

A STUDY TO DETERMINE IF CARE GIVEN A SELECTED
GROUP OF PATIENTS WAS INDIVIDUALIZED

by

Prudence Ellene Ernest

Diploma, School of Nursing, Methodist Hospital
of Indiana, Indianapolis, 1950
B.S., University of Colorado, 1958

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Prudence Ellene Ernest

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by

Patricia VanderLeest

Grace Joews

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Ernest, Prudence Ellene (M. S., Nursing)

A Study to Determine if Care Given a Selected Group of
Patients Was Individualized

Thesis directed by Associate Professor Patricia VanderLeest

The study was designed to determine if the care given a selected group of patients in the hospital emergency department was individualized.

The purposes of the study were: (1) to establish criteria by which it could be determined if patient care was individualized, (2) to utilize the criteria to determine if the care given a selected group of patients was individualized, and (3) to provide data which could serve as a basis for evaluating patient care in the emergency department.

A review of literature from the health professions, behavioral sciences, and lay periodicals was made to ascertain: (1) if there was consensus among the health professions that a need existed for study in the area of patient care, (2) opinions about patient care expressed by persons in the health professions and laymen, (3) opinions about patient care in the emergency department, and (4) opinions of the concept of fundamental human needs.

The descriptive survey research method utilizing the non-participant observation technique was used in the study. The population consisted of fifteen selected patients in one hospital emergency department, from whom data were collected and analyzed by classification and tabulation.

Classifications established for analyzing data were:

(1) need for knowledge, (2) need for personal recognition, and
(3) need for security. For more delimited references to the classifications, sub-classifications were established. Analysis of data revealed that one-fifth of the population had all three needs met. Three patients each had two needs met, seven each had one need met, and two each had none of the needs met. The need for personal recognition was met for four-fifths (twelve) of the population. Needs for knowledge and security each were met for one-third (five) of the population. A little more than one-fourth of the total time in the emergency department patients were attended by the staff. During the remaining time, or a little less than three-fourths of the total time, they were unattended or waiting for care. It was concluded that the care given this selected group of patients in one hospital emergency department was not individualized.

This abstract of about 250 words is approved as to form and content. I recommend its publication.

Signed Patricia VanderLeest
Instructor in charge of thesis

TABLE OF CONTENTS

CHAPTER	PAGE
I. INTRODUCTION	1
Statement of the Problem	3
Purpose of the Study	3
Justification of the Problem	4
Definition of Terms	6
Scope and Limitations	7
Organization of Remainder of Thesis	7
II. REVIEW OF LITERATURE	9
Needs Expressed for Study in the Area of	
Patient Care	10
Opinions of Patient Care Expressed by Persons	
in the Health Professions and Laymen	13
Opinions of Patient Care in the Hospital	
Emergency Department	26
Development of Criteria for Determination of	
Individualized Patient Care	28
Summary	32
III. METHODOLOGY	34
The Method	34
The Technique	35
The Study Setting	36
Preliminary Plans	37

CHAPTER	PAGE
Development of Data-gathering Tool	38
Selection of Patients for the Study	38
Pretest of Data-gathering Tool	40
The Larger Study	43
Method of Analysis	43
Summary	44
IV. PRESENTATION, ANALYSIS, AND INTERPRETATION	
OF DATA	46
Description of the Population	47
Duration of Time Spent by Fifteen Patients in the Emergency Department and in Other Departments of the Hospital	49
Presentation and Analysis of Data Obtained from Individual Verbatim Conversation Records of Fifteen Patients in the Emergency Department	51
Presentation, Analysis, and Interpretation of Data for the Patients as a Group	102
Summary	105
V. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS	110
Summary of the Study	110
Conclusions Drawn	113
Recommendations for Further Investigation	114
BIBLIOGRAPHY	116
APPENDIX A	124
APPENDIX B	126

LIST OF TABLES

TABLE		PAGE
I.	Fifteen Patients Admitted to One Emergency Department According to Age, Sex, and Tour of Duty During Which Admitted	48
II.	Total Time Spent by Fifteen Patients in One Emergency Department According to Minutes and Percent of Total Time Attended and Unattended, and Minutes Spent in Other Departments	50
III.	Needs for Knowledge, Personal Recognition, and Security of Fifteen Patients in One Emergency Department According to Whether These Needs Were Met or Unmet	103

CHAPTER I

INTRODUCTION

Tremendous advances have been made in the art and science of treatment and care for patients during the past three decades. No one doubts the change in patient care has brought more gains than losses; however, it does appear that members of the health professions often may have overlooked the fact that the word "care" has a human as well as a technical meaning. The patient as an individual human being all too frequently has not been recognized. This lack of recognition has created a growing concern illustrated by the statement of one hospital administrator.

In an age when some of our hospitals perform scientific miracles, we hear patients complain--and rightly--of being treated coldly and impersonally.

It is tragic but true that at times patients are ignored, and these include the dying.¹

It is difficult to believe that mid-twentieth century patient care could be so described.

As early as 1956 a study revealed that many complaints center around the impersonal care received in hospital emergency or out-patient departments.² The long delay was a specific point taken--not

¹Martin Cherkasky, "What's Wrong With Our Hospitals?" Parade, Sunday Gazette-Mail, Charleston, West Virginia (December 9, 1962), p. 13.

²Robert Forsberg and Jeanne Marie Lemal, "Why Outpatients Feel Like Outcasts," The Modern Hospital, 86:96, March, 1956.

the actual waiting by the patient but the attitude on the part of the staff that indicated a lack of real interest in the patient and in his needs. Without explanation being given the patient, he wondered whether perhaps he really had been forgotten.

Howell and Buerki³ also mentioned the long waiting period, noting delays provoke criticism no matter how excellent the final patient care. The importance of helping a patient achieve peace of mind must not be underestimated.

Recognizing the pressures felt by emergency patients, it was reported that ". . . one's impression of emergency room care is formed under the kind of stress that makes the way things are done appear at least as important as what is done."⁴ Yet, a recent complaint by a patient still referred to the long waiting without explanation by the staff. Her comment was, "Please let me know if I must wait awhile. Just don't keep me guessing!"⁵ That the same type of complaint seemed to reappear was referred to in Brown's observation that in spite of continuous reference to the necessity for "'meeting patient's psychological needs,' action seems to be predominantly confined . . . to repetition of this admonition."⁶ But, due to pressures of complex

³James T. Howell and Robin C. Buerki, "The Emergency Unit in the Modern Hospital," Hospitals, 31:37-39, March 16, 1957.

⁴Robert S. Myers, "Personal Experience Shows How Efficient Emergency Room Can Be," The Modern Hospital, 95:108, December, 1960.

⁵Silvia Bakst, "What We Did About Patient Complaints," The Modern Hospital, 89:110, April, 1962.

⁶Esther L. Brown, Newer Dimensions of Patient Care, Part One: The Use of the Physical and Social Environment of the General Hospital for Therapeutic Purposes (New York: Russell Sage Foundation, 1961), p. 7.

technology experienced by staff members, the personal needs of patients as human beings may well be overlooked. In order to meet the needs of an individual patient then, it appears to be the responsibility of those who care for him to recognize him as a human being--with needs and expectations peculiar to him--and base his care upon individual considerations.

In view of the foregoing comments it would appear that patient satisfaction with care received in the hospital, especially in the emergency department where patients appear under stress producing circumstances, may depend more on how something is done rather than on what is done. Not only satisfaction but the patient's very recovery may depend upon this.

Statement of the Problem

The problem of this study was to determine if the care given to a selected group of patients in the hospital emergency department was individualized.

Purpose of the Study

The purposes of this study were: (1) to establish criteria by which it could be determined if patient care was individualized, (2) to utilize the criteria to determine if the care given to a selected group of patients was individualized, and (3) to provide data which could serve as a basis for evaluating patient care in the emergency department.

Justification of the Problem

From the review of literature relative to the study many references were found illustrating patients' and former patients' concern with care received while in the hospital. Ingles pointed out:

The quantity and quality of derisive literature which is being written today by lay people indicates pretty widespread dissatisfaction with medical and nursing care.⁷

Dissatisfaction does not necessarily imply that these patients expected to go home "cured" but rather that each left with the feeling that he was cared for improperly. Complaints did not appear to be centered around specific procedures involved in life-saving measures; discomfort and certain delays are generally accepted as necessary in the treatment, so that what is done seems not to be the problem. Then is it not how it is done that is disturbing to individuals?

Masur noted the influence interpersonal and environmental factors have on patients:

What impresses patients either favorably or unfavorably, more than the quality of the medical attention, is the attitude of hospital personnel. If that attitude was courteous, friendly, warm, they remembered and deeply appreciated it. If hospital personnel was rude, peremptory, or indifferent, patients remembered this also. And they resented it.⁸

The most widely verbalized contemporary emphasis in care of patients is termed "comprehensive," "total," "patient-centered," or "individualized." At the beginning of this decade one observer

⁷Thelma Ingles, "Do Patients Feel Lost in a General Hospital?" The American Journal of Nursing, 60:77, May, 1960.

⁸Jack Masur, "Top Brass Should Follow the Golden Rule," The Modern Hospital, 95:77, August, 1960.

indicated that patient-centered care had been given a great deal of "lip-service" for twenty years, "but examination of practice in many places denied its actuality."⁹

From studies reported by McCarroll and Scudder,¹⁰ as well as Barry and others¹¹ it was established that emergency department loads in some hospitals have increased tremendously in the past fifteen years. This would indicate the public obviously looks to the hospital emergency department for care for a wide variety of illnesses. Shortliffe¹² concurred with this view and further stated that patients would expect to be handled properly and efficiently.

In many hospitals the emergency room serves as the port of entry for all patients. A physician noted that in this case what happens to the patient "in the emergency room, how he and those who accompany are treated, inevitably color his judgment of the hospital."¹³ Pointing out the importance of maintaining a good emergency service, another observation was made that "many people get their first impressions of a hospital in its emergency room. And the memory of how

⁹ Wilma A. Minniear, "Annual Administrative Reviews: Nursing Service," Hospitals, 34:110, April 16, 1960.

¹⁰ James R. McCarroll and Paul A. Scudder, "Conflicting Concepts of Function Shown in National Survey," Hospitals, 34:35-38, December 1, 1960.

¹¹ Robert M. Barry, Ernest C. Shortliffe, and Howard J. Wetstone, "Case Study Predicts Load Variation Patterns," Hospitals, 34:34 et seqq., December 1, 1960.

¹² Ernest C. Shortliffe, "Emergency Rooms--Weakest Link in Hospital Care?" Hospitals, 34:33, February 1, 1960.

¹³ Jacob Horowitz, "What It Takes to Provide Good Emergency Room Care," The Modern Hospital, 97:89, September, 1961.

they were treated stays with them."¹⁴

If the emergency department is the scene of an individual's first or only contact with the hospital, then his impression of the care received will reflect his attitude of the hospital as a whole. Relatively few studies have been carried out to evaluate experiences had by patients in the emergency department or to determine if care in this particular facility is truly individualized. It would seem important, then, that a study be made to determine if the care given to a selected group of patients, during what could be for them a distressful experience in the emergency department, was individualized.

Definition of Terms

For the purposes of this study the following definitions were used:

Emergency department. That area within a general hospital in which non-appointment, emergent medical and surgical care is given on an out-patient basis.

Emergency department team. The professional and auxiliary personnel, including physicians, professional and practical nurses, and hospital aides, associated together in the emergency department to render a complex of services for the care of individuals with emergent illness or injury.

Patient care. A problem-solving process by which an individual is assisted in meeting one or more of his physiological, psychological,

¹⁴"The Emergency Room Crisis: How One Hospital is Handling It," R N, 25:56, October, 1962.

or sociological needs.

Individualized care. Patient care given an individual, based upon recognition of human behavior and fundamental needs, specifically encompassing knowledge, personal recognition, and security.

Adult. A person eighteen years of age or over.

Scope and Limitations

The study was conducted in the emergency department of a metropolitan, city-county, 425-bed general hospital in the Rocky Mountain area. The population of the study consisted of fifteen patients selected by restricted random sampling. The patients were chosen on a twenty-four hour basis; that is, five patients were selected from each of the three eight-hour hospital tours of duty.

There were several limitations to the study. The population was limited to adult patients in one hospital emergency department; therefore, the findings cannot be generalized to include the population of an entire hospital or patients in the emergency departments of other hospitals. Fifteen patients comprised the study. If more patients had been included, additional data would have been available concerning a wider variety of experiences and producing more extensive evidence from which to base conclusions and recommendations.

Organization of Remainder of Thesis

Chapter II presents a review of literature concerning the needs expressed for study of patient care, opinions of patient care expressed by persons in the health professions and laymen, and opinions of patient care in the hospital emergency department. It

also includes a presentation of the development of criteria for determining if patient care was individualized. Chapter III presents the methods of research and techniques used for gathering data. Chapter IV contains the presentation, analysis, and interpretation of the data obtained. Chapter V contains a summary of the study, conclusions drawn, and recommendations made for further investigation.

CHAPTER II

REVIEW OF LITERATURE

A systematic review of pertinent literature was undertaken to (1) ascertain whether there was consensus among the health professions that a need existed for study in the area of patient care, (2) ascertain opinions about patient care expressed by persons in the health professions and laymen, (3) ascertain opinions about patient care in the hospital emergency department, and (4) survey opinions of the concept of fundamental human needs in order to develop criteria by which it could be determined if patient care had been individualized.

Since the study was concerned with care given to selected patients by professional and nonprofessional members of the health team, the review made was multifaceted. To establish a knowledgeable foundation for this study, professional and lay periodicals, literature from the behavioral sciences, medicine, nursing, and printed instructional material for hospital aides were selected for review. The review included: The Journal of the American Medical Association, 1959 through 1962; The American Journal of Nursing, 1955 through May, 1963; Nursing Outlook, 1955 through March, 1963; Nursing Research, 1955 through 1962; R N, 1960 through April, 1963; The Modern Hospital, 1955 through March, 1963; Hospitals, 1955 through March, 1963; selected editions of Nursing World; The Columbine P N, 1958 through

1960; Today's Health, 1955 through March, 1963; Ladies' Home Journal, 1955 through March, 1963; Look, 1955 through 1962; The Saturday Evening Post, 1955 through April, 1963; and Good Housekeeping, 1960 through March, 1963. Although all applicable information reviewed was not included in the chapter, contributory references were added to the bibliography.

For the purpose of clarity of presentation, the review was organized in the following manner: (1) needs expressed for study in the area of patient care, (2) opinions of patient care expressed by persons in the health professions and laymen, (3) opinions of patient care in the hospital emergency department, and (4) development of criteria for the determination of individualized patient care.

Needs Expressed for Study in the Area of Patient Care

Recognition of the existing need to personalize patient care or to tailor it to the needs of the patient as an individual human being has become salient in our society in recent years. Progress in this direction, as known in the contemporary world, would be impossible without research. According to Corey, the individuals best qualified to do research involving a change in practice are the persons who will be affected by the change.¹ With regard to the meaning of research as it contributes to the care of the patient, an editorial appearing in The American Journal of Nursing stated that "the eventual crystallization of nursing's unique body of knowledge depends

¹Stephen Corey, Action Research to Improve School Practices (New York: Teachers College, Columbia University, Bureau of Publications, 1953), p. 6.

primarily on research. . . ."²

One of the important problems in nursing, according to Heidgerken, was ". . . the great need for research to be focused on the care of patients. . . ."³ In agreement with this view was the American Nurses' Foundation report which concluded, "the major focus of research effort . . . should now be on patient care."⁴ At the same time Jourard admonished that in studies published recently in professional journals ". . . not many have focused on the patient's mental and physical comfort as the yardstick or gauge of nursing competence."⁵

Brown pointed out, however, that relatively few studies had appeared of patient care in general hospitals that were concerned with psychological and social factors when compared with similar studies of psychiatric hospitals.⁶ More specifically within the general hospital, relatively few studies have appeared of patient care in the emergency department that were concerned with psychological factors. Eight years before Brown's monograph was published, this aspect of patient care in the emergency department was mentioned by

²Barbara G. Schutt, "An Expanding Concern with Research," The American Journal of Nursing, 62:45, August, 1962.

³Loretta Heidgerken, "Some Problems in Modern Nursing," Nursing Outlook, 7:397, July, 1959.

⁴R. Louise McManus, "Today and Tomorrow in Nursing Research," The American Journal of Nursing, 61:71, May, 1961.

⁵Sidney M. Jourard, "To Whom Can a Nurse Give Personalized Care?" The American Journal of Nursing, 61:86, March, 1961.

⁶Esther L. Brown, Newer Dimensions of Patient Care, Part One: The Use of the Physical and Social Environment of the General Hospital for Therapeutic Purposes (New York: Russell Sage Foundation, 1961), p. 5.

Lindquist, who wrote: "emergency patients require as much psychological aid and comfort as they do medical and surgical attention" ⁷ Howell and Buerki were even more emphatic concerning the importance of highest quality patient care in this department, stating that "a hospital's professional reputation often rides on the fate of patient care in its emergency unit." ⁸ That a satisfactory patient experience is extremely important was further emphasized by Shortliffe, because "his lasting impressions of both the emergency room and the hospital will depend upon how well he--in his own eyes--has been cared for." ⁹

According to some writers a crisis is occurring in emergency departments. In many hospitals services have become so overtaxed that care of emergency patients is suffering. In fact, "criticism is so widespread that the American Hospital Association and the American College of Surgeons are undertaking a nation-wide study of hospital emergency rooms." ¹⁰ We must improve patient care in the hospital emergency department, say the authorities--but it will take time. "We are beginning to study--through social research--what patients really need . . . in terms of human support." ¹¹

⁷C. A. Lindquist, "Hospital Facilities Required for Emergency Care," Bulletin American College of Surgeons, 38:378, November, December, 1953.

⁸James T. Howell and Robin C. Buerki, "The Emergency Unit in the Modern Hospital," Hospitals, 31:39, March 16, 1957.

⁹Ernest C. Shortliffe, "Emergency Rooms--Weakest Link in Hospital Care?" Hospitals, 34:33, February 1, 1960.

¹⁰"The Emergency Room Crisis: How One Hospital is Handling It," R N, 25:47, October, 1962.

¹¹Martin Cherkasky, "What's Wrong With Our Hospitals?" Parade, Sunday Gazette-Mail, Charleston, West Virginia (December 9, 1962), p. 13.

From the review of literature made, relatively few published studies were found concerning psychological or human needs of patients in the hospital emergency department. The great need for this type of research was, however, pointed out by several writers. It would seem that a need does exist for a study to determine if the patient care given in the emergency department meets the needs of patients as individual human beings. If hospital emergency departments are experiencing the tremendous change in function with resultant increase in number of patient visits, as indicated by McCarroll and Scudder,¹² then the staff must meet these changes by providing the kind of care which recognizes the patient as an individual human being.

There was agreement among writers that research effort should be focused on patient care, with emphasis directed toward psychological aspects of this care. Further delimiting the need for study, it was pointed out that the emergency department, in part because of its significant role in creating impressions of the hospital, could improve patient care by learning what patients really need in terms of human support.

Opinions of Patient Care Expressed by Persons in the Health Professions and Laymen

The determination of opinions about patient care expressed by persons in the health professions and laymen was accomplished by an extensive review of representative publications. Recognition of the

¹²James R. McCarroll and Paul A. Scudder, "Conflicting Concepts of Function Shown in National Survey," Hospitals, 34:35-38, December 1, 1960.

need for increased understanding of human behavior directed toward better, more personalized patient care was evident from the accordant comments of persons in the health professions; however, the comments of laymen generally referred to the personal qualities of people who gave them care. Often casual mention or indirect reference was made about how a particular incident was handled rather than about what was done.

Since patient care was provided by a team approach which included the physician, professional nurse, practical nurse, and hospital aide with the layman as the recipient of the care, comments by each, illustrative of those found in the literature, were included in this chapter. For clarity of presentation comments concerning those who gave the care was presented first, and then the remainder of the review discussed the recipient of patient care.

The physician and individualized patient care. The major portion of medical literature reviewed recognized that patients do complain about care in the hospital and noted the direction medical care of patients should take.

While Talbott stated "there need be no conflict between the practice of scientific medicine and the sympathetic understanding of the patient,"¹³ Solomon questioned one aspect of hospital care:

Is it an unhappy circumstance that as the hospital becomes the only place where medicine can be "properly" practiced, people are more and more frequently heard to complain about the impersonal, detached environment of hospital care?¹⁴

¹³John H. Talbott, "The Art of Medicine," The Journal of the American Medical Association, 175:899, March 11, 1961.

¹⁴Henry A. Solomon, "Patient Care and Science," The Journal of the American Medical Association, 176:390, April 29, 1961.

Patient dissatisfaction with hospitals, Blum explained, ". . . can be reduced by humanizing routines, by respecting the dignity, individuality, and personal desires of the patient."¹⁵ If care were individualized, patients would then have little justification for complaints about impersonal attitudes.

Among the physician's personal qualities essential to good medical care of the patient, Dickson,¹⁶ Pellegrino,¹⁷ and McKittrick¹⁸ were in general agreement that interest, understanding, kindness, compassion and a responsible attitude were of utmost importance. A good relationship between the physician and patient should permit an understanding of human needs of individual sick persons. Of the over-all objectives of the physician for patient care, as described by Holden, an extremely important one is a "sympathetic understanding of the patient's total problem. . . ."¹⁹

Although it was recognized that patients continue to complain about medical care, most authors advocated the physician's giving the

¹⁵Richard H. Blum, The Management of the Doctor-Patient Relationship (New York: The Blakiston Division, McGraw-Hill Book Company, Inc., 1960), p. 230.

¹⁶Robert C. Dickson, "The Patient, the Physician-Teacher, and the Student," The Journal of the American Medical Association, 173: 1301, July 23, 1960.

¹⁷Edmund D. Pellegrino, "Care of the Patient in the Medical School Setting," The Journal of the American Medical Association, 173:1293, July 23, 1960.

¹⁸Leland S. McKittrick, "The Objectives of Medical Education," The Journal of the American Medical Association, 173:1289, July 23, 1960.

¹⁹William D. Holden, "Developing the Young Physician's Responsibility and Judgment in Patient Care," The Journal of the American Medical Association, 173:1312, July 23, 1960.

type of care which would meet the needs of patients, recognizing them as individual human beings.

The professional nurse and individualized patient care. Patient care which takes into consideration individuals as unique human beings but with common fundamental needs, according to nursing literature, was variously termed "total," "comprehensive," "patient-centered," or "individualized" care. Essentially the collective views pointed out the need for caring about the patient as well as caring for him. As Jourard observed, "one of the events which we believe inspires faith and hope in a patient is the conviction that somebody cares about him."²⁰ In order that the care for an individual be effective then, someone must care about him.

To meet the needs of society today, Fuerst and Wolff concluded that nursing needs members who are skilled not only in direct patient care but also in evaluating and adjusting this care to meet individual needs.²¹ Koos went further, indicating that the nurse, in order to fulfill her professional role, must demonstrate an understanding of the patient who is a person and who has motivations and reactions which may affect his nursing care.²² Providing effective care, which is an outgrowth of effective relationships, requires inner strength and poise. These attributes can be nourished by sensitivity to that

²⁰ Jourard, op. cit., p. 88.

²¹ Elinor V. Fuerst and LuVerne Wolff, Teaching Fundamentals of Nursing (Second edition; Philadelphia: J. B. Lippincott Company, 1958), p. 6.

²² Earl L. Koos, The Sociology of the Patient (Third edition; New York: McGraw-Hill Book Company, Inc., 1959), p. 180.

which is in and around individuals. Copp and Copp said ". . . the patient must be accepted from the very first of the nursing moments as a whole, complex, ever-changing fellow being."²³ The sensitivity which is developed must be manifested in terms of priorities, or things that are most important to the patient's welfare. Nelson reiterated that individualized care can only be provided when the patient is the central concern and his needs for care are looked upon in a professional manner.²⁴ Also, in the health professions, Brown reported that the emphasis in patient care is now concentrated upon the "diagnosis and treatment of persons in their totality."²⁵ In this respect, Brackett and Fogt noted that "the patient is recognized as an individual, and his care is adapted to his individual needs and demands."²⁶ Although today we rarely see a patient who is unclean, they observed we often see patients who are fearful, lonely, untaught, and uncooperative.²⁷

Even as early as 1952, Peplau wrote that nursing's immediate task was:

To be able to sit at the bedside of any patient, observe, and gather evidence on the way the patient views the situation confronting him, visualize what is happening inside the patient,

²³ Laurel Copp and John Dixon Copp, "Look to the Pattern of Relationships," The American Journal of Nursing, 60:1284, September, 1960.

²⁴ Katherine R. Nelson, "Talking About Patient Care," The American Journal of Nursing, 61:58, May, 1961.

²⁵ Brown, loc. cit.

²⁶ Mary E. Brackett and Joan R. Fogt, "Is Comprehensive Nursing Care a Realistic Goal?" Nursing Outlook, 9:402, July, 1961.

²⁷ Ibid., p. 404.

as well as observe what is going on between him in the interpersonal relation.²⁸

Based upon accurate percepts of the individual, patient care then can be effective only when the patient's individual needs are satisfied.

The practical nurse and individualized patient care. Practical nursing too, legally defined in 1956, has emphasized care of ". . . the patient as a person--a human being with personal problems, who is ill."²⁹ Care of the whole person is believed to be essential in order for him to be as well and happy and useful as possible.

The aims of practical nursing have been described by leaders and educators in the field. To work diligently toward the development and growth of sound educational programs that prepare the practical nurse to carry out many of the functions in direct nursing care of the patient, has been indicated as the goal of this program.³⁰

Ross mentioned the various methods used in accomplishing patient care; e.g., functional, team, and private duty nursing. Regardless of the method used, she asserted, the object of each is good nursing care and satisfied patients.³¹ A patient needs nothing so much, she further observed, as an understanding and compassionate person to give him the strength that he is unable to summon for

²⁸ Hildegard E. Peplau, Interpersonal Relations in Nursing (New York: G. P. Putnam's Sons, 1952), p. 44.

²⁹ Florence Dakin, Ella M. Thompson and Margaret LeBaron, Simplified Nursing (sixth edition; Philadelphia: J. B. Lippincott Company, 1956), p. v.

³⁰ Clara Roitero, "Practical Nurse Training Program," The Columbine P N, 11:8, July, August, September, 1960.

³¹ Carmen F. Ross, Personal and Vocational Relationships in Practical Nursing (Philadelphia: J. B. Lippincott Company, 1961), p. 46.

himself.³² Much of what the practical nurse has to give was termed the "human element," and overemphasis of its importance was believed to be impossible. Regarding this human element, Ross elaborated that to "understand your patients is to recognize their individuality and to acknowledge it."³³ The more that is known about patients as individuals, the more accurately care can be tailored expressly for them. Finally, she stressed that patients must not be allowed to feel they have fallen onto a therapeutic assembly line.

There appeared to be a growing recognition of the need for practical nurses who are prepared to care for the patient in such a way that individualization of care would be achieved.

The hospital administrator and individualized patient care.

Articles in hospital administration journals discussed patients' expectations concerning their hospital experiences. Many writers observed that concern continues to be widespread over the goals, complexities, and problems of patient care in hospitals. Of all the many problems discussed, interpersonal and environmental factors were most frequently mentioned.

In his attempt to identify what impresses patients either favorably or unfavorably in the hospital, Masur found ". . . hospital-patient relationships are profoundly influenced by nonmedical, interpersonal, and environmental factors."³⁴ He further stated:

³²Ibid., p. 89.

³³Ibid.

³⁴Jack Masur, "Top Brass Should Follow the Golden Rule," The Modern Hospital, 95:77, August, 1960.

We must remind ourselves again and again that every activity in the hospital must be concerned not only with the health of the patient, but also his comfort and peace of mind.³⁵

An allusion to this peace of mind also was made by Singeisen, who wrote:

Good organization and correct medical treatment give the patient a rational certainty that he is receiving good care. But he needs to be able to feel this emotionally. And this requires a good spirit and atmosphere, which includes the attitudes of the staff, from the ward maid to the hospital director³⁶

The feeling of emotional certainty was mentioned by Pinckney, who stated that "the patient judges medical care by what he sees, hears, tastes, and most of all feels."³⁷

Several comments were found regarding the time spent with the patient caring for his needs. Singeisen synthesized these remarks when he stated:

The daily round of doctors and nurses leaves little time, so we are told, for considering the human needs of individual patients. But human contact does not involve losing time, much less wasting it. Our understanding of psychology would be gravely at fault if we thought it meant always long, time consuming conversations. Most patients do not need this at all.³⁸

It would seem there was general agreement among hospital administrators that in addition to having and knowing how to use the latest scientific discoveries, charitable human contact was also

³⁵ Ibid., p. 78.

³⁶ Fred Singeisen, "Hospitals Need More Patience With Patients," The Modern Hospital, 95:80, December, 1960.

³⁷ Edward Pinckney, "If You Want to Know What People Really Think of the Hospital, Ask Doctors to Report Patients' Comments," The Modern Hospital, 90:96, March, 1958.

³⁸ Singeisen, op. cit., p. 81.

needed.

The hospital aide and individualized patient care. There was little or no mention found in the literature regarding material to which hospital aides specifically might refer, in order to gain a better understanding of the patient and his behavior. Since hospital aides are considered auxiliary, non-professional personnel, each hospital establishes those technical skills and adaptive abilities it will require of hospital aides who will care for patients in that particular institution.

The guides for hospital aide instruction were obtained from three types of institutions--federal government, state, and private. The content in these guides gave indication that no matter who gives the patient care it should be individualized. The guide used in the first institution contained a section which discussed individualizing procedures to meet patients' needs. This discussion was directed toward analyzing the nursing situation in terms of the patient's reaction to his illness, as well as "sizing up" the patient as a person in terms of psycho-socio-cultural influences upon him.³⁹

In the second institution the hospital aide was loaned, early in his period of training, an orientation information pamphlet to be read and returned to the instructor. From this, one objective in the philosophy of nursing service was to "assist the individual to attain maximum physical and emotional health through optimal individual

³⁹Program Guide, Nursing Service, G-2, M-2, Part V, Department of Medicine and Surgery, Office of the Chief Medical Director, VA, (Washington, D. C.: U. S. Government Printing Office, November 1, 1955), p. 5.

care. . . ."⁴⁰ One aspect upon which this philosophy was based was the belief that "individualized care of the patient is given by providing a nursing staff, skillful in techniques and possessing a knowledge of nursing procedures. . . ."⁴¹ During the course of the training program in this hospital, a period of two hours was to be devoted to a discussion of interpersonal relations and psychology of the sick.

The third institution had a less structured guide which was intended to be expanded into comprehensive lesson plans by the instructor. One of the objectives of the course was "to assist her [hospital aide] to grow toward being a kind, sympathetic and understanding person."⁴² In the unit designated as "Human Relations, Communications and Ethics," two objectives were to emphasize the importance of having good human relations, and to assist the student to develop in her relations with others.⁴³ One discussion period on human relations was intended to acquaint the student with how to deal with people and their problems.

In this respect there was general agreement that it was important to teach the hospital aide how to care for the patient in an

⁴⁰"Information for Hospital Attendants," Nursing Service, Hospital Attendants--Orientation, University of Colorado Medical Center, Colorado General Hospital, Denver, Colorado, Revised, August, 1958, p. 3.

⁴¹Ibid.

⁴²"Nurse Aide Trainee Course," prepared by the Nursing Service Department, In-Service Education Program, General Rose Memorial Hospital, Denver, Colorado, 1963, p. 1.

⁴³Ibid., p. 3.

individualized, personal manner.

The layman and individualized patient care. A study by Abdellah and Levine indicated hospitalized patients often express their basic insecurities by complaints about familiar things (cold coffee, noise, a hard bed), but that these complaints may not define their real patient care needs.⁴⁴ Brown reiterated this point:

Complaints often appear to be about relatively unimportant items, such as temperature or strength of the coffee. . . . As a consequence, the staff tend either to disregard them or to interpret them literally and seek some improvement, if possible. The interesting fact is that, even when complaints are manifestations of deeper and more serious difficulties they are frequently expressed in the simple and socially acceptable terms of details of daily living.⁴⁵

In Part II of the Abdellah and Levine study, patients' reports of omissions in nursing care were analyzed. In general, it was found that in hospitals where a larger amount of nursing care was provided by professional nurses, patients reported fewer needs than did patients in hospitals where a smaller amount of professional care was provided.⁴⁶

A progress report on a research project, which analyzed interviews about the patient's view of the patient role, revealed that over one half of the patients expressed the need to receive their care in the form of personalized relationships. It indicated that patients

⁴⁴Faye G. Abdellah and Eugene Levine, "Polling Patients and Personnel, Part I: What Patients Say About Their Nursing Care," Hospitals, 31:44-48, November 1, 1957.

⁴⁵Brown, op. cit., pp. 25-26.

⁴⁶Faye G. Abdellah and Eugene Levine, "Polling Patients and Personnel, Part II: What Factors Affect Patients' Opinions of Their Nursing Care?" Hospitals, 31:61-64, November 16, 1957.

are conscious of an increase in the complexity and impersonal nature of the hospital. Many needs, the report revealed, stem from the risk of becoming anonymous, of becoming a number--another case in a complex production line. To be known as an individual makes the patient feel he is recognized from others.⁴⁷ In fact, "personalized care implies that the patient be known and recognized."⁴⁸

The majority of opinions found were expressed by people after they had left the hospital. Koos⁴⁹ and Silverman⁵⁰ found individuals who had recently been hospitalized were quite verbose in their criticisms of patient care. In another article a layman indicated that hospitals have forgotten all about common courtesy. He observed that it is human nature to want to know the names of people you deal with, but in a hospital you generally meet as strangers and part as strangers. He also mentioned that doctors and nurses are always busy, but patients are supposed to have all the time in the world.⁵¹

An article which appeared in a lay magazine and one which precipitated many professional responses stated some of the reasons why

⁴⁷Hans O. Mauksch and Daisy L. Tagliacozzo, The Patient's View of the Patient Role (second edition; Chicago: Illinois Institute of Technology, Health Research Center, April, 1963), p. 23.

⁴⁸Ibid.

⁴⁹Earl Koos, "'Metropolis,' What City People Think of Their Medical Services," American Journal of Public Health, 45:1555, 1955.

⁵⁰Milton Silverman, "Are Patients Human Beings?" The Saturday Evening Post, 228:116, October 1, 1955.

⁵¹"They Have Such Awful Manners in Hospitals," The Modern Hospital, 90:95 et seqq., March, 1958.

patients are unhappy in hospitals:

Patients have been complaining for years about the mistreatments, thoughtlessness and inadequate care they encountered in hospitals. But little has been done to determine if their complaints are justified and, if so, what hospitals can do to eliminate them.

Too concerned with their own problems and dissatisfactions, the members of the staff lose sight of the patient's emotional needs. And even though his medical needs are ultimately satisfied, the patient regards the staff as hard, callous and uncaring.

Some persons when asked what they would consider the "ideal" hospital, envisioned one that was "warm and friendly." Few mentioned hospital equipment or standards. Obviously, the emotional needs of the patient are as important to him as his immediate medical problem.⁵²

A somewhat more erudite survey by professional persons was undertaken by the Joint Commission on Accreditation of Hospitals. It was reported that the opinion of a Pennsylvanian echoed those of many persons when she stated "doctors are so filled with self-importance that they can't see you as a person."⁵³ McPeak also indicated that one of patients' concerns was the doctor's "general demeanor as a human being while dealing with other human beings during what are, for them, times of stress."⁵⁴

Despite members of the health professions' basic obligations to provide excellent diagnostic services and appropriate care, they must also deal with patients in a warm and concerned way. The

⁵² Roland H. Berg, "A Report on Hospitals," Look, 23:16 et seqq., February 3, 1959.

⁵³ "What Women Really Think About Their Doctors," Good Housekeeping, 153:150, August, 1961.

⁵⁴ William McPeak, "The Small, Frantic Voice of the Patient," Postgraduate Medicine, 27:120, January, 1960.

patient, fearful and anxious, should be able to feel "someone in the hospital 'really cares' about him."⁵⁵

Reference to this personal attitude on the part of persons who care for patients seemed to reappear in the literature. Cunningham summarized opinions for everyone when he wrote, "so feelings toward hospitals . . . range from a high degree of approval on the scientific medical side to a partly submerged feeling of disapproval on the personal side."⁵⁶

Opinions of Patient Care in the Hospital Emergency Department

It has been pointed out that "a hospital's professional reputation often rides on the fate of patient care in its emergency unit."⁵⁷ The patient who may never have been admitted to a hospital bed for care requiring several days may be cared for in the emergency department. From this contact alone may come his impression of the hospital in general and the quality of care given to its patients. In fact, a hospital medical director has emphasized that good public relations were extremely important in maintaining a good emergency service because here is where many people get their first impressions of the hospital; and every staff member should bear this in mind.⁵⁸

⁵⁵Cherkasky, loc. cit.

⁵⁶Robert M. Cunningham, Jr. (ed.), "The Public Likes Doctors Better Than Hospitals," The Modern Hospital, 91:70, November, 1958.

⁵⁷Howell and Buerki, loc. cit.

⁵⁸"The Emergency Room Crisis: How One Hospital is Handling It," op. cit., p. 56.

Many complaints were heard concerning the long delay waiting for care in the emergency department. A housewife mentioned that her husband had crushed his hand and had lost so much blood by the time she got him to the emergency department that he could hardly stand; but he was told to sit down and wait his turn, and they were asked to fill out a standard form. Her comment was ". . . I think it's cruel the way they treat you."⁵⁹ Similar opinions were revealed in another report which stated:

Many were the tales we heard of long hours spent on a hard stretcher in the emergency room, the person so reclining wondering what would happen to him eventually and whether perhaps he really had been forgotten.⁶⁰

Realizing that delays do provoke criticism, one writer suggested that "when delays are anticipated, a studied explanation to both the patient and his relatives has no substitute."⁶¹ Similarly, in another hospital it was recognized that a wait is sometimes inevitable, in which case the patient should be told he must wait awhile rather than have him wait and wonder if he would be cared for or had been forgotten.⁶²

From the review it appeared that since illness involves the entire person, members of the health professions must recognize that the patient does have anxieties, insecurities, and fears. They must

⁵⁹Ibid., p. 54.

⁶⁰Robert Forsberg and Jeanne M. Lemal, "Why Outpatients Feel Like Outcasts," The Modern Hospital, 86:96, March, 1956.

⁶¹Howell and Buerki, loc. cit.

⁶²Silvia Bakst, "What We Did About Patient Complaints," The Modern Hospital, 89:110, April, 1962.

then discover these concerns by demonstrating interest in the patient and have the patience to observe and listen to his concerns and difficulties. If recognition of this concept is instrumental in the care of patients in the general hospital, then its applicability to patients in the hospital emergency department should be of even greater significance.

Development of Criteria for Determination of Individualized Patient Care

To discover what needs must be met in order to interpret effectively the individualized aspect of patient care, it was necessary to learn the fundamental needs of human beings expressed as concepts of the behavioral sciences. It was believed that if these needs related to the aspect of individualizing patient care they could then be developed into criteria for determining if patient care was individualized.

Persons interested in the behavioral sciences long have been concerned with ascertaining the dynamic factors responsible for the activities of human beings. Various concepts of biological and psychological needs or desires, with considerable overlapping, have been proposed to explain human behavior. From among those surveyed, several were selected as being representative applicable fundamental facts from the behavioral sciences which motivate the behavior of human individuals.

One of America's pioneer behavioral scientists advocated four basic desires which he believed to be present in all persons regardless of their cultural environment. Although the desires have a

variety of forms, Thomas believed they were capable of general categories termed (1) desire for new experience, (2) desire for security, (3) desire for affectional response, and (4) desire for recognition.⁶³ Although an incomplete explanation of every motivation problem and, by no means universal, this or its near counterpart stands as a valuable concept in the explanation of human behavior. From studies of the emotions or motives of human activity, Prescott concluded that in the underlying basis of every individual's behavior (1) personal needs, (2) physical needs, and (3) social needs could be identified.⁶⁴

Maslow approximated the classification by Thomas but added a fifth desire. His categories included the needs for (1) self-actualization, (2) safety, (3) love, (4) esteem, and (5) the desire to know and understand.⁶⁵ Several of the categories, and similar to Prescott's, were combined by Thorpe, who referred to three fundamental human needs identified as the (1) need to maintain physical well-being, (2) need for personal recognition, and (3) need for security.⁶⁶ The need for being regarded as a person of worth and importance was considered inherent in the need for personal recognition, while the need for security encompassed that for love and affection as well as

⁶³W. I. Thomas, The Unadjusted Girl (Boston: Little, Brown and Company, 1923), p. 4.

⁶⁴Daniel A. Prescott, Emotion and the Educative Process (Washington, D. C.: The American Council on Education, 1938).

⁶⁵A. H. Maslow, "A Theory of Human Motivation," Psychological Review, 50:379-82, 1943.

⁶⁶Louis P. Thorpe, The Psychology of Mental Health (New York: The Ronald Press Company, 1950), pp. 39-40.

for comfort and safety.

The need for these basic concepts to be applied to the care of patients was recognized by Fuerst and Wolff. Cognizant of the fact that it is not possible to identify the absolute needs of any one person at a given time, they introduced three broad principles based upon human needs or desires. These they believed were basic for guiding action in giving the care needed by a patient. Their criteria were:

1. Psychologic: Maintaining the individuality of man.
2. Physiologic: Maintaining physiologic functioning in man.
3. Preventive: Protecting man from external causes of illness.⁶⁷

A similar indication of the need for synthesis of these concepts to be applied to the care of patients was expressed by Kron, who suggested that basic needs of people are the (1) need for recognition, (2) need to belong, (3) need for understanding, (4) need for stimulation and personal growth, and (5) need for security.⁶⁸ When basic needs are satisfied, according to this author, a feeling of pleasure and happiness will follow. She further believed it was important to learn the patient's evaluation of his care in order to find out how well his needs were being met.

As a mainspring of human behavior, Dennis mentioned that it is common to list seven fundamental needs which are basic to survival:

⁶⁷Elinor V. Fuerst and LuVerne Wolff, Teaching Fundamentals of Nursing (second edition; Philadelphia: J. B. Lippincott Company, 1958), p. 23.

⁶⁸Thora Kron, Nursing Team Leadership (Philadelphia: W. B. Saunders Company, 1961), pp. 17-22.

(1) food, (2) water, (3) oxygen, (4) sleep, (5) protection from temperature extremes, (6) excretion, and (7) sexual activity.⁶⁹ Since the biological needs are not man's only concern, secondary or psychosocial needs become dynamic forces underlying behavior. An arbitrary selection of a few of the many secondary needs was employed by Dennis, which included the need for (1) love or security, (2) status and recognition (related to the need to belong and the need for approval and acceptance), and (3) self-development.⁷⁰ Utilization of similar criteria to effect more adequate and personalized patient care could be an extremely worthwhile aim of the health professions.

There appeared to be agreement regarding fundamental needs common to individuals in this society, although there was variation in terminology referring to similar attributes. The concepts established by the behavioral sciences were combined and modified, and the following criteria were developed:

1. Knowledge: familiarity with a fact due to reception of information requisite, desired, or useful.
2. Personal recognition: the acknowledgment of an individual as a person of worth and dignity, by expression of interest and friendliness in, as well as understanding of him.
3. Security: the awareness of comfort, safety, or certainty evoked by freedom from fear or doubt.

These criteria were selected as representative of needs which

⁶⁹Lorraine B. Dennis, Psychology of Human Behavior for Nurses (second edition; Philadelphia: W. B. Saunders Company, 1962), p. 48.

⁷⁰Ibid., pp. 54-62.

supported the patient's autonomous personality or sense of individuality. It was believed that if the care met these criteria it would have been individualized.

Summary

There was consensus among the health professions that a need existed for study in the area of patient care. It was pointed out by several writers that research should be directed toward improving the care of the patient. Emphasis, in fact, should be placed upon learning to care about the patient as an individual human being.

Relative to opinions about patient care and in particular about care in the hospital emergency department, many references were found which centered around the personal attitude of individuals who care for the patient. An impersonal attitude almost consistently made the patient feel he was just another case rather than an individual human being, deserving respect and personal consideration. In the emergency department in particular, where stress is a significant factor in the patient's experience, seeing him as a "person" appeared to be far more important to him than technical competency of the staff.

To establish criteria by which it could be determined if patient care was individualized, all of the aspects of the concept of fundamental or basic human needs, i.e., physiological, psychological, and sociological, were examined. For the purpose of the study, however, attention was given only to the concepts of behavior relating to psychological human needs. Although these concepts were many in number, with some variation and considerable overlapping, they could be synthesized essentially into three categories--knowledge, personal

recognition, and security. These were believed to be representative of needs which supported the patient's autonomous personality or individuality. These, then, became the criteria for the determination of patient care which was individualized.

CHAPTER III

METHODOLOGY

The Method

To determine if the care given to a selected group of patients in the hospital emergency department was individualized, the descriptive survey method was utilized. This method, according to Hillway, ". . . attempts usually to describe a condition or to learn the status of something and, whenever possible, to draw valid general conclusions from the facts discovered."¹ A similar explanation of this method, variously termed status study or normative survey, was presented by Good and Scates:

The essential procedure of the . . . method is to take account of all pertinent aspects of one thing or situation, employing as the unit for study an individual, an institution, a community, or any group considered as a unit. The complex factors involved in the given behavior are examined to determine the existing status and to identify the causal factors operating.²

This method appeared to be the most appropriate tool for the kind of problem undertaken and the nature of the available data.

¹Tyrus Hillway, Introduction to Research (Boston: Houghton Mifflin Company, 1956), p. 175.

²Carter V. Good and Douglas E. Scates, Methods of Research (New York: Appleton-Century-Crofts, Inc., 1954), p. 726.

The Technique

There are several devices or techniques for gathering data from other people, using the descriptive survey method. These techniques were reviewed in order to select that which was most appropriate for obtaining the desired data. Two of the principal devices for gathering information from people, the interview and the questionnaire, were examined as possible techniques for the study. Neither was believed to be entirely satisfactory for learning the various relevant aspects of the patient's care. Since many aspects of behavior can be studied satisfactorily in no other way, observation was selected as the technique to examine the patient care experience in the emergency department.

Observation. As indicated by Good and Scates, observation seeks:

. . . to ascertain the overt behavior of persons (and what it may reveal) by watching them as they express themselves in a variety of situations, selected to typify the conditions of . . . some special set of factors.³

Observation was recognized, then, as the most direct means of studying people when interested in their overt behavior. In order to learn exactly what had taken place in the patient's experience, it was necessary to observe what occurred during the entire course of his care in the emergency department. The significant elements taken account of were: (1) the participants (e.g., physician, nurse, patient), (2) the setting (e.g., emergency department, hallway, patient's cubicle), (3) the purpose (e.g., what brought the

³Ibid., p. 647.

participants together), (4) the social behavior (e.g., what actually occurred, what the participants did, with whom and with what they did it), and (5) frequency and duration (e.g., when the situation occurred, how long it lasted).⁴ The elements suggested directions of observation that otherwise may have been overlooked.

Having realized the vantage point must be selected carefully, it was believed desirable to view clearly the situation under study, yet effect the least possible change in the course of events. Since it was intended that conditions merely be observed and recorded without interpretation at the time, nonparticipant observation was a further delimitation. "The nonparticipant observer takes a position where his presence is not disturbing. . . ."⁵ The observer did not converse with the individuals being observed, i.e., the emergency department team or patients in the study, or contribute to the situation by participating in any of the events.

The Study Setting

The study was conducted in the emergency department of a metropolitan, city-county, 425-bed general hospital in the Rocky Mountain area. This institution receives all persons within the city limits who are ill or injured, taken by ambulance or police department vehicle for required hospital care; however, the patient or his family

⁴Claire Selltitz et al., Research Methods in Social Relations (revised one-volume edition; New York: Henry Holt and Company, Inc., 1959), pp. 209-10.

⁵Carter V. Good, Introduction to Educational Research (New York: Appleton-Century-Crofts, Inc., 1959), p. 227.

may request being taken to an institution of his choice. All indigent persons residing within the city limits, prisoners from the city-county jail, and city employees injured on the job were brought to this hospital for emergency care.

The emergency department also served a number of patients with non-emergency problems who entered for a change of plaster casts, prescription refill orders, or to have clothing listed and checked for a pre-planned admission to the hospital.

Preliminary Plans

Permission to conduct the study was received verbally from the director of nurses, the chief resident physician, and the nurse supervisor in charge of the emergency department.

The study was discussed at length with the director of nurses and the supervisor of the emergency department. It was agreed that in order not to effect a change in the established method of performance and personal interaction, the staff would be given the following information only: the observer (name) (1) is a graduate student in nursing, (2) is doing a study of selected patients in a hospital emergency department, (3) will be observing in the department at intervals on each of the three tours of duty, and (4) will not assist in the care of the patients. The supervisor of the emergency department agreed to inform the staff that individual staff members were not being evaluated and that no data were being reported which would identify them personally.

Development of Data-gathering Tool

To gather data in an orderly manner so that relevant facts about each patient would be organized for availability, an observation record form was designed. The form was a sheet of paper eight and one half by eleven inches in size. At the top one third, space was provided for recording the patient's name; hospital number; sex; age; race, or ethnic group; admission time; dismissal time; duration of time in the emergency department, both attended and unattended; and duration of time out of the emergency department. The key to abbreviations for identifying the patient and each member of the emergency department team, for the purpose of recording the conversation, was placed in the center of the page. This information included:

DR = Physician (Doctor)
RN = Professional Registered Nurse
PN = Licensed Practical Nurse
HA = Hospital Aide
PT = Patient
SR = Surgical Resident Physician
OR = Orthopedic Resident Physician

The remainder of the page, as well as additional size eight and one half by eleven inch sheets of paper, was left blank for recording the conversation verbatim. The observation record forms were contained in a loose-leaf folder which was to be placed in a convenient location within the emergency department, but outside the patient's immediate area. This was to facilitate recording of data at each opportunity.

Selection of Patients for the Study

Selection of patients for the study was by random sampling

with certain modifications. The following criteria were established for selection of the population: (1) an adult admitted for non-appointment emergent medical and/or surgical care; and (2) upon completion of observation of one patient, the next patient encountered who met the first criterion was selected. Children, who would be unable to grasp the significance of the experience, were not considered. Also, it was believed that patients who entered for the purposes of having a plaster cast changed, having a prescription refilled, or who were in the emergency department to have clothing checked enroute to a pre-planned hospital admission were non-representative of emergency type patients. Their visits were seen as non-emergent and they were not selected for the study.

The varying time span spent by each patient in the department did not permit the setting up of a predetermined schedule for observation. When a patient who met the criteria for the study was admitted, he was followed throughout the entire period of time in the emergency department. Upon completion of the observation, data were recorded and the next patient who met the established criteria was selected. For accuracy of data it was important that it be recorded at the earliest possible moment following observation; therefore, the number of patients who could be studied in a given time was limited.

Due to the variation in staffing patterns and the patient load fluctuation during a twenty-four hour period, it was believed to be more representative of the total type of experiences if patients were selected from each of the three hospital tours of duty. Therefore, the population of the study was distributed selectively from 7:00 a.m. to 3:30 p.m., from 3:00 p.m. to 11:30 p.m., and from 11:00 p.m. to

7:00 a.m.

Pretest of Data-gathering Tool

"Much difficulty can be avoided by carefully pretesting the techniques to be used, to ensure that they will collect the information needed."⁶ The purposes of conducting a pretest were: (1) to assist the researcher in improving technique in observation, (2) to obtain an indication of the type of data likely to be found, (3) to determine if the desired data could be obtained, and (4) to determine if the data could be analyzed.⁷

For the aforementioned purposes a pretest of the data-gathering tool was made. Four patients who met the criteria established for selection were observed in order to indicate any need for revisions or more careful planning for the study proper. To obtain a representative sample, the patients were chosen from each of the three tours of duty--one during the night, one during the day, and two during the evening.

During the course of the pretest the observer wore a long laboratory coat over street clothing; other identification was a name tag attached to the coat pocket. The intention was not to be identified with a specific professional group, which might influence interaction between the persons being observed.

Observation period. As the patient entered the emergency

⁶Selltiz et al., op. cit., p. 71.

⁷Amy F. Brown, Research in Nursing (Philadelphia: W. B. Saunders Company, 1958), p. 87; Selltiz et al., op. cit., pp. 69-71.

department the observer was present in a nonparticipant role, or that of an attentive listener. A judgment was made as to whether the patient qualified to participate in the study. When selected then, the observer was with the patient whenever any staff member was with him, throughout his entire period of time in the emergency department. When the patient was not attended by the staff, the observer was not present in his immediate area, but in proximity to observe any interaction that might take place.

Recording observation data. The best time for recording is at the time during the event, to eliminate bias and memory distortion as much as possible. Selltiz et al. stated, however, that "constant note-taking may interfere with the quality of observation."⁸ It was suggested further that relevant aspects of the situation easily may be lost if the observer divides his attention between observing and writing.⁹ Most writers of research methods agree that however the immediate impressions are recorded, the complete account of everything in the situation should be written immediately after the observation.

Notes were not taken in the patient's presence. As time permitted, when no staff member attended the patient and no interaction was taking place, data were recorded from the patient's clinical chart onto the observation record. This included the name of the patient (which was then coded), hospital number, sex, age, date, and race or ethnic group. The hospital number served only as a safeguard

⁸Ibid., p. 210.

⁹Ibid.

to identify a particular clinical chart and patient in the event patients with similar names might be present in the department. It served no other purpose in the study.

Admission and dismissal times were noted and recorded by the observer. Duration of time in the emergency department was later computed from the completed record, as were the periods of time attended, unattended, and other. Attended time referred to the period when any member of the emergency department team was with the patient. Unattended time referred to the period when the patient was without any member of the emergency department team in his presence. Other time referred to any period the patient was out of the emergency department, e.g., in X-ray department or in Admission Office. Using the key to abbreviations for identifying individuals, conversation between patient and team members was recorded as nearly verbatim as possible. Along with the conversation, the time the team member entered or left the patient's cubicle, and the time the patient left the emergency department temporarily and returned, were also recorded.

Plain three by five note cards were carried in the laboratory coat pocket for jotting down brief reminders to be entered on the patient's observation record at the earliest possible moment. This was only for accuracy in recording time or other significant detail not to be forgotten.

The pretest indicated the desired data could be obtained and that these data could be analyzed. Since the pretest indicated the data-gathering tool was effective for pursuing the study, the four observation records of patients in the pretest were retained for inclusion with the larger study.

In the original planning for data-gathering, it was believed that the recording of race and/or ethnic group would be of value in analysis and interpretation of the patient's experience. However, following the analysis of data obtained in the pretest, race and/or ethnic group was found to be irrelevant in determination of patient care which was individualized. Therefore, the space provided for recording these data on the observation record was eliminated. After this minor change was made, the observation record was approved and adopted for use as the data-gathering tool for the study. A copy of the observation record may be found in Appendix A.

The Larger Study

Using the previously established criteria, eleven additional patients were selected for observation in the larger study. Of these eleven patients, four were selected between 7:00 a.m. and 3:30 p.m., three were selected between 3:00 p.m. and 11:30 p.m., and four were selected between 11:00 p.m. and 7:00 a.m. Using the data-gathering technique described in the pretest, data concerning these eleven patients were obtained and recorded. Since the data regarding the four patients in the pretest were included, at the completion of the study data were obtained from a population of fifteen patients. Of these fifteen, five were selected during the period of 7:00 a.m. to 3:30 p.m., five were selected during 3:00 p.m. to 11:30 p.m., and the remainder were selected during the period from 11:00 p.m. to 7:00 a.m.

Method of Analysis

The method of analysis used for this study was classification.

According to Good and Scates, one of the techniques useful for analysis of data obtained in a descriptive survey is classification, which "... in essence is seeing similarities and differences among experiences. . . ." ¹⁰ They further stated that there is a human tendency to classify things, "... to group them according to kind, to draw delimiting lines around each kind, and to seek a fuller understanding of what each particular kind means." ¹¹

After classifying the data according to kind or similarities, they were then tabulated. "The essential operation in tabulation is counting to determine the number of cases that fall into the various categories." ¹² The classified, tabulated data then existed as a conceptual unity for interpretation.

Summary

The problem of the study was to determine if the care given to a selected group of patients in the hospital emergency department was individualized. Descriptive survey was the method of research used in the study. The technique for data-gathering was nonparticipant observation.

The study was conducted in the emergency department of one metropolitan, city-county, 425-bed general hospital in the Rocky Mountain area. Approval for the study was obtained from Nursing Administration and Medical Service directors of the hospital. The

¹⁰ Good and Scates, op. cit., p. 493.

¹¹ Ibid.

¹² Selltitz et al., op. cit., pp. 406-07.

observation record form was designed as the data-gathering tool. On it, space was provided for recording data from the patient's clinical chart, and for recording conversation verbatim during the observation period. The key to abbreviations used for identifying emergency department team members and the patient, also appeared on the observation record. Criteria established for selection of the population were: (1) an adult admitted for non-appointment emergent medical and/or surgical care; and (2) upon completion of observation of one patient, the next patient encountered who met the first criterion was selected. The data-gathering tool was pretested in order to ascertain its effectiveness in obtaining the desired data. In the pretest four patients were observed; data from the clinical chart as well as verbatim conversation between the patient and team members were noted on the observation record. The pretest indicated the desired data could be obtained and these data could be analyzed. Eleven additional patients were selected for the larger study. Data were gathered in the same manner as described for the pretest. Since the pretest had indicated that the tool for data-gathering as well as the technique for conducting the study were satisfactory, observation records of the four patients in the pretest were included in the total study. To ensure a representative sample insofar as possible, the population was proportioned uniformly from 7:00 a.m. to 3:30 p.m., 3:00 p.m. to 11:30 p.m., and 11:00 p.m. to 7:00 a.m. At the completion of the total study the population consisted of fifteen patients. The method of analysis was classification and tabulation of the data.

CHAPTER IV

PRESENTATION, ANALYSIS, AND INTERPRETATION OF DATA

The problem of this study was to determine if the care given to a selected group of patients in the hospital emergency department was individualized. The purposes of the study were: (1) to establish criteria by which it could be determined if patient care was individualized, (2) to utilize the criteria to determine if the care given to a selected group of patients was individualized, and (3) to provide data which could serve as a basis for evaluating patient care in the emergency department.

It was believed that care of the patient should be individualized. The concept of individualized care is based upon recognition of certain fundamental needs, basic to all human beings. The concepts of fundamental human needs were determined by a review of representative literature from among the behavioral sciences. The concepts of behavior based upon human needs were generally found to be described under groupings of physiological, psychological, and sociological needs. In the analysis of this study only statements indicating psychological needs, or those which concern awareness or mental processes, were identified from the patient's observation record. The manner in which the verbatim statements from the observation record were classified was a subjective determination by the researcher alone.

This chapter is presented in four sections. Section one describes the population of the study. It presents the age, sex, and tour of duty during which the patients were admitted.

Section two consists of data about the population relating to time spent in the emergency department, and indicating how much of the time patients were attended or unattended by the staff. It also indicates the time spent by patients in other departments of the hospital.

Section three consists of presentation and analysis of data obtained from direct observation of the individual patients in the emergency department and subsequent record of verbatim conversation.

Section four presents a synthesis of the data analyzed in section three, viewing the fifteen patients as a group.

Description of the Population

The population of the study consisted of fifteen patients who met the established criteria. Table I, page 48, presents the age and sex of the fifteen patients as well as the tour of duty during which they were admitted. The age range was from eighteen to sixty-six years with the predominant number of patients being between the ages of thirty to fifty-five years. Seven of the fifteen patients in the study were male and eight patients were female. Five patients were admitted to the emergency department between the hours of 7:00 a.m. to 3:30 p.m., five were admitted between 3:00 p.m. to 11:30 p.m., and the remainder were admitted between the hours of 11:00 p.m. to 7:00 a.m. These data indicated that the population was almost equally distributed between male and female patients who were predominantly

TABLE I

FIFTEEN PATIENTS ADMITTED TO ONE EMERGENCY
DEPARTMENT ACCORDING TO AGE, SEX AND
TOUR OF DUTY DURING WHICH ADMITTED

Patient	Age	Sex		Tour of Duty Admitted		
		Male	Female	7:00-3:30	3:00-11:30	11:00-7:00
A	48		F		X	
B	66	M			X	
C	54		F	X		
D	33	M				X
E	43		F	X		
F	52	M			X	
G	30		F	X		
H	55	M				X
I	38	M			X	
J	43	M			X	
K	24	M		X		
L	24		F			X
M	54		F	X		
N	40		F			X
O	18		F			X
Total		7	8	5	5	5

middle-aged.

Duration of Time Spent by Fifteen Patients in the Emergency
Department and in Other Departments of the Hospital

Table II, on page 50, indicates the total time spent by the fifteen patients in one emergency department according to minutes and percent of total time attended and unattended, and minutes spent in other departments of the hospital. Duration of time spent by each patient in the emergency department varied from twenty minutes to five hours. This included both the time attended by the emergency department team, and the unattended time spent by the patient in the department but waiting for some aspect of care. For these fifteen patients the average duration was two hours and four minutes. The average time attended by emergency department team members was thirty-five minutes, or 28 percent of the patient's total time in the department. Unattended or waiting alone for some aspect of care, the average time was one hour and twenty-nine minutes, or 72 percent of the patient's total time in the department. In addition to time in the emergency department, five patients spent a certain amount of time, ranging from five minutes to one hour and twenty-three minutes, in another department of the hospital, e.g., X-ray. This latter time was recorded independently, in minutes only, and was not computed in the percentage of attended and unattended time in the emergency department per se.

The data indicated that for this group of patients in one hospital emergency department, the patients were attended by the staff a little more than one-fourth of the total time. During the

TABLE II

TOTAL TIME SPENT BY FIFTEEN PATIENTS IN ONE EMERGENCY
DEPARTMENT ACCORDING TO MINUTES AND PERCENT OF
TOTAL TIME ATTENDED AND UNATTENDED, AND
MINUTES SPENT IN OTHER DEPARTMENTS

Patient	Time in Emergency Department					Time in other Departments <u>Min.</u>
	<u>Total</u>	<u>Attended</u>		<u>Unattended</u>		
		<u>Min.</u>	<u>Percent</u>	<u>Min.</u>	<u>Percent</u>	
A	20	10	50	10	50	
B	204	19	9	185	91	10
C	35	16	46	19	54	
D	30	6	20	24	80	10
E	300	56	19	244	81	
F	145	83	57	62	43	5
G	130	20	15	110	85	
H	180	83	46	97	54	
I	124	35	28	89	72	83
J	45	18	40	27	60	
K	50	40	80	10	20	
L	105	51	49	54	51	
M	277	56	20	221	80	
N	121	19	16	102	84	
O	94	10	11	84	89	5
Total	1860	522		1338		113

remaining time, or a little less than three-fourths of the total time, they were unattended or waiting for care.

Presentation and Analysis of Data Obtained from Individual
Verbatim Conversation Records of Fifteen Patients
in the Emergency Department

It was established that all human beings have fundamental needs which they desire to have fulfilled regardless of the situation in which they are involved. Three needs were considered to be inherent in all patient care situations. These needs were (1) need for knowledge, (2) need for personal recognition, and (3) need for security. In order for patient care to be individualized, it was believed these needs must be met. Since the problem of the study was to determine if the care given to a selected group of patients was individualized, it was necessary to determine if the care given met these criteria.

Three main classifications were then established for analysis of verbatim conversation from the observation record. These three main classifications were:

1. Need for knowledge
2. Need for personal recognition
3. Need for security

To facilitate classification and analysis of data, it was believed that more specific aspects of these needs could be identified. These aspects, then, were sub-classified for a delimited description of references made to the main classification. Therefore, under the classification need for knowledge, the sub-classifications were:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or
procedures
4. Need for health instruction

Under the classification need for personal recognition, the sub-classifications were:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Under the classification need for security, the sub-classifications were:

1. Need for anticipated events to occur with reasonable
sequence in time
2. Need for an awareness of being cared for.

Each of the records of verbatim conversation was analyzed and statements which indicated the need in each of the main classifications were classified according to their particular applicability in the sub-classification. In the sub-classifications the statements were classified according to their indication that the need was met or was not met.

It was recognized that some aspects of each need would appear to be relatively more significant in the determination of whether the need was met or unmet. There were four aspects each under need for knowledge and need for personal recognition, and there were two aspects under need for security. It was arbitrarily decided that if three

aspects of the need for knowledge, three aspects of the need for personal recognition, and one aspect of the need for security were met, then the three criteria necessary for patient care were met and the care was considered to have been individualized. If there was no occasion or opportunity for one aspect of a need to be met, or if there were a similar number of statements indicating met and unmet needs for one aspect, it was considered a neutral point and was computed with the number of needs met. If more than 50 percent of the patient's total time in the emergency department was spent waiting for care, essentially without explanation of the reason, the need for anticipated events to occur with reasonable sequence in time was considered to have been unmet.

The following presents individually the fifteen patients in the study.

Patient A

This forty-eight year old woman was admitted during 3:00 to 11:30 p.m. tour of duty, complaining of a cough and pain in her chest. She spent twenty minutes in the emergency department.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were

sub-classified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedure
4. Need for health instruction

Need to know the name of the team member who cared for him.

Although there was opportunity for team members to introduce themselves to the patient, no one did so. This aspect of the need was unmet.

Need for information about his illness, injury, or condition. There was evidence that this aspect of the need was met. An example was:

"You don't have any evidence of pneumonia; it sounds good. What you have is a bronchitis; your coughing just makes it sore down there."

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met.

An example was:

"I'll give you some medicine to stop your cough since you say you don't cough up much, and that'll let your chest rest and let the sore areas heal."

Need for health instruction. There was evidence that this aspect of the need was met. An example was:

"Well, you know you only get TB if you're in contact with somebody who has it."

Need for Personal Recognition

According to their particular applicability, data were sub-classified as follows:

1. Need to be spoken to by name

2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. Although team members had opportunity to speak to the patient by name, no one did so. This aspect of the need was unmet.

Need for privacy when indicated. There was evidence that this aspect of the need was met. An example was:

"You take your dress and straps down and then just hold it under your arms. (stepped outside cubicle) Okay?"

Need for a courteous approach. There was evidence that this aspect of the need was met. An example was:

"Can I help you?" (pleasant, smiling)

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"What have you been doing for your cold?" (friendly, concerned voice)

Need for Security

According to their particular applicability, data were subclassified as follows:

1. Need for anticipated events to occur with reasonable sequence in time
2. Need for an awareness of being cared for

Need for anticipated events to occur with reasonable sequence in time. Patient A was in the emergency department twenty minutes, attended ten minutes and unattended ten minutes. Although each represented fifty percent of her time, the duration was relatively

short and no one unattended period exceeded eight minutes. She did not wait, without explanation, for any length of time. This would indicate that this aspect of the need was met.

Need for an awareness of being cared for. Since three aspects of the need for knowledge and three aspects of the need for personal recognition were met, and the need for anticipated events to occur with reasonable sequence in time was met, it was believed that these contributed to an awareness of being cared for. This would indicate that this aspect of the need was met.

In the care given Patient A, the data indicated that the need for knowledge, personal recognition, and security were met.

Patient B

This sixty-six year old man was admitted during 3:00 to 11:30 p.m. tour of duty, complaining of "flu" and pain in his chest. He spent three hours and twenty-four minutes in the emergency department and ten minutes in X-ray department.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from the verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for him

2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedure
4. Need for health instruction

Need to know the name of the team member who cared for him.

Although there was opportunity for team members to introduce themselves to the patient, no one did so. This aspect of the need was unmet.

Need for information about his illness, injury, or condition. There was evidence that this aspect of the need was met. An example was:

"I just looked at your X-ray and it looks like there might be something in your chest--a little congestion."

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met. An example was:

"The nurse will give you a shot of penicillin tonight and I want you to come back every day for five days to get another shot and I think that'll do it then."

Need for health instruction. Although there was opportunity for giving health instruction, this was not pointed out by any statement. This aspect of the need was unmet.

Need for Personal Recognition

According to their particular applicability, data were subclassified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach

4. Need for concern or interest from team members.

Need to be spoken to by name. The patient was spoken to by name. This aspect of the need was met.

Need for privacy when indicated. There was no particular situation in which the patient required privacy.

Need for a courteous approach. There was evidence that this aspect of the need was unmet. An example was:

"What's your trouble?" (not a pleasant manner)

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"Is anybody else sick at your house?" (concerned manner)

Need for Security

According to their particular applicability, data were sub-classified as follows:

1. Need for anticipated events to occur with reasonable sequence in time

2. Need for an awareness of being cared for.

Need for anticipated events to occur with reasonable sequence in time. Patient B was in the emergency department three hours and twenty-four minutes, during which he was attended for nineteen minutes and unattended for three hours and five minutes. In addition, he spent ten minutes in the X-ray department. During much of the time in the emergency department, in fact, one continuous period of two hours and five minutes he was sitting alone in his cubicle, without explanation of the reason, waiting for care. Since he was attended only 9 percent of the time and was unattended 91 percent of the time,

essentially without explanation, this aspect of the need was considered unmet.

Need for an awareness of being cared for. This aspect was not pointed out by any statement. Two aspects of the need for knowledge and three aspects of the need for personal recognition were met, while the need for anticipated events to occur with reasonable sequence in time was unmet. Since the need for knowledge and the first aspect of the need for security, both of which would contribute to security, were unmet, it was believed that this aspect of the need was unmet.

In the care given Patient B, the data indicated that the need for personal recognition was met, but that the needs for knowledge and security were unmet.

Patient C

This fifty-four year old woman was admitted during 7:00 a.m. to 3:30 p.m. tour of duty, complaining of sores (a fungus-type infection) on both feet. She spent thirty-five minutes in the emergency department.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedures
4. Need for health instruction

Need to know the name of the team member who cared for him.

Although there was opportunity for team members to introduce themselves to the patient, no one did so. This aspect of the need was unmet.

Need for information about his illness, injury, or condition.

There was no statement which indicated that the patient was given information about her condition, although the opportunity appeared to exist. This aspect of the need was unmet.

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met.

An example was:

"Now, this is three times a day and you use the ointment at night and the powder during the day. The ointment will be kind of fluffy and you just spread it all over the area. The socks will just keep the bed from getting greasy with the ointment."

Need for health instruction. There was evidence that this aspect of the need was met. An example was:

"Well, you leave off the bleach now; that might not be doing your feet any good. Just wash them real good with soap and water."

Need for Personal Recognition

According to their particular applicability, data were sub-classified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. Although there was opportunity for team members to speak to the patient by name, no one did so. This aspect of the need was unmet.

Need for privacy when indicated. There was no particular situation in which the patient required privacy.

Need for a courteous approach. There was evidence that this aspect of the need was unmet. An example was:

"What's your trouble?" (abruptly, not pleasant or smiling)

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"Does anyone else in your family have the same thing?"

Need for Security

According to their particular applicability, data were sub-classified as follows:

1. Need for anticipated events to occur with reasonable
sequence in time
2. Need for an awareness of being cared for

Need for anticipated events to occur with reasonable sequence in time. Patient C was in the emergency department thirty-five

minutes, during which she was attended sixteen minutes and unattended nineteen minutes. The longest period of time spent waiting without explanation was thirteen minutes. Since she was attended only 46 percent of the time and was unattended 54 percent of the time, essentially without explanation, this aspect of the need was considered unmet.

Need for an awareness of being cared for. This aspect was not pointed out by any statement. Only two aspects of the need for knowledge and two aspects of the need for personal recognition were met. The need for anticipated events to occur with reasonable sequence in time was unmet. Since these needs which would contribute to an awareness of being cared for were unmet, this aspect of the need was considered unmet.

In the care given Patient C, the data indicated that the needs for knowledge, personal recognition, and security were unmet.

Patient D

This thirty-three year old man was admitted during 11:00 p.m. to 7:00 a.m. tour of duty, to have a wood tick removed from the lower abdominal skin surface. He spent thirty minutes in the emergency department and ten minutes in the admission office.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedure
4. Need for health instruction

Need to know the name of the team member who cared for him.

Although there was opportunity for team members to introduce themselves to the patient, no one did so. This aspect of the need was unmet.

Need for information about his illness, injury, or condition.

There was no statement which indicated that the patient was given information about his condition, although the opportunity appeared to exist. This aspect of the need was unmet.

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met. An example was:

"You can lie down again now and let's see where this animal is. We'll use a little ether on the area around him and then lift his head out."

Need for health instruction. Although there was opportunity for giving health instruction, this was not pointed out by any statement. This aspect of the need was unmet.

Need for Personal Recognition

According to their particular applicability, data were sub-classified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. Although there was opportunity for team members to speak to the patient by name, no one did so. This aspect of the need was unmet.

Need for privacy when indicated. There was evidence that this aspect of the need was met. Privacy was given when the nurse closed the curtain after showing the patient to his cubicle and instructing him in how to prepare for the physician.

Need for a courteous approach. There was evidence that this aspect of the need was met. An example was:

"Can I help you?" (pleasant, interested)

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"Well, I'll say you were burned (some years ago); you must have been lucky at that." (smiling)

Need for Security

According to their particular applicability, data were sub-classified as follows:

1. Need for anticipated events to occur with reasonable sequence in time
2. Need for an awareness of being cared for.

Need for anticipated events to occur with reasonable sequence in time. Patient D was in the emergency department thirty minutes, during which he was attended six minutes and unattended twenty-four minutes. In addition he spent ten minutes in the admission office. During one continuous twenty-two minute period of time he was waiting for care, without explanation of the reason. Since he was attended only 20 percent of the time and was unattended 80 percent of the time, essentially without explanation, this aspect of the need was considered unmet.

Need for an awareness of being cared for. There was evidence that this aspect of the need was unmet. One aspect of the need for knowledge and three aspects of the need for personal recognition were met, while the need for anticipated events to occur with reasonable sequence in time was unmet. In addition, the patient stated:

"Boy, I didn't know how long it was going to be and I couldn't lay on that hard table any longer. I thought maybe you forgot about me."

In the care given Patient D, the data indicated that the need for personal recognition was met, but that the needs for knowledge and security were unmet.

Patient E

This forty-three year old woman was admitted during 7:00 a.m. to 3:30 p.m. tour of duty, complaining of pain in her abdomen. She spent five hours in the emergency department.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from

the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedures
4. Need for health instruction

Need to know the name of the team member who cared for him.

There was evidence that this aspect of the need was met. An example was:

"I'm Dr. _____, the surgical resident."

Need for information about his illness, injury, or condition.

There was evidence that this aspect of the need was met. An example was:

"Well, it sure sounds like you might have appendicitis. I'm sure something is going on down there. It could be a ruptured ovarian cyst but more likely is an appendix."

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met. An example was:

"This is your surgery permit we'd like to have you sign--for permission to operate. You can sign right here. Your legal name. Good."

Need for health instruction. Although there was opportunity to give health instruction, this was not pointed out. This aspect of the need was unmet.

Need for Personal Recognition

According to their particular applicability, data were sub-classified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. The patient was spoken to by name. This aspect of the need was met.

Need for privacy when indicated. This aspect was not pointed out by any statement; however, the patient was given privacy when the curtain was pulled before she changed clothing. This aspect of the need was met.

Need for a courteous approach. There was evidence that this aspect of the need was met. An example was:

"Is someone helping you?" (pleasant manner)

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"You were! (born in Iowa) Well, I'm an old Hawkeye myself. Where are you from?" (very pleasant, sincerely interested)

Need for Security

According to their particular applicability, data were sub-classified as follows:

1. Need for anticipated events to occur with reasonable sequence in time

2. Need for an awareness of being cared for

Need for anticipated events to occur with reasonable sequence in time. Patient E was in the emergency department five hours, during which she was attended fifty-six minutes and unattended three hours and forty-four minutes. The three longest periods of time spent waiting without explanation were thirty-eight minutes, one hour and twenty-nine minutes, and one hour and five minutes. Since she was attended only 19 percent of the time and was unattended 81 percent of the time, essentially without explanation, this aspect of the need was considered unmet.

Need for an awareness of being cared for. This aspect was not pointed out by any statement. Three aspects of the need for knowledge and four aspects of the need for personal recognition were met. The need for anticipated events to occur with reasonable sequence in time was unmet. Since it was believed the need for knowledge and the need for personal recognition were met, and which contributed to the awareness of being cared for, this aspect of the need was met.

In the care given Patient E, the data indicated that the needs for knowledge, personal recognition, and security were met.

Patient F

This fifty-two year old man, who was admitted during 3:00 to 11:30 p.m. tour of duty, had a laceration over his right eye. He spent two hours and forty-five minutes in the emergency department. In addition, five minutes were spent outside the department with

policemen.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedures
4. Need for health instruction

Need to know the name of the team member who cared for him.

Although there was opportunity for team members to introduce themselves to the patient, no one did so. This aspect of the need was unmet.

Need for information about his illness, injury, or condition.

There was evidence that this aspect of the need was met. An example was:

"Looks like it pretty much stopped bleeding. Got a good sized goose egg there."

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met.

An example was:

"I want some pressure on there now so it will stop bleeding. You have to have some pressure and it has to stay clean."

Need for health instruction. Although there was opportunity to give health instruction, this was not pointed out. This aspect of the need was unmet.

Need for Personal Recognition

According to their particular applicability, data were sub-classified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. The patient was spoken to by name. This aspect of the need was met.

Need for privacy when indicated. The situation did not particularly indicate the need for privacy.

Need for a courteous approach. There was evidence that this aspect of the need was met. An example was:

"Hi. Let's see what you got here." (friendly tone)

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"Sure, bring him a glass of water."

Need for Security

According to their particular applicability, data were sub-classified as follows:

1. Need for anticipated events to occur with reasonable sequence in time

2. Need for an awareness of being cared for.

Need for anticipated events to occur with reasonable sequence in time. Patient F was in the emergency department two hours and forty-five minutes, during which he was attended one hour and twenty-three minutes, and unattended one hour and two minutes. The longest period of time spent waiting without explanation was fifty minutes. Since he was attended 57 percent of the time and was unattended 43 percent of the time, even though essentially without explanation, this aspect of the need was considered met.

Need for an awareness of being cared for. This aspect was not pointed out by any statement. Two aspects of the need for knowledge, four aspects of the need for personal recognition, and the need for anticipated events to occur with reasonable sequence in time, were met. Since these were believed to contribute to the awareness of being cared for, this aspect of the need was met.

In the care given Patient F, the data indicated that the needs for personal recognition and security were met, but the need for knowledge was unmet.

Patient G

This thirty year old woman was admitted during 7:00 a.m. to 3:30 p.m. tour of duty, complaining of pain in both ears. She spent two hours and ten minutes in the emergency department.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and

need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedures
4. Need for health instruction

Need to know the name of the team member who cared for him.

There was evidence that this aspect of the need was met. An example was:

" . . . I'm Dr. ____."

Need for information about his illness, injury, or condition.

There was evidence that this aspect of the need was met. An example was:

"Your lymph nodes here are a little larger than usual, which would indicate an infection up there."

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met. An example was:

"I think we'll give you some medicine here that will help clear up all the infection and you should be all right within

a couple days. The worst of it will have subsided. We'll give you a shot and some medicine to take at home."

Need for health instruction. Although there was opportunity to give health instruction, this was not indicated by any statement. This aspect of the need was unmet.

Need for Personal Recognition

According to their particular applicability, data were sub-classified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. Although there was opportunity for team members to speak to the patient by name, no one did so. This aspect of the need was unmet.

Need for privacy when indicated. The situation did not particularly indicate the need for privacy.

Need for a courteous approach. There was evidence that this aspect of the need was met. An example was:

"Hello there, I'm Dr. ____."

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"What's wrong with your back that you had to be off work for so long?"

Need for Security

According to their particular applicability, data were sub-classified as follows:

1. Need for anticipated events to occur with reasonable sequence in time

2. Need for an awareness of being cared for

Need for anticipated events to occur with reasonable sequence in time. Patient G was in the emergency department two hours and ten minutes, during which she was attended twenty minutes, and unattended one hour and fifty minutes. The longest period of time spent waiting without explanation was one hour and fourteen minutes. Since she was attended only 15 percent of the time, and unattended 85 percent of the time, essentially without explanation, this aspect of the need was considered unmet.

Need for an awareness of being cared for. This aspect was not pointed out by any statement. Three aspects of the need for knowledge, and three aspects of the need for personal recognition were met. The need for anticipated events to occur with reasonable sequence in time was unmet. Since knowledge and personal recognition were believed to contribute to an awareness of being cared for, this aspect of the need was considered met.

In the care given Patient G, the data indicated that the needs for knowledge, personal recognition, and security were met.

Patient H

This fifty-five year old man was admitted during 11:00 p.m. to 7:00 a.m. tour of duty, for removal of a wood splinter from his hand. He spent three hours in the emergency department.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and

need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedures
4. Need for health instruction

Need to know the name of the team member who cared for him.

Although there was opportunity for team members to introduce themselves to the patient, no one did so. This aspect of the need was unmet.

Need for information about his illness, injury, or condition.

There was evidence that this aspect of the need was met. An example was:

"Well, by tomorrow you could have had a bad hand with the start of a good infection."

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met. An example was:

"Now, I'm going to try to probe in here with this needle; if it hurts, you tell me and we can put in some anesthetic."
(probed in wound about fifteen minutes)

Need for health instruction. Although there was opportunity to give health instruction, this was not indicated by any statement. This aspect of the need was unmet.

Need for Personal Recognition

According to their particular applicability, data were sub-classified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members.

Need to be spoken to by name. The patient was spoken to by name. This aspect of the need was met.

Need for privacy when indicated. The situation did not particularly indicate the need for privacy.

Need for a courteous approach. There was evidence that this aspect of the need was met. An example was:

"Sure. Goodnight." (smiled, though appearing weary)

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"... what's the trouble with your hand? Tell me how you hurt it." (pleasant)

Need for Security

According to their particular applicability, data were sub-classified as follows:

1. Need for anticipated events to occur with reasonable
sequence in time

2. Need for an awareness of being cared for.

Need for anticipated events to occur with reasonable sequence in time. Patient H was in the emergency department three hours, during which he was attended one hour and twenty-three minutes, and unattended one hour and thirty-seven minutes. The longest period of time spent waiting without explanation was fifty-five minutes. Since he was attended only 46 percent of the time, and unattended 54 percent of the time, essentially without explanation, this aspect of the need was considered unmet.

Need for an awareness of being cared for. There was evidence that this aspect of the need was unmet. An example was:

"Say, I've been soaking my hand for a long time but the splinter doesn't seem to be moving and I wonder if someone should see it or if I can maybe go back to work? It might work itself out."

Two aspects of the need for knowledge and four aspects of the need for personal recognition were met. The need for anticipated events to occur with reasonable sequence in time was unmet. Although personal recognition was believed to contribute to an awareness of being cared for, this aspect was considered unmet.

In the care given Patient H, the data indicated that the need for personal recognition was met, but the needs for knowledge and security were unmet.

Patient I

This thirty-eight year old man was admitted during 3:00 p.m. to 11:30 p.m. tour of duty. He had an injured hand and wrist (fractured). He spent two hours and four minutes in the emergency department. In

addition, he spent one hour and twenty-three minutes in X-ray department.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedures
4. Need for health instruction

Need to know the name of the team member who cared for him.

Although there was opportunity for team members to introduce themselves to the patient, no one did so. This aspect of the need was unmet.

Need for information about his illness, injury, or condition.

There was evidence that this aspect of the need was met. An example was:

"Well, it looks okay; (pleasant) the bones are in good position." (after looking at X-ray)

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met. An example was:

"Now this is going to hurt, my friend, so try to bear with it. I'm going to pull on your finger and bend it down under."

Need for health instruction. Although there was opportunity to give health instruction, this was not pointed out. This aspect of the need was unmet.

Need for Personal Recognition

According to their particular applicability, data were subclassified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. The patient was spoken to by name. This aspect of the need was met.

Need for privacy when indicated. The situation did not particularly indicate the need for privacy.

Need for a courteous approach. There was evidence that this aspect of the need was met. An example was:

"Okay, bye." (pleasant)

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"What kind of work do you do?"

Need for Security

According to their particular applicability, data were sub-classified as follows:

1. Need for anticipated events to occur with reasonable sequence in time
2. Need for an awareness of being cared for

Need for anticipated events to occur with reasonable sequence in time. Patient I was in the emergency department two hours and four minutes, during which he was attended thirty-five minutes, and unattended one hour and twenty-nine minutes. In addition, he spent one hour and twenty-three minutes in X-ray department. The longest period of time spent waiting without explanation was forty-two minutes. Since he was attended only 28 percent of the time, and unattended 72 percent of the time, essentially without explanation, this aspect of the need was considered unmet.

Need for an awareness of being cared for. This aspect of the need was not pointed out by any statement. Two aspects of the need for knowledge, and four aspects of the need for personal recognition were met. The need for anticipated events to occur with reasonable sequence in time was unmet. Although personal recognition was believed to contribute to an awareness of being cared for, this aspect of the need was considered unmet.

In the care given Patient I, the data indicated that the need for personal recognition was met, but the needs for knowledge and security were unmet.

Patient J

This forty-three year old man, who was admitted during 3:00 to 11:30 p.m. tour of duty, complained of pain in an injured foot. He spent forty-five minutes in the emergency department.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedures
4. Need for health instruction

Need to know the name of the team member who cared for him.

Although there was opportunity for team members to introduce themselves to the patient, no one did so. This aspect of the need was unmet.

Need for information about his illness, injury, or condition.

There was evidence that this aspect of the need was met. An example was:

"No, I can't feel anything like that. (fractured bone) No, I think you have a bad strain or sprain but I feel sure you haven't any broken bones. I think we won't even X-ray it because if you did have a fracture since two o'clock and walking around, there would be more swelling and some discoloration.

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met.

An example was:

"Well, it will help protect the tissues. (elastic bandage) When you get home, you stay off it and do what I told you. Then see your doctor tonight or first thing in the morning."

Need for health instruction. There was evidence that this aspect of the need was met. An example was:

"No, this is wrong. For twelve hours you have to use cold to keep it from bleeding and swelling inside; then, that's about the end of the swelling and it starts to go down. Then is when you use warm water and hot packs to help speed up the process to relieve swelling."

Need for Personal Recognition

According to their particular applicability, data were subclassified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. Although there was opportunity for team members to speak to the patient by name, no one did so. This aspect of the need was unmet.

Need for privacy when indicated. The situation did not particularly indicate the need for privacy.

Need for a courteous approach. There was evidence that this

aspect of the need was met. An example was:

"Well, what happened to you?" (smiled)

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"I'm sorry it took so long to see you, but you're a city-county employee and you can understand what we're up against. We've got people bleeding who need to be taken care of immediately and it's kind of a rough situation."

Need for Security

According to their particular applicability, data were subclassified as follows:

1. Need for anticipated events to occur with reasonable sequence in time
2. Need for an awareness of being cared for.

Need for anticipated events to occur with reasonable sequence in time. Patient J was in the emergency department forty-five minutes, during which he was attended eighteen minutes and unattended twenty-seven minutes. The longest period of time spent waiting, without explanation, was twenty minutes. Since he was attended only 40 percent of the time, and unattended 60 percent of the time, essentially without explanation, this aspect of the need was considered unmet.

Need for an awareness of being cared for. There was evidence that this aspect of the need was unmet. An example was:

(patient yelled at HA passing doorway) "Hey, when am I going to get taken care of? I just been sittin' here waitin'. God, you could die in here an' nobody'd even know it or care." (loud voice)

Although three aspects of the need for knowledge and three aspects of

the need for personal recognition were met, the need for anticipated events to occur with reasonable sequence in time was unmet. Since this aspect of the need for security was unmet, and the patient mentioned his lack of care, it was believed that this aspect of the need was unmet.

In the care given Patient J, the data indicated that the needs for knowledge and personal recognition were met, but that the need for security was unmet.

Patient K

This twenty-four year old man who was admitted during 7:00 a.m. to 3:30 p.m. tour of duty, had a deep stab wound in his left hand. He spent fifty minutes in the emergency department.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or

procedures

4. Need for health instruction

Need to know the name of the team member who cared for him.

Although there was opportunity for team members to introduce themselves to the patient, no one did so. This aspect of the need was unmet.

Need for information about his illness, injury, or condition.

There was evidence that this aspect of the need was met. An example was:

"Boy, you really got a good one (stab wound) down here. It's just a little place but must go almost all the way through your hand."

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met. An example was:

"Okay, you're all set. (dressing wound) I'm going to give you a tetanus booster for this. In about five days you come back and have this looked at. The sutures may come out then. Just stay here now--the nurse will be in."

Need for health instruction. Although there was opportunity to give health instruction, this was not indicated by any statement. This aspect of the need was unmet.

Need for Personal Recognition

According to their particular applicability, data were sub-classified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. Although there was opportunity for team members to speak to the patient by name, no one did so. This aspect of the need was unmet.

Need for privacy when indicated. The situation did not particularly indicate the need for privacy.

Need for a courteous approach. There was no statement which pointed to this aspect of the need. This aspect of the need was unmet.

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"No more playing darts with your pocket knife, huh?"
(smiled)

Need for Security

According to their particular applicability, data were subclassified as follows:

1. Need for anticipated events to occur with reasonable sequence in time
2. Need for an awareness of being cared for

Need for anticipated events to occur with reasonable sequence in time. Patient K was in the emergency department fifty minutes, during which he was attended forty minutes and unattended ten minutes. The longest period of time spent waiting without explanation, was ten minutes. Since he was attended 80 percent of the time and unattended only 20 percent of the time, even though without explanation, this aspect of the need was considered met.

Need for an awareness of being cared for. There was evidence that this aspect of the need was unmet. An example was:

"Hey, I'm bleedin' to death, doc--I'm just gonna bleed to death an' die. Somebody do something!" (very frightened)

Only two aspects of the need for knowledge and two aspects of the need for personal recognition were met. Although the need for anticipated events to occur with reasonable sequence in time was believed to have contributed to an awareness of being cared for, this aspect of the need was considered unmet.

In the care given Patient K, the data indicated that the need for security was met, but the needs for knowledge and personal recognition were unmet.

Patient L

This twenty-four year old woman who was admitted during 11:00 p.m. to 7:00 a.m. tour of duty, had rather severe head and nose lacerations. She spent one hour and forty-five minutes in the emergency department.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were subclassified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedures
4. Need for health instruction

Need to know the name of the team member who cared for him.

Although there was opportunity for team members to introduce themselves to the patient, no one did so. This aspect of the need was unmet.

Need for information about his illness, injury, or condition.

There was evidence that this aspect of the need was met. An example was:

"These cuts are very close to your eye and you should see him (private doctor) to be sure everything is all right."

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met. An example was:

"Now, I'm going to inject something around the cuts to make it numb---this will hurt a little."

Need for health instruction. Although there was opportunity to give health instruction, this was not pointed out. This aspect of the need was unmet.

Need for Personal Recognition

According to their particular applicability, data were sub-classified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. Although there was opportunity for team members to speak to the patient by name, no one did so. This aspect of the need was unmet.

Need for privacy when indicated. The situation did not particularly indicate the need for privacy.

Need for a courteous approach. There was evidence that this aspect of the need was met. An example was:

"Hi--let's take a look at you."

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"Let's just pull your sleeve down here and we won't have to take off your robe. Hmmm--you got some nasty cuts there--next time you'll have to duck faster." (laughed)

Need for Security

According to their particular applicability, data were sub-classified as follows:

1. Need for anticipated events to occur with reasonable
sequence in time
2. Need for an awareness of being cared for

Need for anticipated events to occur with reasonable sequence in time. Patient L was in the emergency department one hour and forty-five minutes, during which she was attended fifty-one minutes and unattended fifty-four minutes. The longest period of time spent waiting without explanation was ten minutes. There was a forty-three minute period of time during which she waited for an available room where her suturing could be done; however, this delay was explained to her in advance. Since she was attended only 49 percent of the time and was unattended 51 percent of the time, even though the delay was explained, this aspect of the need was considered unmet.

Need for an awareness of being cared for. This aspect of the need was not pointed out by any statement. Two aspects of the need for knowledge, and three aspects of the need for personal recognition were met. The need for anticipated events to occur with reasonable sequence in time was unmet. Although personal recognition was believed to have contributed to an awareness of being cared for, this aspect of the need was considered unmet.

In the care given Patient L, the data indicated that the need for personal recognition was met, but the needs for knowledge and security were unmet.

Patient M

This fifty-four year old woman who had diabetes was admitted during 7:00 a.m. to 3:30 p.m. tour of duty, complaining of nausea and vomiting. She spent four hours and thirty-seven minutes in the emergency department.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedures
4. Need for health instruction

Need to know the name of the team member who cared for him.

Although there was opportunity for team members to introduce themselves to the patient, no one did so. This aspect of the need was unmet.

Need for information about his illness, injury, or condition.

There was evidence that this aspect of the need was met. An example was:

"Well, you've got too much sugar in your system now (520 mg. percent) so we're going to give you some insulin to help bring it down. (pleasant) I think you'll feel better then."

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met. An example was:

"No, better not now (have a drink of water); it would probably come back up, too. You're getting water in this bottle. Pretty soon you won't feel quite so dry. We want to get a urine specimen, too, to see if you have any sugar in it."

Need for health instruction. Although there was opportunity to give health instruction, no statement pointed to this aspect of the need. This aspect of the need was considered unmet.

Need for Personal Recognition

According to their particular applicability, data were sub-classified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. The patient was spoken to by name. This aspect of the need was met.

Need for privacy when indicated. Although there was a need for privacy, this was not indicated by any statement or action noted in the conversation. This aspect of the need was unmet.

Need for a courteous approach. There was evidence that this aspect of the need was unmet. An example was:

"What's the trouble?" (very unconcerned)

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"Tell me about your trouble." (pleasant)

Need for Security

According to their particular applicability, data were sub-classified as follows:

1. Need for anticipated events to occur with reasonable sequence in time
2. Need for an awareness of being cared for

Need for anticipated events to occur with reasonable sequence in time. Patient M was in the emergency department four hours and thirty-seven minutes, during which she was attended fifty-six minutes, and unattended three hours and forty-one minutes. There were many periods of time during which she was waiting without explanation for the reason--the longest was forty-nine minutes. Since she was attended only 20 percent of the time and was unattended 80 percent, essentially without explanation, this aspect of the need was considered unmet.

Need for an awareness of being cared for. This aspect of the need was not pointed out by any statement. Only two aspects of the need for knowledge and two aspects of the need for personal recognition were met. The need for anticipated events to occur with reasonable sequence in time was unmet. Since none of the above needs was essentially met, this aspect of the need was considered unmet.

In the care given Patient M, the data indicated that the needs for knowledge, personal recognition, and security were unmet.

Patient N

This forty year old woman who was admitted during 11:00 p.m. to 7:00 a.m. tour of duty, had a back muscle injury as a result of

an automobile accident. She spent two hours and one minute in the emergency department.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedures
4. Need for health instruction

Need to know the name of the team member who cared for him.

There was evidence that this aspect of the need was met. An example was:

"I'm Dr. ____."

Need for information about his illness, injury, or condition.

There was evidence that this aspect of the need was met. An example was:

"Well, I think neurologically you're all right. This seems to be muscle injury producing your soreness. I feel quite sure that you have no nerve injury or damage to your spine. What you have is what we usually see with this type of accident--being hit from behind; that is, a bad flexion type injury. We're not used to being suddenly bent backward as we are to bending forward to pick up something. This makes the muscles try to stretch the other way and consequently they are sore and go into spasms."

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met. An example was:

". . .here's your medicine for pain. You can take it as he has ordered--one every four hours if you need it. Then I think he wants you to see your own doctor, too."

Need for health instruction. Although there was opportunity to give health instruction, this was not pointed out. This aspect of the need was unmet.

Need for Personal Recognition

According to their particular applicability, data were sub-classified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. The patient was spoken to by name. This aspect of the need was met.

Need for privacy when indicated. Although there was a need for privacy, no statement or action indicated that privacy was given. This aspect of the need was unmet.

Need for a courteous approach. There was evidence that this aspect of the need was met. An example was:

"You're welcome."

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"Tell me how you were hurt." (pleasant)

Need for Security

According to their particular applicability, data were sub-classified as follows:

1. Need for anticipated events to occur with reasonable sequence in time
2. Need for an awareness of being cared for

Need for anticipated events to occur with reasonable sequence in time. Patient N spent two hours and one minute in the emergency department, during which she was attended nineteen minutes, and unattended one hour and forty-two minutes. The longest period of time spent waiting without explanation was one hour and eight minutes. Since she was attended only 16 percent of the time and was unattended 84 percent of the time, essentially without explanation, this aspect of the need was considered unmet.

Need for an awareness of being cared for. There was evidence that this aspect of the need was unmet. An example was:

"Say, I've been sitting here for a long time. When will a doctor see me, do you know?"

Three aspects of the need for knowledge and three aspects of the need for personal recognition were met. The need for anticipated

events to occur with reasonable sequence in time was unmet. Although knowledge and personal recognition were believed to have contributed to security, this aspect of the need was considered unmet.

In the care given Patient N, the data indicated that the needs for knowledge and personal recognition were met, but the need for security was unmet.

Patient O

This eighteen year old girl who was admitted during 11:00 p.m. to 7:00 a.m. tour of duty, complained of a severe headache and dizziness after having inhaled carbon monoxide fumes. She spent one hour and thirty-four minutes in the emergency department. In addition, she spent five minutes with the admission officer.

Data obtained from the verbatim conversation were classified according to need for knowledge, need for personal recognition, and need for security. For the purpose of illustration, excerpts from the verbatim conversation are included. The complete list of verbatim statements grouped according to sub-classifications is found in Appendix B.

Need for Knowledge

According to their particular applicability, data were sub-classified as follows:

1. Need to know the name of the team member who cared for
him
2. Need for information about his illness, injury, or
condition

3. Need for information about his treatment, medicine, or procedures

4. Need for health instruction

Need to know the name of the team member who cared for him.

Although there was opportunity for team members to introduce themselves to the patient, no one did so. This aspect of the need was unmet.

Need for information about his illness, injury, or condition.

There was evidence that this aspect of the need was met. An example was:

"By morning you should feel fine." (pleasant)

Need for information about his treatment, medicine, or procedures. There was evidence that this aspect of the need was met. An example was:

"I think we'll give you a little oxygen for awhile. It will help your headache clear up faster and take away that pinkness in your cheeks and ears."

Need for health instruction. Although there was opportunity to give health instruction, this was not done. This aspect of the need was unmet.

Need for Personal Recognition

According to their particular applicability, data were subclassified as follows:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Need to be spoken to by name. The patient was spoken to by name. This aspect of the need was met.

Need for privacy when indicated. The situation did not particularly indicate the need for privacy.

Need for a courteous approach. There was evidence that this aspect of the need was met. An example was:

"Hi--what's the trouble?" (pleasant voice, smiling)

Need for concern or interest from team members. There was evidence that this aspect of the need was met. An example was:

"How did it happen?" (pleasant voice, smiling)

Need for Security

According to their particular applicability, data were sub-classified as follows:

1. Need for anticipated events to occur with reasonable sequence in time
2. Need for an awareness of being cared for

Need for anticipated events to occur with reasonable sequence in time. Patient O was in the emergency department one hour and thirty-four minutes, during which she was attended ten minutes and unattended one hour and twenty-four minutes. Although there was a waiting period of fifty-six minutes, the longest waiting period without explanation was twenty-three minutes. Since she was attended only 11 percent of the time and was unattended 89 percent of the time, this aspect of the need was considered unmet.

Need for an awareness of being cared for. This aspect of the need was not pointed out by any statement. Two aspects of the need

for knowledge and four aspects of the need for personal recognition were met. The need for anticipated events to occur with reasonable sequence in time was unmet. Although personal recognition was believed to have contributed to an awareness of being cared for, this aspect of the need was considered unmet.

In the care given Patient O, the data indicated that the need for personal recognition was met, but the needs for knowledge and security were unmet.

Analysis of Data Obtained From Verbatim Conversation of Fifteen Patients

Need for knowledge. There were four sub-classifications under this need.

1. Need to know the name of the team member who cared for him. Of the fifteen patients in the study, only three (one-fifth of the population) had this aspect met.

2. Need for information about his illness, injury, or condition. This aspect of the need was met for thirteen, or a majority, of the patients.

3. Need for information about his treatment, medicine, or procedures. This aspect of the need was met for the entire population of the study.

4. Need for health instruction. For only three of the patients (one-fifth of the population) were there definite statements which indicated this aspect of the need was met.

Need for personal recognition. There were four sub-classifications under this need.

1. Need to be spoken to by name. This aspect of the need was met for eight, or a little over one-half of the patients.

2. Need for privacy when indicated. Privacy was not a salient point for ten of the fifteen patients. Of the remaining five for whom privacy indeed was indicated, three had this aspect of the need met.

3. Need for a courteous approach. This aspect of the need was met for eleven, or a majority, of the patients.

4. Need for concern or interest from team members. The entire population of the study had this aspect of the need met.

Need for security. There were two sub-classifications under this need.

1. Need for anticipated events to occur with reasonable sequence in time. On the basis of time unattended, and explanation for delays in giving care to the patient, this aspect of the need was judged. If more than 50 percent of the patient's time was spent waiting for care, essentially without explanation for the delay, this aspect was believed to have been unmet. Of these fifteen patients, only three (one-fifth of the population) had this aspect met.

2. Need for an awareness of being cared for. Judgment of this aspect of the need was based upon two points: (1) the contribution made to an awareness of being cared for, by having his needs met for knowledge, personal recognition, and anticipated events to occur with reasonable sequence in time, and (2) a patient's statement

which indicated his awareness of not being cared for. Four patients (less than one-third) had this aspect met as a result of contributions made by needs for knowledge, personal recognition, and anticipated events to occur with reasonable sequence in time having been met. Five patients (one-third of the population) made statements which indicated their awareness of not being cared for.

Presentation, Analysis, and Interpretation of Data
for the Patients as a Group

Table III, page 103, presents the needs for knowledge, personal recognition, and security of fifteen patients in one emergency department according to whether these needs were met or unmet. Analysis of data from the individual records of verbatim conversation revealed that of the fifteen patients in this study, only one-third (five) had the need for knowledge met, the majority (twelve) had the need for personal recognition met, and one-third (five) had the need for security met.

Three of the patients, A, E, and G (one-fifth of the population), had all three needs met. None of the needs was met for two of the patients, C and M. Three of the patients, F, J, and N, had two of the three needs met. The remaining seven patients, B, D, H, I, K, L, and O, each had only one need met.

Three needs, or those for knowledge, personal recognition, and security, were believed to be inherent in all patient situations. The data indicated that for this group of patients in one hospital emergency department, the need for personal recognition was met twelve, or the most number of times. Needs for knowledge and

TABLE III

NEEDS FOR KNOWLEDGE, PERSONAL RECOGNITION, AND SECURITY
OF FIFTEEN PATIENTS IN ONE EMERGENCY DEPARTMENT
ACCORDING TO WHETHER THESE NEEDS
WERE MET OR UNMET

Patient	Need for Knowledge		Need for Personal Recognition		Need for Security	
	Met	Unmet	Met	Unmet	Met	Unmet
A	x		x		x	
B		x	x			x
C		x		x		x
D		x	x			x
E	x		x		x	
F		x	x		x	
G	x		x		x	
H		x	x			x
I		x	x			x
J	x		x			x
K		x		x	x	
L		x	x			x
M		x		x		x
N	x		x			x
O		x	x			x
Total	5	10	12	3	5	10

security each were met five times, or for five patients. Personal recognition was accredited with having been met the most number of times for patients because speaking to a patient by name, allowing him privacy, approaching him courteously, and showing concern or interest in him are the spontaneous, non-programmed considerations most readily granted strangers. It would seem the little thoughtful contributions to a person's existence are of inestimable value in recognizing him as an individual human being.

Knowledge, which embraces both information and understanding, is acquired due to the reception of facts that are necessary, desired, or useful. This is relatively more difficult to communicate. Although for many patients facts were given about the particular injury, illness, treatment, and medicine, many aspects of the need remained unmet because much was taken for granted. It is human nature to want to know the names of people with whom one deals, and even more significant when those people are giving some aspect of personal care. Not knowing the name of a person or persons who care for the patient promotes the feeling of being a stranger in a world that is new and often frightening. In addition, it would seem that in this particular institution, where many of the patients are indigent, the emergency department plays the role of the family physician, or perhaps the only knowledgeable exposure patients have to health teaching which would lead to a more healthy individual, functioning more productively. No opportunity, however remote, should be overlooked for commending patients on their good health practices, recommending practices which lead to better health, or

stimulating an awareness of the importance of good health to the individual. In part due to lack of meeting these two aspects of the need just mentioned, the need for knowledge was met in only one-third of the population.

The need for security was met in only one-third of the population, also. Many factors contributed to an individual's security. In this study it was determined that a part of security was based upon care being given the patient within what appeared to be a reasonable length of time. It was recognized that time has a way of appearing much longer to the individual who is waiting and to some extent is apprehensive about his condition and what will be done to help him. It was decided, however, that if he waited more than one-half of his entire period of time in the emergency department, essentially without explanation of the reason for delay, this aspect of the need for security was unmet. In addition, security was based upon an awareness of being cared for, which would have been created by having needs met for knowledge, personal recognition, and receiving care with reasonable progression in time. Finding himself in an uncomfortable and insecure situation, the patient became aware of being cared for, and thereby more secure, because someone recognized what it meant to be this person and met his needs for psychological comfort.

Summary

The problem of the study was to determine if the care given to a selected group of patients in the hospital emergency department was individualized. Data concerning the age; sex; tour of duty

during which admitted; total time spent in the emergency department, both attended and unattended by team members; time spent in other departments of the hospital; and the verbatim conversation were presented and analyzed.

The population consisted of fifteen patients, seven male and eight female, ranging between the ages of eighteen and sixty-six years. The data indicated that the population was almost equally distributed between male and female patients who were predominantly middle-aged. Five patients were admitted during each of the three hospital tours of duty, i.e., between 7:00 a.m. and 3:30 p.m., 3:00 p.m. and 11:30 p.m., and between 11:00 p.m. and 7:00 a.m.

The duration of time spent by each patient in the emergency department varied from twenty minutes to five hours. Five patients spent an additional amount of time, ranging from five minutes to one hour and twenty-three minutes in another department of the hospital; e.g., X-ray. The data indicated that for this group of patients in one hospital emergency department, the average duration of time was two hours and four minutes. The average time attended by emergency department team members was thirty-five minutes, or 28 percent of the patient's total time in the department. Unattended or waiting alone for some aspect of care, the average time was one hour and twenty-nine minutes, or 72 percent of the patient's total time. For this group of patients the data revealed that patients were attended by the staff a little more than one-fourth of the total time. During the remaining time, or a little less than three-fourths of the total time, they were unattended or waiting for care.

Inherent in all patient care situations three needs were believed to exist: (1) need for knowledge, (2) need for personal recognition, and (3) need for security. If patient care was to be considered individualized, it was established that these three needs must be met. In order to determine if the care given was individualized, it was requisite to determine if the care given met these criteria. For analysis of verbatim conversation from the observation records, three main classifications were established. These were:

1. Need for knowledge
2. Need for personal recognition
3. Need for security

To facilitate classification and analysis of data sub-classifications were established for a more delimited reference to the main classification. Under the classification need for knowledge, were the sub-classifications:

1. Need to know the name of the team member who cared for him
2. Need for information about his illness, injury, or condition
3. Need for information about his treatment, medicine, or procedures
4. Need for health instruction

Under the classification need for personal recognition, were the sub-classifications:

1. Need to be spoken to by name
2. Need for privacy when indicated
3. Need for a courteous approach
4. Need for concern or interest from team members

Under the classification need for security were the sub-classifications:

1. Need for anticipated events to occur with reasonable sequence in time
2. Need for an awareness of being cared for

There were four aspects under the need for knowledge, four under the need for personal recognition, and two under the need for security. If three of the four aspects under need for knowledge, three aspects under need for personal recognition, and one of the two aspects under need for security were met, each of the three needs for knowledge, personal recognition, and security was considered to have been met. The analysis of data revealed that under the need for knowledge, the aspects of need for information about his illness, injury, or condition, and need for information about his treatment, medicine, or procedures each were met in thirteen or more of the patients. The majority had these two aspects of the need met. The aspects of need to know the name of the team member who cared for him, and need for health instruction each were met in only three of the fifteen patients, or one-fifth of the population.

The analysis of data revealed that under the need for personal recognition, the aspect of need for concern or interest from team

members was met in the entire population. Eight or more of the patients had the aspects of need to be spoken to by name, and need for a courteous approach met. Three of the five patients for whom the need for privacy was indicated, had this aspect met; for the remaining ten patients privacy was not a requisite, although it was considered a courtesy which might be given all patients as opportunity permitted.

Under the need for security, data indicated that of the fifteen patients in the study, only three (one-fifth of the population) had the aspect of need for anticipated events to occur with reasonable sequence in time met. Twelve of the fifteen patients were attended less than 50 percent of their total time in the emergency department. The aspect of the need for an awareness of being cared for was met in four patients as a result of contributions made to this aspect by needs for knowledge, personal recognition, and anticipated events to occur with reasonable sequence in time having been met. Five patients (one-third of the population) made statements which indicated their awareness of not being cared for.

Analysis of data relative to the fifteen patients as a group revealed that only three patients (one-fifth of the population) had all three needs met.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary of the Study

The problem of this study was to determine if the care given to a selected group of patients in the hospital emergency department was individualized.

The purposes of the study were: (1) to establish criteria by which it could be determined if patient care was individualized, (2) to utilize the criteria to determine if the care given to a selected group of patients was individualized, and (3) to provide data which could serve as a basis for evaluating patient care in the emergency department.

A review of literature revealed there was agreement among individuals in the health professions that research effort should be focused on patient care, with emphasis placed upon psychological aspects of this care. It was further indicated that in the emergency department, in part because of its significant role in creating impressions of the hospital, patient care might be improved by learning what patients really need in terms of human support. Where stress was a significant factor in the patient's experience, how things were done appeared to be far more important to him than what was done.

The descriptive method of research was used in the study. The technique for gathering data was nonparticipant observation. Designed for use as the data-gathering tool was the observation record form. On it was provided space for recording data from the patient's clinical chart and for recording verbatim conversation during the observation period. The population consisted of fifteen patients, selected according to established criteria, admitted to the emergency department in one metropolitan, city-county, 425-bed general hospital in the Rocky Mountain area.

Selected literature from the behavioral sciences was reviewed to determine the concepts of human behavior which might apply to effective identification of individualized patient care. From these concepts criteria were established delimiting three fundamental needs of human beings, which could be termed psychological, or those supporting the patient's autonomous personality or sense of individuality. These were: (1) need for knowledge, (2) need for personal recognition, and (3) need for security. Using these criteria, classifications were established for analysis of verbatim conversation from the observation record. The main classifications were: (1) need for knowledge, (2) need for personal recognition, and (3) need for security. Sub-classifications were established to delimit references and to reflect needs under the main classifications. Need for knowledge sub-classifications were: (1) need to know the name of the team member who cared for him, (2) need for information about his illness, injury, or condition, (3) need for information about his treatment, medicine, or procedures, and (4) need for health instruction. Need for personal recognition sub-classifications were:

(1) need to be spoken to by name, (2) need for privacy when indicated, (3) need for a courteous approach, and (4) need for concern or interest from team members. Need for security sub-classifications were: (1) need for anticipated events to occur with reasonable sequence in time, and (2) need for an awareness of being cared for.

An analysis of the data gathered in the study revealed that one-fifth of the population (three) had all three needs met. None of the needs was met for two of the patients, while three patients had two of the three needs met. The remaining seven patients each had only one need met. The need for personal recognition was met for the greatest number of patients, or four-fifths (twelve) of the study population. The needs for knowledge and security each were met for one-third (five) of the population. These data indicated that for this group of patients the average duration of time spent in the emergency department was two hours and four minutes. The average time attended by team members was thirty-five minutes or 28 percent of the patient's total time. The average unattended time, waiting for some aspect of care, was one hour and twenty-nine minutes, or 72 percent of the patient's total time. The patients in this study, then, were attended by the staff a little more than one-fourth of the total time. During the remaining time, or a little less than three-fourths of the total time, they were unattended or waiting for care.

Conclusions Drawn

The following conclusions were drawn as a result of this study:

1. The focus of individualized patient care is on actions of team members which meet or fail to meet needs of the patient independent of his particular physiological condition.

2. Since it was established that the needs for knowledge, personal recognition, and security were inherent in all patient care situations, then all three of these needs must be met in order for patient care to be individualized.

3. Since of this group of fifteen patients only one-fifth (three) had all three of the needs met, it was concluded that care given to this group of patients in one hospital emergency department was not individualized.

4. Technical knowledge and proficiency of team members are indispensable in care of the patient; however, the more complex behavioral aspects of caring about the patient are equally exigent if individualization is to be achieved.

5. Since they are based on a small sample, the findings of this study can be offered only tentatively, but they certainly suggest that the patient is not given individualized care which meets his psychological needs, exclusive of whatever his physiological and sociological needs might be.

6. Behind each oversimplified aspect of patient care is an enormously complex set of influences, many of which were not considered in this study.

7. The technique for gathering data in this study is effective only in the embryonic stage of investigation into patients' needs and behavior.

8. This study is considered only a preliminary approach to one which might prove far greater in significance.

Recommendations for Further Investigation

On the basis of the data obtained in this study, it is recommended that:

1. The effectiveness of patient care be evaluated, utilizing a similar classification of psychological needs, but a different data-gathering tool, as a basis for planning patient care in the emergency department.

2. More extensive studies be made concerning psychological needs, to secure quantitative and qualitative data from a wider sampling of patients in the emergency department.

3. The data revealed by this study be utilized as a basis for planning inservice education concerning patient care in the emergency department.

4. A nursing care plan be considered for use in the emergency department to provide a means for giving individualized patient care, directing team efforts toward a common goal, providing continuity of care, and evaluating patient care given.

It is further recommended that:

1. A study be made to determine the disparity between the kind of care persons in the health professions believe they are

giving and the kind of care patients believe they are receiving or should receive.

2. A greater number of learning experiences be provided in the clinical situation for students in the health professions to develop increased understanding of human behavior and better interpersonal relationship skills for meeting emotional or psychological needs of patients.

3. A study be made to identify the more complex, aggregate pattern of patients' physiological, psychological, and sociological needs.

4. Since empirical research has demonstrated human behavior to be observable, predictable, and measurable, nursing studies be made in order to devise measures of patients' behavior and inner experience.

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APPENDIX A

OBSERVATION RECORD

Patient's name _____

Hospital number _____

Sex _____ Age _____ Date _____

Admission time _____

Dismissal time _____

Duration in emergency department _____ minutes

1. attended _____ minutes

2. unattended _____ minutes

Duration in other department _____ minutes

Key to Abbreviations	DR	Physician (Doctor)
	RN	Professional Registered Nurse
	PN	Licensed Practical Nurse
	HA	Hospital Aide
	PT	Patient
	SR	Surgical Resident Physician
	OR	Orthopedic Resident Physician

OBSERVATION

APPENDIX B

STATEMENTS EXCERPTED FROM VERBATIM CONVERSATION OF FIFTEEN PATIENTS

1. Need for Knowledge
2. Need for Personal Recognition
3. Need for Security

1. Need for Knowledge

Need to know the name of the team member who cared for him.

Patients A, B, C, D

None

Patient E

DR: Hi. I'm Dr. _____.

SR: I'm Dr. _____, the surgical resident.

Patient F

None

Patient G

DR: . . . I'm Dr. _____.

Patients H, I, J, K, L, M

None

Patient N

DR: I'm Dr. _____.

Patient O

None

Need for information about his illness, injury, or condition.

Patient A

DR: Your chest sounds clear; I don't hear anything there at all.

DR: You don't have any evidence of pneumonia; it sounds good.
What you have is a bronchitis; your coughing just makes it
sore down there.

DR: You don't have to worry about this turning into TB--that
just won't happen.

DR: I think it's just a bronchitis . . .

DR: But you don't have any bugs down there so penicillin won't do any good.

Patient B

DR: I just looked at your X-ray and it looks like there might be something in your chest--a little congestion.

DR: I think you've got a little congestion down there from the looks of your picture.

Patients C and D

None

Patient E

DR: Looks like you might have a little Bartholin cyst there.

SR: Well, it sure sounds like you might have appendicitis. I'm sure something is going on down there. It could be a ruptured ovarian cyst but more likely is an appendix.

SR: I'm sure it must be an appendix but something is going on down there and we should see.

Patient F

HA: You better believe there's a bump there--now just lay down here and stay there.

DR: Looks like it pretty much stopped bleeding. Got a good sized goose egg there.

DR: You're doing fine . . .

DR: I keep finding new cuts to sew up that I couldn't see before; (to HA) see, there, that's a jagged one that didn't show up before.

Patient G

DR: Well, you have a little fever.

DR: That one (ear) looks good; I don't see anything there. Hmm--this right one looks a little red and like there might be a little pressure inside.

DR: Um-hmm, your throat is red too.

DR: Your lymph nodes here are a little larger than usual which would indicate an infection up there.

DR: Um-hmm, there is pus in these two (wounds); they're red and a little infected.

DR: Um-hmm. Let me just feel under your arms here--(pause)-- You do have a little lymph involvement here, too, from your infection. I think it is possible--quite probable--that your upper respiratory infection is caused from your back; that is, the infection in these wounds probably was the source of infection for your ear.

Patient H

DR: Yeah, I think I feel it here. (splinter)

DR: Well, by tomorrow you could have had a bad hand with the start of a good infection.

Patient I

DR: (after examination) Yeah, it could very well be (fractured) with that swelling.

DR: Well, you sure do have a fracture. In fact, one bone is broken here in your hand and in your wrist--does this hurt at all up here? Bend your wrist for me--doesn't hurt at all here? Well, it sure is broken but not so bad as the one down here in your hand. I'm surprised there isn't more swelling here--guess it all went down in your hand.

DR: You're not going to be able to use that hand for awhile.

DR: Well, it looks okay; (pleasant) the bones are in good position. (after looking at X-ray)

Patient J

DR: No, I can't feel anything like that. (fractured bone) No, I think you have a bad strain or sprain but I feel sure you haven't any broken bones. I think we won't even X-ray it because if you did have a fracture since two o'clock and walking around, there would be more swelling and some discoloration.

Patient K

DR: (applying tourniquets) You're not going to bleed to death. Just lie down and take it easy.

RN: No, you're not going to die. Just try to hold your hand still here where the doctor wants it.

RN: I know it (hand getting numb) but it won't stop bleeding if you keep moving it away.

DR: Boy, you really got a good one down here (stab wound). It's just a little place but must go almost all the way through your hand.

Patient L

HA: Let's see how bad it is. Hmm--yeah, you'll need several stitches; that's a bad one on your nose.

DR: Hmmm--got several places to sew up.

DR: That's a nasty one there but I think it should heal all right.

DR: Say, there's a little cut down under your chin too. Think we'll put a butterfly over that--doesn't look big enough or deep enough to need a stitch.

DR: These cuts are very close to your eye and you should see him (private doctor) to be sure everything is all right.

Patient M

DR: Well, it looks like more than that to me, the way you're lying there. This stuff you vomited doesn't look very normal either. Looks like it might have some blood in it too.

DR: Well, it (emesis) has blood in it, that's why I wondered.

DR: Well, you've got too much sugar in your system now (520 mg. percent) so we're going to give you some insulin to help bring it down. (pleasant) I think you'll feel better then.

DR: (to family in patient's presence) Well, it seems serious enough. (pleasant, courteous) Her blood sugar is way up, she hasn't had enough insulin to cover it, and she can't eat right now, besides vomiting blood. It seems like she needs some help to get straightened out and see if the bleeding in her stomach stops.

DR: But she isn't in any condition to go home now. Maybe she can in a day or two. But her diabetes is way out of control now. They'll take her to the ward here in a few minutes. She'll be all right.

Patient N

DR: Yes, that's what happens to people struck from behind.

DR: Let me see your hands--both sides. Doesn't look like anything there. Now stand up here. I'm going to stick you

with this pin; you tell me if it feels sharp everywhere.
Can feel it everywhere, hmmm? (pleasant)

DR: Well, I think neurologically you're all right. This seems to be muscle injury producing your soreness. I feel quite sure that you have no nerve injury or damage to your spine. What you have is what we usually see with this type of accident--being hit from behind; that is a bad flexion type injury. We're not used to being suddenly bent backward as we are to bending forward to pick up something. This makes the muscles try to stretch the other way and consequently they are sore and go into spasms.

DR: I'm sure you can. (feel her back hurt all over) And this will stay with you for awhile too.

Patient O

RN: Yeah, you're both (patient and friend) kinda pink clear down to your neck. (pleasant) Okay, you just rest for a little while.

DR: By morning you should feel fine. (pleasant)

Need for information about his treatment, medicine, or procedures.

Patient A

HA: The doctor will be back in a minute. (pleasant)

DR: I'll give you some medicine to stop your cough since you say you don't cough up much, and that'll let your chest rest and let the sore areas heal.

DR: You can get dressed now and I'll write a prescription for you.

DR: Now you take this prescription down to the pharmacy downstairs and they'll fix you up. You take the medicine just the way it says on the bottle; the directions will be there. (pleasantly, informative, smiling)

HA: You can come back here with me. You sit down here and stick this thermometer under your tongue. (pleasant)

Patient B

RN: Come down here. (looked at patient's chart; left station with chart and thermometer) Take everything off on top down to your waist. Put this gown on and hold this under your tongue. (very much matter of fact)

DR: Well, I think we'll get another picture of your chest and see what that looks like. We'll send you to X-ray in a little bit. (pleasant but not smiling)

HA: Put this gown on and then stand here outside the curtain and wait for me. We're going to X-ray as soon as I round up a couple other people. (matter of fact)

DR: Let me listen to your chest again.

DR: The nurse will give you a shot of penicillin tonight and I want you to come back every day for five days to get another shot and I think that'll do it then.

DR: The nurse will be back in a minute with your shot.

RN: The doctor wants you to spit in this bottle so we can have a sputum specimen. I'll be back in a minute.

RN: This will have to go in your hip. Now you wait for ten minutes to see that you don't have a reaction from the shot, and then you can go. (hurriedly, matter of fact)

Patient C

HA: (picked up thermometer, walked out of station) Come with me. (very routine, no expression of interest) You sit down on that chair, take off your shoes and socks and put your feet up here (pulled chair over), and hold this thermometer under your tongue.

DR: Good. (smiling) I'm going to give you some medicine for your feet. I'll be back in a minute.

DR: Now here is what we'll have you do. I've got two prescriptions here and you can take them down to the pharmacy and get the medicine. You know about that?

DR: Now when you get home you wash your feet real good with lots of soap and warm water. Then sprinkle on the powder they'll give you; I don't know, it'll be in a can probably or in some kind of a container. Sprinkle it over the sore places all over your feet. (pleasant, spoke slowly and with emphasis) Put on clean white socks. Then tonight when you go to bed you wash your feet again with lots of soap and warm water. Then you put the ointment on your feet and toes and put on a pair of your old socks, but clean ones. Then in the morning when you get up you wash your feet again the same way, and this time put on powder again. Put on clean socks again then. This way you wash your feet three times a day and put on some of the medicine and a pair of clean socks.

DR: Now, this is three times a day and you use the ointment at night and the powder during the day. The ointment will be kind of fluffy and you just spread it all over the area. The socks will just keep the bed from getting greasy with the ointment. Okay? (pleasant)

Patient D

HA: Yeah, you go down this hall, turn left and go right past the ambulance entrance where you came in. There's a sign says admissions. They'll give you a chart. (matter of fact)

RN: You come back here with me; we'll find a place for you and get the tick out. (pleasant)

RN: Well, you lie down on the table and take your trousers down and the doctor will be in in a minute. (pleasant, curtain closed)

RN: You can lie down again now and let's see where this animal is. We'll use a little ether on the area around him and then lift his head out.

RN: We'll put this ether on it and then lift his head out like so. (smiling) There he is. That's all. We'll have the doctor look at it and then you can go.

DR: Okay, you can go then.

DR: No, that's all--nothing else. (to patient's question about what else he should do)

Patient E

PN: You can come down here. (led the way to an exam room-- pulled the curtains when inside) Take off all your clothes and hang them on that hook. Put this gown on and you can lay down on the table. (informative, matter of fact)

PN: Will you just stick this under your tongue.

DR: Can you sit up so I can listen to your chest. Okay, you can lie down.

DR: (smiling) Well, you hold your arm out here and we'll have the blood out in two shakes of a puppy dog's tail. Make a fist a couple times--good. There, that doesn't look so bad. Now, bend your arm up and hold the cotton there so the hole will close in a minute or two.

RN: We want to get a urine specimen from you. (very matter of fact)

- RN: Well, he wants it this way. (prepared tray for catheterization, beside patient) This will be cold--(pause)--have you ever been catheterized before?
- RN: Well, this won't hurt; you can relax. It won't hurt at all.
- PN: Okay, you want to get on your back? You can put your feet in here.
- SR: Well, I think we'll take you up and have a look inside; you should feel better then.
- SR: This is your surgery permit we'd like to have you sign--for permission to operate. You can sign right here. Your legal name. Good.
- SR: I'm going to start this I.V. in your arm so we can get a little fluid in you. (smiling) If you can hold your arm still I'd rather not restrain it since they'll be moving you on a cart. You'll feel a little stick.
- PN: Well, I think I have everything down here now. You can sign it right here. Are you right or left handed? I think we can hold it up here. Okay. You'll be going upstairs soon but you can rest now. (smiling, friendly manner)

Patient F

- HA: Here, hold this gauze over there instead of that and lay down here on the table.
- HA: The doctor'll come in and take care of you.
- DR: . . . you'll get an infection if we sew it up right in the hair.
- DR: Come on now, just let us get this cleaned up now so we can see where the bleeding is coming from and try and get some of the blood out of that bump there beside your eye. It'll heal much faster then.
- DR: I'm going to inject a little anesthetic to make it numb around here. No--just keep your hands down--this is all sterile up here where I have to work.
- DR: Okay, that's it--all finished. I thought I could aspirate some blood out of that bump but couldn't get anything.
- DR: (patient's arm went to sleep) Move it around a little and rub it. It's probably because you had it folded over your chest.

- DR: I want some pressure on there now so it will stop bleeding. You have to have some pressure and it has to stay clean.
- DR: Now you leave this bandage on and come back here in three days so we can look at it and see when to take out those stitches.
- DR: Well, I guess you've had the shots (tetanus) so you're probably not allergic to tetanus.
- DR: Well, the nurse will be in to give you a shot and an appointment slip to come back here so we can take a look at this. You wait right here.
- RN: Here's your slip to come back so they can look at your head. . . . Don't lose it. I'm going to give you a shot in your arm now. (pleasant)
- RN: (laughed, in response to statement they needed a whole army to hold him down for a shot) Well, we've got a whole gang. Okay, you're all set, you can get dressed.

Patient G

- DR: Well, I want to look in your ears here.
- DR: Well, I'd like to take a look at the wounds on your back for a minute. I'll have the nurse come in and help you. Just a minute.
- PN: Strip to the waist and put this on, tied in back. (no display of interest)
- DR: I think we'll give you some medicine here that will help clear up all the infection and you should be all right within a couple days. The worst of it will have subsided. We'll give you a shot and some medicine to take at home.
- DR: Well, the nurse will be in to give your injection and I will make out some prescriptions for you to have filled. Okay, you can get dressed now.
- RN: Here are your prescriptions and the directions will be on each one.
- RN: You'll get a shot in just a minute. (medicine not in stock on the unit--injection came one hour and fourteen minutes later)
- RN: Okay, here's your shot.
- RN: There you are. Okay, you can go now. Take your slips to the cashier downstairs.

HA: (patient just said her ears hurt, especially the right one) Okay. (took thermometer from cupboard, started toward a cubicle without further comment--patient followed--arrived at open cubicle, patient entered and turned around, thermometer was stuck in her mouth--HA pulled curtains closed and left)

Patient H

- HA: Come on down here. You can sit down here and someone will see you.
- HA: Which hand is it? Okay, you soak your whole hand in here until someone comes in to take a look at it.
- HA: Well, I'll see. (patient had been soaking hand one hour--asked if he could just go back to work--HA went out to check blackboard) You're next--it shouldn't be much longer. The doctor should see you--he'll be in soon I think.
- DR: Well, if it's in there it'll have to come out. By tomorrow it would be infected. Just a minute, I want to see where we can go where I can work better.
- DR: Come on down here to the suture room where we can see. Here's a mask for you to put on--everybody does in here, I guess.
- DR: Now just put your hand here and try to relax it then and don't move.
- DR: Now, I'm going to try to probe in here with this needle; if it hurts you tell me and we can put in some anesthetic. (probed about fifteen minutes)
- DR: Nope, can't get it; we'd better put in some Xylocaine and try to reach in there with a forcep.
- DR: Guess I'll have to make a little nick with a knife so I can find the end and get ahold of it.
- DR: I'll feel around a little more just to be sure we have it all. We can't X-ray something like this for a check because wood doesn't show on X-ray like metal splinters do--so that's no good. (few minutes passed) Now I think it'll take just one stitch to hold it together.
- DR: Let me check with the nurse to see if there's anything else. (left, returned almost immediately) One of the nurses will be here in a minute to tell you when to come back.
- DR: Well, okay, you can go. But come back about Monday so we can take a look at it and take out that stitch.

Patient I

HA: Okay, let's see if we can find a place for you. Here, sit here and the doctor will see you.

DR: We'll get an X-ray first to see if anything is broken in there and see where to go from here. They'll take you to X-ray here in a minute.

HA: Do you know where X-ray is? (no) Go out the double doors there, turn right, take the elevator up to second, turn left when you get off. Come back here when they're done. (matter of fact tone)

DR: We'll have to put a cast on your hand so it will heal right.

DR: You can come down here (cast room) and we'll get you fixed up. (put hand on patient's shoulder)

OR: (smiled) Well, my friend, let's give you a new hand here. Hop up on the table--we'll throw this sheet around you and try not to plaster you everywhere.

OR: Now this is going to hurt, my friend, so try to bear with it. I'm going to pull on your finger and bend it down under.

OR: (noticed felt on table--forgot to put it under the plaster) Oh, gees--I didn't put the damn thing on. Sure we have to use it; cut this damn plaster--we'll have to take it off. See, this doctor saved your life, sir. (smiled) You should have told me sooner. (cast reapplied to below elbow) There, that looks like a first class job--now if it's not too heavy, if he can just lift it.

OR: Okay, my friend, now we want to get another picture of this to be sure we didn't do you more harm than good. Tell you what, (hand on patient's shoulder) we have to get over to eat before they close so we'll send you to X-ray and we'll eat, then come back here and look at your picture. If it's okay, then you're all set to go. Come over here, let's wash off some of the extra plaster. (washed fingers) Okay, they'll bring in your X-ray slip and we'll be back to see you.

HA: Do you know where X-ray is? Okay, take this up there and then come back here.

DR: Now when you're up tonight keep the arm up, not hanging down at your side. When you're walking hold it up in front of you and when you're sitting put it up on a pillow just so it won't swell anymore and make the cast tight. The nurse will give you an appointment slip and you come back

in two weeks. We'll take a look at it then to see if everything is all right. Keep moving those other fingers and thumb--work them all the time but don't try to lift anything with that hand. Don't let the cast get wet or it will get soft and weak and won't keep the finger in position. Okay? (smiled) The nurse will bring your appointment slip in just a minute.

RN: Here's your slip, Mr. _____. Your appointment is for _____, so you come back and the doctor will see you then.

Patient J

RN: Okay, sit down in this wheelchair and--(interrupted)

RN: If you're going to come in here and be seen by the doctor, you're going to sit down in that chair and be taken care of. Now sit down. (now, an angry voice)

RN: Okay, you'll get taken care of, just take it easy. Did you stop by admission for your chart?

DR: (patient swearing--doctor walked past open doorway) Hey, fella--cut out that language; there are ladies here and you just stop that now. (angry)

RN: Okay, the doctor will be in to see you in a little bit.

HA: The doctors are all busy--they'll take care of you pretty soon. (matter of fact)

DR: (walking past doorway--spoken to by patient) Someone will see you as soon as possible; we're pretty busy here right now.

DR: I'm going to put on this elastic bandage and you go and see your doctor tonight or in the morning. Tuesday you come in to employee's clinic and get the compensation form here--they'll write your emergency care on it, and then you take it to your private doctor and he has to finish filling it out. Now, when you get home you put this foot up whenever you sit--at least straight with where you're sitting or a little higher. Also tonight when you get home put on an ice pack in a hot water bottle or plastic bag. Do this during the night and in the morning.

DR: Well, you use ice now and then the heat later. Now, stand up on the foot and see how it is. (with elastic bandage)

DR: Well, it will help protect the tissues. When you get home you stay off it and do what I told you. Then see your doctor tonight or first thing in the morning.

DR: Just put on your shoe for support and take it off when you get home. Okay, you're all set. You don't have any slips to take anywhere. But don't forget to come in Tuesday for the slip. You can go ahead and go now.

Patient K

DR: Bring him in here--put him up on the table--get me a tourniquet and a blood pressure cuff. God, it's just a little cut.

DR: Well, we'll stop the bleeding first.

DR: Well, there's only one solution. I'll have to extend the cut so I can get a suture inside over the blood vessel. Just keep holding his fingers down; maybe that hemostat will do some good.

DR: (finished placing one suture inside wound) By golly, that did it. Now I guess a couple outside should fix it up.

DR: Okay, you're all set. (dressing wound) I'm going to give you a tetanus booster for this. In about five days you come back back and have this looked at. The sutures may come out then. Just stay here now--the nurse will be in.

PN: Okay, fella, here's your shot. (smiled) Let's put it in the good arm.

PN: Okay, let's get your jacket on here so you can go home. The doctor is out talking to your wife. Now how about sitting over here until they come in to take you home. You're all set now.

Patient L

HA: Well, let's see, where shall we put her. We've got so many people to sew up already. I tell you, bring her back here and we'll find a place for her to wait until we can get her into the suture room. Here's a place--you lay down here and the doctor will see you pretty soon.

DR: (smiled) Well, you need a few stitches up there.

DR: Well, I'm going to see; I think the room is ready for you up here now--just a minute.

HA: Okay, you can sit here (wheelchair) and we'll take you up to the suture room. Here, just step on this chair and then down. Good. (pleasant)

HA: Okay, now step up on the foot stool and lay down with your head at this end.

- DR: Now, I'm going to inject something around the cuts to make it numb--this will hurt a little.
- DR: Well, if you've had it (tetanus) that's all right and I know you can take it then. I'm going to give you a tetanus booster here now. Will you be coming back here to have your stitches taken out or do you have a private doctor?
- DR: Good, then you be sure to see him (private doctor), or call for an appointment to see him about the middle of the week.
- DR: A couple aspirin every four hours or so should take care of your headache and the throbbing in your face. Now I've put a plastic coating over two of these areas where you have stitches. You can see the stitches but that's okay--it doesn't need a bandage because it is sealed by this coating. Leave the other bandage on your head and the little one under here until you see your doctor. Okay?
- DR: The nurse will be in to give you a shot so you just stay here on the table until she comes.

Patient M

- RN: Bring that wheelchair. Let her sit down. Will one of you (family) go around to get her chart. Leave her here just a minute (center of hallway) and we'll find a place for her.
- RN: Okay, let's put her to bed in there. (RN and PN assisted patient into bed--undressed her, put on hospital gown) Did you take too much insulin? (concerned, pleasant)
- RN: Okay, the doctor will see you in a little bit.
- DR: I'll be back in a little bit here. We'll want to get some blood and urine to test.
- RN: I'm going to stick you now, honey. The doctor wants some blood and wants you to have this I.V. Just hold your arm down--I'll try to stick you just once. (drew blood, connected intravenous tubing with needle--solution infiltrated into tissues almost immediately) Oh, darn, that makes me so mad--those darn plastic things--it happens every time.
- DR: No, better not now (have a drink of water); it would probably come back up too. You're getting water in this bottle. Pretty soon you won't feel quite so dry. We want to get a urine specimen too, to see if you have any sugar in it.
- RN: Here, honey, you sit on this and see if you can go. (urinate) (pleasant) (returned in nineteen minutes) Did you use the pan?

RN: No. You can't have anything (to drink) right now; maybe pretty soon you can have a little water but not now.

DR: Well, we're going to give you some insulin now and I think we better keep you here in the hospital and see if we can find out why you're bleeding. Maybe it's just from not having eaten for a long time and because you've been vomiting.

DR: Want to get a little more blood here--let's try this other arm. Make a fist now. Little stick. Now relax. Okay, that's all. I'll be back in a minute to give you some insulin. Then pretty soon they'll take you to the ward.

DR: Going to be a stick in your arm now. (patient asked if it was insulin) Yes. You're getting some in the I.V. up there and NPH in your arm.

Patient N

RN: Well, let's see--you can come in here and sit down. (very unconcerned, matter of fact) Take off your clothes and put on this gown. The doctor will be in to examine you.

HA: No, I don't know, (when the doctor would see her) there are a lot of people here. Pretty soon maybe. (not very pleasant, hurriedly)

DR: Well, I think the best thing would be for you to arrange to see him (private doctor) in the morning. He probably will want to check you over since he does follow your family's medical care. I'll give you some medicine--some tablets--to take for pain to hold you over until you can see him, and then I would do that tomorrow if I were you.

DR: I think just take a tablet for pain as you need it about every four hours and take it easy. Don't do anything strenuous. That's about all you can do for this type of thing. Sitting in a tub of warm water tonight probably would make you feel good. (pleasant) Well, the nurse will bring your medicine here in a minute.

RN: . . . here's your medicine for pain. You can take it as he has ordered--one every four hours if you need it. Then I think he wants you to see your own doctor too.

RN: You can go now.

Patient O

RN: You come down here--both of you. (led toward cubicle) Just have her lie down here on the table. You'll be all right in a few minutes. You can stay with her.

DR: I think we'll give you a little oxygen for awhile. It will help your headache clear up faster and take away that pinkness in your cheeks and ears. (then to RN): Give it to both of them for awhile.

RN: . . . I'm going to give you this mask over your face (very pleasant) and you'll just be breathing oxygen like you breathe air. There, that should be tight enough. (left cubicle--returned with another oxygen tank) And this is for you; even though you don't have a headache your ears are pretty red and even your neck. It will make you feel better soon. There. And--you're a mechanic--(smiled) you can turn off these two valves after about half an hour if you feel pretty good by then. Okay? Good.

DR: You sit up here on the edge of the bed for a couple minutes and then you can leave.

Need for health instruction

Patient A

DR: No, you know penicillin is for things like pneumonia where there are bugs.

DR: You know some people think penicillin will cure everything and want it for everything that's wrong, but it just doesn't work that way.

DR: Well, you know you only get TB if you're in contact with somebody who has it.

Patient B

None

Patient C

DR: Well, you leave off the bleach now, that might not be doing your feet any good. Just wash them real good with soap and water.

Patients D, E, F, G, H, I

None

Patient J

DR: No, this is wrong. For twelve hours you have to use cold to keep it from bleeding and swelling inside; then that's about the end of the swelling and it starts to go down. Then

is when you use warm water and hot packs to help speed up the process to relieve swelling.

Patients K, L, M, N, O

None

2. Need for Personal Recognition

Need to be spoken to by name

Patient A

None

Patient B

DR: Okay, Mr. ____ . . .

Patients C and D

None

Patient E

SR: (entered) Mrs. ____, I'm Dr. ____.

Patient F

DR: We can't do that, Mr. ____ . . .

DR: Now you'll feel this a little, Mr. ____.

DR: You're doing fine, Mr. _____. (smiled)

RN: . . . so they can look at your head, Mr. ____.

Patient G

None

Patient H

DR: Mr. ____, what's the trouble . . .

Patient I

RN: Here's your slip, Mr. ____.

HA: What did you want? (very matter of fact, no note of interest)

HA: Yeah, well have you been around to the admission office yet? (rather impatient)

Patient E

PN: Is someone helping you? (pleasant manner)

DR: Hi. I'm Dr. _____.

Patient F

HA: Yeah, you sure did. Come on down here.

DR: (friendly) Hi. Let's see what you got here.

Patient G

HA: What's the trouble? (nicely, but not smiling)

DR: Hello there, I'm Dr. _____.

Patient H

HA: (took patient's chart) It's about two inches long (splinter) and you can't even see it? (laughed) That must be some splinter.

DR: Sure. Goodnight. (smiled, though appearing weary)

Patient I

RN: Okay, bye. (pleasant)

HA: What's your trouble? (very gruff, almost indignant)

Patient J

RN: Well, what happened to you? (smiled)

Patient K

None

Patient L

HA: What happened? (pleasant, courteous)

DR: Hi--let's take a look at you.

PN: Okay then, bye now. (pleasant)

Patients J, K, L

None

Patient M

DR: Mrs. _____ . . .

Patient N

DR: You're Mrs. _____?

RN: Mrs. _____, here's your medicine . . .

Patient O

RN: Now, _____, I'm going to give you . . .

Need for privacy when indicated.

Patient A

DR: You take your dress and straps down and then just hold it under your arms. (stepped outside cubicle) Okay?

Patients B, C, D, E, F, G, H, I, J, K, L, M, N, O

None

Need for a courteous approach.

Patient A

HA: Can I help you? (pleasant, smiling)

Patient B

RN: What's your trouble? (not too pleasant)

Patient C

HA: What's your trouble? (abruptly, not pleasant or smiling)

Patient D

RN: Can I help you? (pleasant, interested)

RN: Bye. (smiling)

Patient M

RN: What's the trouble? (very unconcerned)

Patient N

RN: You're welcome.

Patient O

RN: Hi; what's the trouble? (pleasant voice, smiling)

Need for concern or interest from team members.

Patient A

DR: What have you been doing for your cold? (friendly, concerned voice)

DR: Mexican oil--what's that? (interested, surprised)

DR: Well, that's a new one on me; I never heard of that before.

Patient B

DR: (looked at chart) And you don't feel any better at all?

DR: It made you tired after you did that for a little while, hmm? (mowing lawn)

DR: Is anybody else sick at your house? (concerned manner)

DR: Did they tell you to come back when your medicine was gone?

Patient C

DR: Does anyone else in your family have the same thing?

DR: Did that help it?

DR: Do you wear socks in the summer? How often do you change them? How about at night? Can you wear clean ones every night?

Patient D

RN: My! what happened there? (interested tone) (patient had exposed tick on abdomen--entire abdomen and chest was extremely scarred and area was contracted)

RN: Well, I'll say you were burned; you must have been lucky at that. (smiling)

DR: Feel okay? (smiling, pleasant)

Patient E

DR: You been having a little trouble, I hear. Tell me about it. (very pleasant voice, smiling)

DR: You were! (where she was born) Well, I'm an old Hawkeye myself. Where are you from? (very pleasant, sincerely interested)

DR: I'm from _____. You're up in the northern part and I'm way down south.

SR: Hear you're having some trouble--can you tell me about it?

SR: You must really be dry not to have taken any water even. (smiling)

PN: Honey, is there anyone here with you? (friendly manner)

PN: Are these all the things you have with you?

PN: I'll count your money here so we don't lose any. Three dollars and sixty-four cents--does that sound right?

Patient F

HA: Did anyone come with you?

HA: What happened to you?

DR: Okay (concerned) (in response to patient's refusal to have on a certain type of bandage).

DR: Sure, bring him a glass of water.

Patient G

DR: Well, tell me about your ears. (pleasant manner, smiled)

DR: What's wrong with your back that you had to be off work for so long?

RN: Do you know where the pharmacy is?

Patient H

HA: How'dja do it? (seems interested)

HA: My gosh, don't imagine that feels so good. (smiled)

DR: . . . what's the trouble with your hand? Tell me how you hurt it. (pleasant)

DR: Tell me if I hurt you too much.

DR: There she is (splinter); does that look like about all of it?

DR: I know how hard it is for a working man to keep on a bandage and keep it clean. (smiled) I'll put on some gauze with adhesive now, and then you carry around some band-aids and change it whenever you need to, to keep it clean and dry.

Patient I

DR: Hi. (smiled) What happened to your hand?

DR: What kind of work do you do?

RN: Want to put your jacket on? (very pleasant manner)

Patient J

RN: How'd you hurt your foot?

DR: Okay, okay, take it easy.

DR: I'm sorry it took so long to see you, but you're a city-county employee and you can understand what we're up against. We've got people bleeding who need to be taken care of immediately and it's kind of a rough situation.

Patient K

DR: No more playing darts with your pocket knife, huh? (smiled)

PN: Take it easy now, huh? (helped patient on with jacket)

DR: How did you do this?

Patient L

DR: How did this happen? (pleasant, concerned)

DR: Does it hurt much? I'll bet.

DR: How do you feel now? (concerned voice)

PN: Let's just pull your sleeve down here and we won't have to take off your robe. Hmmm--you got some nasty cuts there--next time you'll have to duck faster. (laughed)

PN: There--now do you have a coat? (pleasant, helpful) There you are, all set.

PN: Can you make it all right now? (concerned, sincere)

PN: Shall we take you out to the ramp in a wheelchair? I can if you need it. (concerned voice)

Patient M

DR: Tell me about your trouble. (pleasant)

Patient N

DR: Tell me how you were hurt. (pleasant)

DR: I see. And what happened to you; where were you hurt?

Patient O

RN: How did it happen? (inhaling carbon monoxide fumes)
(pleasant, concerned voice)

DR: How do you feel now?

3. Need for Security

Need for anticipated events to occur with reasonable sequence in time.

No statements were excerpted which were related to this aspect of the need for security.

Need for an awareness of being cared for.

Patients A, B, C

None

Patient D

PT: Boy, I didn't know how long it was going to be and I couldn't lay on that hard table any longer. I thought maybe you forgot about me.

Patients E, F, G

None

Patient H

PT: Say, I've been soaking my hand for a long time but the splinter doesn't seem to be moving and I wonder if someone should see it or if I can maybe go back to work? It might work itself out.

Patient I

(Patient appeared at door to nurse's station, ambulatory, holding his chart. Stood there a good two minutes during which team members passed in and out, apparently busy.)

Patient J

PT: (yelled at HA passing doorway) Hey, when am I going to get taken care of? I just been sittin' here waitin'. God, you could die in here an' nobody'd even know it or care. (loud voice)

PT: (yelled at doctor passing doorway) Hey, doc, when's somebody gonna take care of me? I'm sittin' here an' this damn thing is swellin' an' hurts like hell.

PT: Yeah! well how about bein' busy with me, huh? I need someone in here too. (angry) I just been sittin' here an' this thing pains--I'm in pain! (like a hurt little boy)

Patient K

PT: Then I'm not gonna die? You guys are great!

PT: Hey, I'm bleedin' to death, doc--I'm just gonna bleed to death an' die. Somebody do something! (very frightened)

PT: Hey, nurse, am I goin' to die? That blood makes me sick.

Patients L and M

None

Patient N

PT: Say, I've been sitting here for a long time. When will a doctor see me, do you know?

PT: My back is sore. I just hope nothing serious is wrong. I've been sitting here so long. (had waited one hour and eight minutes since the RN had said the doctor would be in to examine her)

Patient O

None