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Being a professional friend: hospital nurses' strategies in promoting healthy lifestyles

INTRODUCTION

This paper discusses a part of a study that provided a medium for the participants' 'story' about their health promotion work with patients. The researcher had discovered a paucity of literature concerning the health promotion activities of hospital nurses and what information there was suggested there were problems with this role. It was claimed that hospital nurses engaged in victim blaming (Delaney, 1994), they are identified as not recognising opportunities for health promotion or health education (Jones 1993, McBride 1994, Ask et al, 2000), of not having developed skills in, or understanding about health education (Honan et al 1988, Gott and O'Brien 1990, Macleod Clark et al 1992, McBride 1994, Twinn and Lee 1997, Robertson and Hill, 1999), of not being able to differentiate between health promotion and health education (Delaney 1994, Davis 1995) or lacking confidence in their ability to differentiate between them (Davis, 1995) and of not presenting as 'healthy' role models and avoiding health topics because of this (Goldstein et al 1987, Matarazzo and Leckliter 1988, Haughey et al 1992). Furthermore, Robertson and Hill (1999) have concluded that hospital environments themselves are unhealthy, and this coupled with poor management and lack of collaboration, all form impediments to hospital nurses fulfilling a health promotion role. The central concern of this study was the untold story of health promotion as perceived from the perspective of hospital nurses. The nurses' views on health promotion indicated that they considered a central component of their health promotion work to be the relationship they form with the patient. The nurses did not consider that theoretical recipes of 'how to do health promotion' were what their nursing practice relied on. Rather they drew on close, individualised encounters informed by 'knowing their patient' (Radwin, 1996) to tailor their health-promoting care-giving to the patient's needs though Forming a Relationship. This relationship carried particular characteristics, labelled by the researcher as the concepts of: being human, sharing, and being a professional friend.

METHOD

This study employed principles for the generation of grounded theory (Glaser and Strauss 1967, Strauss 1987, Glaser 1992, Strauss and Corbin 1998). The grounded theory method was first described by Glaser and Strauss in their seminal text The Discovery of Grounded Theory (1967) and was claimed to be a solution to the problems of handling qualitative data. The purpose of grounded theory research is to generate inductively based theoretical explanations of social and psychological processes (Baker et al, 1992). It has an emphasis on theory development and was devised as a method for the development of theory that is grounded in data that have been systematically gathered and analysed (Strauss and Corbin, 1998).

THE RESEARCH DESIGN

The design of the study involved fifty loosely structured in-depth interviews with qualified nurses practising in hospital settings. The researcher conducted, transcribed and analysed the interviews personally. The methodological features of this design are discussed below.

THE RESEARCH SAMPLE

An eventual sample of fifty volunteers was recruited from various hospital sites in Scotland. All participants, therefore, were practising registered nurses, four of whom were men. The nurses who participated reflected a wide variation in terms of age, home responsibilities, length and range of experience and types of initial preparation and academic qualification. They practised in a spectrum of National Health Service and private sector hospital settings from acute adult care to acute rehabilitation care for older people and in community hospitals. The initial sample consisted of thirty-nine nurses based in acute wards, including elderly assessment units in large city hospitals. Further sample sites were identified during the conduct of the study through theoretical sampling. This resulted in the participation of a further six nurses working in rural community hospitals and another five nurses practising in an acute hospital in the private sector.

ANALYSIS

The analysis of the data was undertaken hand-in-hand with their generation, the focus of each subsequent interview being determined by the analyses conducted on data gathered as the study progressed. This feature of grounded theory analysis depended on ‘constant comparative analysis’ (Glaser and Strauss, 1967), a process of comparing incident to incident as they appear in the data. In order to do this, each interview was transcribed as quickly as possible following the encounter and the researcher analysed the data through the strategies of coding, sorting, memo writing and diagramming (Strauss and Corbin, 1998). These strategies enabled the emergence of categories and their elements in order to generate a conceptual framework. This paper discusses one category of this framework.

FORMING A RELATIONSHP: one category of the conceptual framework

The forming of a close, sharing relationship that involved the nurses’ self disclosure and allowed the patient to see the nurse as ‘human’, was perceived as an essential component to

the nurses' perceptions of their health promoting practice. The relationship that the nurses formed carried the qualities of a naturally developing friendship. In order for health promotion activities to be successful, however, the relationship was mediated through professional exchanges. This mediation resulted in the friendship being of a particular tenor: the nurse became the patient's professional friend. The relationships that the nurses described portray a sense of intimacy and closeness and developed as a natural consequence of the contact between nurse and patient, rather than any deliberate use of strategy.

The relationship that the nurse has with a patient is understood to be central to the provision of high quality nursing care (Savage, 1995) and to nurses' health promotion role (Davis 1995, Caraher 1994), putting nurses in an excellent position to promote health (Maben and Macleod Clark 1995, Delaney 1994, Lindsey and Hartrick 1996, Brenchley and Robinson, 2001). Savage points out, however, that the physical intimacy that characterises the work of nurses with the physically ill has, until recently, resulted in nurses being encouraged to maintain emotional distance from their patients. The potential of nurse-patient interaction to promote improvements in care underpins contemporary rejection of this emotional distancing, and characterises the 'new nursing' initiatives (Savage, 1995). In the present study these influences could be seen in the nurses' accounts when they reflected on how they carried out a health promotion role.

A quote from Mhairi* (* all names are fictitious) offers an example of how the nurses believed their relationships with patients were important to their health promotion activities.

Mhairi: I mean a lot of the things that we do in nursing is curing illness and we could be preventing so many things by health promoting and the thing is we're privileged, as nurses we are privileged to have our relationships with patients, we have relationships with patients that doctors, physiotherapists and all this don't have. We are with our patients for a good few hours in the day and you get quite close to them, like if you are a primary nurse or whatever then you'll manage to develop that relationship and they'll often really listen to what you've got to say, they'll ask your advice.

The nurse-patient relationship appeared central to the nurses' perceptions of how they managed their health promoting roles and was introduced time and time again in the accounts. Analysis of the data resulted in the generation of the category Forming a Relationship that carried the subcategories of: being human, sharing and being a professional friend.

BEING HUMAN

Being human was perceived as a positive attribute in both the development of a helpful relationship and also in the nurses' ability to give health promotion messages to patients. The concept of being human was suggested in the first interview of the study with Carol who gave the first allusion to the helpfulness of using personal experience, the suggestion of allowing the patient to see the nurse as being human.

Carol:I think the thing I've learned is basically that as a nurse that I'm not …., I don't have to present this image of being the perfect person, that's just not true you know, we're human too.

Megan was clear about what was important for her patients with respect to health promotion.

Megan: They want you to be human, they want you to understand the hurt, their pain and they want you to understand what you're asking them to do, and me as a person perfectly honest with them, and me being a human being, not this paragon.

The above quotes were typical of how the nurses expressed themselves. The nurses saw the power of being a person, rather than some unrealistic paragon as a positive thing, but by its nature nothing unusual. Taylor (1994) has described similar issues and observes that ordinariness is not inconsequential to everyday life and elevates accepted definitions of the term 'ordinary' to refer to the essential nature of being human. Neil's quote below seems to capture how the nurses viewed being human for their patients. He introduced an idea of 'ordinariness' as being human, emphasising a view that nurses are ordinary people, contrary to popular rhetoric.

Neil: When we're looking for a pay rise or something like that, we're all angels but in actual fact we're not, we're just ordinary people doing a job. They have an idea that we're nice people, well I think we are really but we're not angels we're just ordinary people doing a job that we basically enjoy.

These data of indicate that the nurses perceived their being human - that is, being in touch and empathizing with the patients' emotional experiences - as a positive intervention for their patients. The patients' perceptions of the nurses' being human interventions as 'angelic' were dismissed. These interventions were, according to the nurses, not superhuman or characteristically nurse-like but ordinarily or commonly human, but because of that, powerful in helping the patient. The nurses' ideas resonate strongly with the concept of 'presencing', derived from Heideggerian theory and described by Benner and Wrubel when applied to nursing practice as 'to be with a patient in a way that acknowledges your shared humanity' (Benner and Wrubel, 1989 p. 13). This definition, with its emphasis on mutual acknowledgement of being, and, it can be argued, carrying connotations of equality and solidarity between patient and nurse, serves to introduce a related concept, sharing.

SHARING

A condition of being human, that is, appearing as a normal person to the patient, appeared to rely on allowing the patient to see certain parts of the nurses' 'real life'. This was to do with the nurse acknowledging common experience with the patient and being willing to disclose that experience. The following quotes show how this might appear to the nurses.

Ann: Yes, I would (disclose), I do that all the time because I don't think you can have a relationship with somebody if you are not going to be honest with them, to say that you appreciate how difficult it is, but I think you've got to share your experiences because I think I've learnt about them (the patients) and I don't see why they shouldn't know about me.

Ann's quote offers a good demonstration of the essence of sharing. Ann considered that nurses being in a position of knowing about a patient, an essential component of nursing work, must be reciprocated, the patient should be allowed to know about the nurse. Natalie too considered that the patient knowing that the nurse shares an aspect of their problem is helpful.

Natalie: I remember, it's slightly different, but thinking back to my days in the matty (maternity services) there were a number there who didn't have any family (family meaning children in this context) and the number of patients who came in labour and said 'do you have any family nurse?', and you would say 'no' and their faces fell as much as 'what help are you going to be to me you don't know what I'm going through' but once you've had family (experienced childbirth) they feel they can trust you because you really do know what it's all about.

The element of sharing, where the nurse shares aspects of his or her own experience with the patient, has congruence with the element being human, in that sharing seems to be important in encouraging the patient to experience the nurse as being human. Self disclosure is well recognised as a helpful strategy in counselling texts, where there is recognition of the relationship being therapeutic in itself (Egan, 1998). Jourard (1971) thirty years ago called for nurses to be self-disclosing, but like the nurses in this study, he considered it essential for this disclosure to be authentic and honest allowing the patient to see the 'real' person. Without this, he claimed, the patient could not be disclosing to the nurse.

The literature supports disclosure and being seen as a real person, as helpful in establishing relationships viewed as empathic and therapeutic. Work by Grafanaki and McLeod (1995 p. 321), for example, identifies features that are helpful to therapeutic relationships. These being 'the client could relate to counsellor as a person', 'same wavelength/shared experience', 'everything was happening naturally', and 'common ideas with the counsellor'. The elements being human and sharing echo these features in that the interpersonal encounters described carried qualities of natural human exchange and sharing of mutual experience.

Teaching of communication or interpersonal skills has received more attention in nursing curricula in recent years and it is important to note that a few of the nurses participating in the study had undertaken basic counselling skills training in their pre- or post-registration education. Most, however, had not had any specialist or focused preparation, supporting the researcher's perception that the views the nurses held about sharing with the patient arose from reflecting on their nursing practice, rather than any conscious application of counselling theory. Sharing and being human arose as spontaneous factors, as matter-of-fact and common-sensical features in the descriptions of the nurses' contact with patients.

Ann's observations that the patient should know the nurse in the same way as the nurse knows the patient, was typical of the nurses' descriptions of closeness with their patients. Such closeness or 'connection' characterises caring in nursing practice (Benner and Wrubel, 1989 p. 4). Kitson (1993) cites Benner as being instrumental in linking caring to ethical positioning. Caring as an ethical position, according to Kitson, indicates that therapeutic skills are applied reflexively as the nurse responds to the patient according the contextual judgement he or she makes.

Ethical caring practices are argued by Benner as being best focused on health promotion rather than illness (see Benner 1984, Benner and Wrubel 1989). This has relevance to the present study with these practices being seen as 'grounded in the shared experiences of the nurse and the patient' (Kitson, 1993 p. 41). Sharing was seen by the nurses as helpful in the development of a trusting relationship. The patient was able, through the self-disclosure of the nurse to see him or her as human and, the nurses argued, better able to respond to the nurses' health promoting endeavours.

BEING A PROFESSIONAL FRIEND

Described in the elements above are aspects of a relationship that involve close, personal encounters where exchange of personal details and close co-operation between the patient and nurse could take place. The nurses perceived these conditions as therapeutic for the patient and helpful to the nurse in health promotion interventions. These qualities, however, also have to be considered in the context of what the nurses said the relationship was not like. Views were expressed that indicated both patient and nurse might have to be protected from the relationship. The concept being a professional friend seems to offer a clue to how the nurses manage this situation. In the midst of their discussions about their relationships,

in which they seemed to offer what could be described as elements of friendship, a protective reserve was evident.

INT.: So is it something to do with being close to the person, or there's not these professional barriers if you like?

Neil: umm (thinks) Well I think you've got to be, I don't know about close, but Certainly try not to have barriers between you, I don't know if that makes sense or it's difficult to try and define to be both friend and also a nurse, you both know that you can only go so far with each other, I think that's it.

James' comments infer that some identification with the patient and relatives is powerful, but it must remain professional: he cannot be 'one of the boys'.

James: I'm sort of aware of how I would come across, especially dealing with relatives you don't want to be sort of, I'm referring to younger people, I can talk to sort of grandsons of grannies or whatever and talk away to them about their grandma's health or whatever, but at the same time you've got a professional element where you don't want to say I'm one of the boys just the same as you. You're sort of talking to them as if 'this is what we should be doing and your grandma's ill because she smoked 20 a day for 40 years' or whatever.

Judy discussed the importance of having warm and even loving relationships with patients, but she too indicated that there had to be a professional boundary.

Judy: I think sometimes older nurses can be very starchy and even call dying patients Mrs Smith and I think 'Oh no, she's not going to die Mrs Smith is she', it's awful cold. But I think you have to draw the line between the patient and the nurse and this is where the confidence in the nurse comes in.

INT.: Is it that you can be friendly but not really their actual friend?

Judy: You can be their confidante but not over familiar.

Yolande's quote illustrates another aspect of protective fronts.

Yolande: I'm not in favour of that, I'm not in favour of sharing because it's all too easy to latch onto you.

The above quotes seem to illustrate how things could go wrong if the relationship, which carried features of a friendship, but moved into something more like a 'reciprocal' friendship (Reissman, 1979). A reciprocal friendship according to Reissman is one that is characterised by mutual loyalty and commitment where each party regards the other as equals. This, the nurses felt, should not be allowed to happen. The patient should not be burdened with the nurse's problems as a 'real' friend might. Yolande's quote also suggests a burden to the nurse: the nurse cannot be expected to bear the burden of a vulnerable 'friend'.

Reissman (1979) also describes 'associative' friendships where no loyalty or commitment is generated and the relationship does not endure beyond the circumstances that brought the parties together. It could be argued that this may characterise the relationship nurses develop with their patients due to the time limited encounters that are involved in acute settings. However, what the nurses in the present study seemed to be promoting as helpful to the patient is nearer what Reissman considers a 'receptive' friendship. Here one of the parties is primarily a giver to the other, similar to Peplau's (1969) notions of professional closeness where the nurse puts him or herself aside to give the patient space to grow, to learn and to be strengthened.

The findings of the present study echo those of Gordon's (1992) work with psychotherapy clients. Gordon's clients saw their therapist as being similar to, but not actually, a friend as a powerful and therapeutic element of the relationship. Gordon argues that what is helpful in the therapy relationship is that the client experiences the positive aspects of friendships: warmth; support; personal knowledge of the client; mutual sharing; understanding and acceptance; along with the positive aspects of a professional relationship: the therapist is ex-

ternal to the situation; is not involved in the client's life; carries professional status; has knowledge and can provide explanations. The characteristics described above support the present study's findings regarding the element being a professional friend with respect to the sort of relationship the nurses believe is helpful to the patients in their health promotion work.

The nurses talked about their health promotion activities with patients as an interpersonal endeavour and this became a pivotal statement of their perspective on health-promoting nursing. The relationships they form with patients were perceived as the key to any 'success' they might have in being able to raise health-promoting issues with their patients. Although the nurses perceived health promotion ‘knowledge’ (the message the nurse can give) as important to the health promotion intervention, this relationship is more than a professional ‘expert led’ encounter. The relationship described was warm and close, placing both the nurse and the patient at the centre of the intervention through sharing and mutual disclosure resulting in the nurse being the patient's professional friend.

THE IMPLICATIONS OF BEING A PROFESSIONAL FRIEND

The findings reported in this paper indicate that the nurses perceived that the relationships they formed with patients were fundamental to health promoting nursing practice. The formation of these relationships appeared to be a strategy of practice in order to promote a professional friendship similar to what Rawnsley (1990 p. 42) has described as an ‘instrumental friendship’ which, she claims, is a salient characteristic of professional nursing. This use of self to create a warm and close connection with the patient typifies nursing practice and contrasts with an artificial legal bonding, as suggested by the professional status of nursing, where a service is rendered from a contractual basis (Rawnsley, 1990).

The professional friendship that the nurses in the present study described is complex when considered in the context of health promotion interventions. It appeared that the nurses' descriptions incorporated what Beattie (1991) describes as two types of health persuasion technique. These were on the one hand a self-empowerment humanist model involving personal counselling for health, and on the other hand the preventative medical model. The nurses appeared to be committed to counselling their patients to help them take control of their health status but often had an outcome of prevention in mind.

Commitment to a prevention outcome is understandable when considering the setting in which the nurses practised. Both nurse and patient were confronted with the patient's illness, and both were interested in how to alleviate and prevent reoccurrence of that illness. This work, according to the nurses, required to be undertaken through the medium of a caring relationship. Forming such relationships, however, carries implications for the nurses and their patients. Savage (1995) indicates that these implications include the fact that such interactions can be emotionally costly for the nurse and 'failure' to form therapeutic relationships can be blamed on individual nurses with the collective nature of nursing work being overlooked. The implications for the patient can be that they are offered conditions in which they are empowered to consider their health status, needs and wishes and able to make decisions from this perspective. Another implication however, is that nurses' skill in forming therapeutic relationships, and their honed powers of persuasion may result not in empowerment of the patient, but in the exertion of power by the nurse, resulting in a form of social control (Piper and Brown, 1998).

With respect to the personal coping of nurses who are closely involved with their patients, clinical supervision has been identified as a strategy that assists nurses to cope with and make sense of their experiences. This has the outcomes of supporting the nurse, assist-

ing his or her learning and also of ensuring good practice for the benefit of the patient (Fish and Twinn, 1997). Bond and Holland (1998) indicate that there is increasing emphasis on the need for systems of clinical supervision to be implemented in nursing practice and cite the factors that are part of this impetus. These include concerns about practitioner health and the prevention of burnout; and, with the development of therapeutic interventions, the need to facilitate self-awareness.

The nurses' 'story' mediated through this study suggests that health-promoting nursing interventions in hospital settings rely on the nurse forming close, facilitative relationships with patients. Such relationships carry both positive and negative connotations for nurses and patients and nurses require support systems to enable them to establish and maintain such interventions in their practice. If nurses are to develop their practice according to the dictates of their own practice theories, supportive strategies such as the implementation of clinical supervision are necessary to sustain and promote health-promoting nursing.

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ABSTRACT

This paper is based on the findings of a grounded theory study that set out to explore hospital nurses' perspectives on how health promotion was incorporated into their practice. Central to what the participants perceived as effective health promoting practice was the relationship that they formed with their patients. This relationship was described as warm, close and involving mutual disclosure, although the nurses' unilateral 'giving' to their patients characterised the relationship as that of being a professional friend. It will be claimed in this paper that if nurses are to practise health-promoting nursing according to the direction that their own practice theory suggests, they must be supported to do so through the implementation of systems such as clinical supervision.