’ No information was given about the X-ray.

Inhumanity
According to Halldorsdottir and Hamrin (1997), this aspect is the most severe form of uncaring. Inhumanity is characterized by various forms of inhumane attitudes such as being totally ignored as a person, which is very negative for the patient, who suffers and easily feels victimized. Inhumanity appeared in two of the episodes and could be illustrated in the following way:

In the presence of other people and with doors to the corridor open, a nurse catheterized a patient’s urine bladder. After the catheterising, the nurse wiped the patient’s genitals while speaking with the anaesthesiologist at the same time.

Discussion
The findings in our study indicate that the aspects of caring in Halldorsdottir’s theory (Halldorsdottir, 1990, 1991, 1996; Halldorsdottir & Karlsdottir, 1996; Halldorsdottir & Hamrin, 1997) are applicable to emergency care, but the aspects did not cover the theory completely. A new aspect, instrumental behaviour, emerged, which is representative of the care in the situations reported at an A & E, where the aspect appeared in four of five episodes. Furthermore, it was the most frequent aspect. Previous studies concerning instrumental behaviour have not been found.

Professional caring (Halldorsdottir & Karlsdottir, 1996; Halldorsdottir & Hamrin, 1997) consists of five elements of competence. In the present study, ‘doing tasks and taking action on behalf of people’ was predominant. In this aspect of competence, the nurses’ verbal and non-verbal communication was poor. They adopted a wait-and-see attitude characterized by the fact that no attention was paid to the patient. The nurses merely stood and waited for the physicians’ prescriptions. Their relationship with the patient was initiated through the physicians’ prescriptions. The nurses’ behaviour does not correspond to any of the theories that stress a relationship as a prerequisite for good nursing (Paterson and Zderad, 1988; Travelbee, 1971; Watson, 1988; Halldorsdottir, 1990, 1991; Halldorsdottir & Karlsdottir, 1996; Halldorsdottir & Hamrin, 1997).

The instrumental behaviour aspect emerged from this wait-and-see attitude and is a variant in the spectrum of uncaring aspects. A pattern of poor communication among nurses at an emergency department has also been observed in the study by Moore and Schwartz (1993). In their study nurses reported that they were communicating verbally and non-verbally with the trauma victim, but the researcher observed that the nurses delivered less psychosocial support than they reported.

Four other aspects of caring were identified. Being genuinely concerned for the patient and being truly present appeared in three episodes but less often than instrumental behaviour. Most notably, the two aspects appeared in one episode. The nurses in the present study showed physically based caring behaviours more often than affective caring behaviours. Other studies (Greenhalgh et al., 1998; Huggins et al., 1993; Hegedus, 1999; Baldursdottir & Jonsdottir, 2002) show that patients understand important caring behaviour as clinical competence, in a sense of doing tasks. These studies describe differences between nurses’ and patients’ perception of important caring behaviours.

However, the aspects of uncaring were completely identified. In this respect, the theory is applicable. Several aspects of caring and uncaring could be identified in each episode.

The dominance of the uncaring aspects indicates that the importance of meeting the patients’ psychological needs is neglected. The study by Bergsten et al. (2001) indicates the importance of meeting the patients’ psychological needs. It should be an urgent issue for the trauma nurse to be truly present for the patient to be able to create an authentic encounter. Such behaviour could reduce the risk of developing PTDS. To create an authentic encounter the nurses have to use all their senses (Paterson & Zderad, 1988). In trauma care, this means that nurses have to change between medical perspectives and a humanistic one.

Methodological aspects of the study
Data collection by videotaping has many advantages. It is a method of non-participant observation and makes it possible to observe behaviours as well as verbal and non-verbal communication (Latvala et al., 2000). The camera used in this study was permanently installed, and it was not possible to change view or zoom into patients and nurses. In spite of this, the videotapes provided considerable information. A problem pertaining to validity is the change in behaviour in a setting where a camera is present. In our study the nurses in the trauma team started the camera themselves. This was intended to be a guarantee for proper behaviour by the nurses. If the videotaping had influenced their behaviour, they would probably have made an effort to pay more attention to the patients. The nurses may have considered that good trauma care consists merely of technical caring.

Videotaping made it possible to study all the nurses in the trauma team and gave the opportunity frequently to study the
course of events. In terms of credibility, videotaping is a valuable method of data collection as it offers opportunities to look at the course of events several times throughout the analysis.

We did the content analysis individually and then compared the results. We did not calculate agreements in percentage, which could have strengthened reliability.

As this is a qualitative study, the findings cannot be generalized to all caring situations in an A & E. One qualitative study alone will not provide the whole picture of nurses’ caring behaviour when caring for trauma patients.

Conclusion

The caring aspects of the theory of Halldorsdottir (Halldorsdottir, 1990, 1991, 1996; Halldorsdottir & Karlsdottir, 1996; Halldorsdottir & Hamrin, 1997) are applicable in emergency care. One aspect could not be identified, and a new aspect emerged. The new aspect, instrumental behaviour, seemed to be predominant in this specialized care. The nurses’ behaviour in these five episodes must be labelled as uncaring. We also stress that authentic nurse–patient encounters must be a fundamental element of good nursing.

Implications

• The importance of meeting the patients’ psychological needs and nurses’ affective caring behaviour should be emphasized in trauma care, trauma courses and in nursing education.
• Further studies are required to explore the other elements of the theory, aspects of competence and stages of connection.
• It is also necessary to measure the caring behaviour of trauma nurses with this study as a base.

Contributions

Study design: EW, KW; data analysis: EW, KW; manuscript preparation: EW, KW; literature review: EW.

References


