# EXPLORATORY STUDY OF PATIENTS' COMMUNICATION PATTERNS DURING INITIAL HOSPITALIZATION IN A SPECIFIC INSTITUTION

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THESIS

ABSTRACT

EXPLORATORY STUDY OF PATIENTS' COMMUNICATION PATTERNS
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By

Carroll Ann Lutz

Much advice for health professionals on communicating with patients is based on the professionals' casual observations or extrapolations from general communication theory without specific validation from patients. The aim of this study was to collect data from patients regarding their communication contacts during initial hospitalization in a particular institution.

Nonacutely ill patients were interviewed by the author between their third and tenth hospital day in two western Michigan general hospitals. Notes were taken during the interview, expanded and clarified before another day of interviews began, and later coded by categories and transferred to five-by-eight inch cards for sorting and tabulating.

Although participation was voluntary and dependent upon hospital routines, the thirty-five patients interviewed approximate national averages in the proportion of married and divorced persons, of service and farm workers, and in median years of schooling of employed persons.

In general, patients' most extensive and most important communications were face-to-face and took place in their

hospital rooms which satisfied them. Hospitalization seemed to favorably influence opinions of hospitals and health workers, both of which showed fewer negative opinions during the interview than recalled prehospitalization negative opinions.

The concept that patients are overwhelmed with communications while hospitalized was not supported by this study. Patients named a mean of 2.3 different most extensive or most important contacts of which 0.9 were health workers. Patients seemed to obtain affective support from their significant others and information from their physicians. In only one area of communication, most important contact on the patient's health, did more than one-third of the patients responding name a health worker as a contact. Of the total sample, 31.4 percent admitted a communication underload in connection with this hospitalization, only 9.1 percent of which could have been answered by orientation booklets.

In describing a good patient regarding communication with health workers, 65.7 percent of the patients characterized him as undemanding, compared with 20 percent who described the good patient as being open, and 14.3 percent who were unable to describe a good patient.

These data suggest little discernable difference between the communication patterns of patients at the two hospitals, one of which is three times the size of the other.

Considering the fact that the patients were given opportunities to express dissatisfaction on fifty areas of communication, a finding that 54.3 percent of the thirty-five patients in the present study expressed dissatisfaction on at least one area may not be extrapolated to a negative vote of confidence for health institutions and workers, however, it does indicate a probably fruitful field for future study.

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# CHAPTER I

## BACKGROUND OF THE STUDY

### Introduction

Although several volumes purport to advise nurses on nurse-patient communication, usually they are extrapolations from general communication theory or from case studies, often autobiographical, rather than from broadly based empirical studies.

The aim of this study is to begin constructing a framework for a theory of communicating with patients. To begin to visualize the patient's communication network when confined to a hospital, patient interviews were conducted in a field study involving two western Michigan general hospitals. The data generated are descriptive of those patients only but offer perimeters for narrowing the focus in more controlled studies in the future.

Graduate school teaches the student to examine data which support statements or theories. This study was undertaken to begin to define the patient's perception of his communications while in the hospital in contrast to the nurse-focused intuitive interpretations of the patient's communication behavior which have dominated nursing literature in the past.

## Review of the Literature

### Interpersonal Communication

Much of the provision of health care requires a one-to-one relationship, albeit not a role-free one. Interpersonal communication variables have been recorded or manipulated in a number of health worker-patient studies. King reported the twice weekly interactions of one psychiatric patient and one nurse over a nine month period. Sethee developed an instrument to study verbal responses of public health nurses, comparing the responses with the nurses' self-perceived interviewing problems. Palmer, by interviewing 167 patients on discharge from a British hospital, found the asking of questions positively related to social class. Conant, applying Bales' interaction analysis to forty-eight home visits by public health nurses to antepartal patients, found nurse interaction varied significantly with the race of the patient in two categories. Korsch and Negrete's use of Bales' technique to analyze 800 pediatric clinic visits found no correlation between the length of the visit and the parent's satisfaction or the clarity with which she perceived the child's diagnosis. The authors stated the impression that physicians use excessively technical language was strongly confirmed. Holder manipulated source, message, and audience characteristics, measuring their influence on 122 maternity patients' beliefs and compliance with recommendations, finding primigravidas' delayed compliance was greater when similarity with the source was suggested than when it was not.

## Message Content

Message content was studied by the greatest number of research teams. Couture experimented with nursing students in five types of programs, rating their extemporaneous responses to hypothetical patient questions as supportive 38 percent and accurate 23 percent of the time. Faulkner cared for fifty postpartum patients, recording their communication of 166 needs to her which she categorized as 78 percent patient initiated but only 20 percent call light initiated. Gue observed 3,000 services rendered to hospitalized patients, finding 4 percent initiated by call light, usually bedpan related. Mary Meyers invented an "allergy skin test" to serve as a stimulus for seventy-two patients accompanied by three types of communication, finding a significant positive relationship between patient talkativeness and estimation of the size of the equipment. Barnes manipulated fear messages to parents of school children needing dental treatment, finding behavior change not statistically significant. Ley's three experiments on patient memory for diagnostic, advisory, or other statements found the subjects recalled best what they were told first and what they considered most important. Dlouhy and others interviewed ninety-six patients on twenty-four dimensions of information regarding diagnostic tests, finding over one-half of the patients would always want to know ten items of information. Allen interviewed twenty-five patients within seventy-two hours after cerebral angiography, pneumoencephalography, or myelography, finding the largest

gap between desired and received information was on the topic of environment, equipment, and position the patient assumes.

The greatest number of communication studies dealing with similar content are those focusing on preoperative patient instruction. Billie Meyers found no difference in anxiety as measured by blood pressure and pulse changes between preoperative patients engaged in conversation about the operating room and those who were not. Healy gave 181 patients and their families intensive preoperative instruction while using for controls 140 patients who received routine instructions, reporting 75 percent of the experimental patients were discharged three to four days before expected compared with 2 percent of the control patients. Edwards' experiment with preoperative and postoperative visits by operating room nurses to gall bladder surgery patients indicated the experimental visited group recovered more rapidly than the control unvisited group as measured by mode of reaction from the anesthetic, quality of ventilation efforts, amount of sedation in the first twenty-four postoperative hours, earliness of postoperative ambulation, and length of postoperative hospitalization. Lindeman and Stetzer's experiment with preoperative visits by operating room nurses to ninety experimental and eighty-six control patients showed statistically significant differences in anxiety in adults having minor surgery as measured by the Palmer Sweat Index and in preparedness of operating room staff as self-evaluated.

Schmitt and Wooldridge used twenty-five matched pairs of presurgical patients in an experiment giving special preoperative instructions to the experimental group, reporting urinary retention occurred ten times as frequently in the control group as in the experimental one, with mean postoperative hospitalization lasting 2.1 days longer in the control group than in the experimental one.

## Message Source

Research relating to the source of the message given to patients has been reported by others in addition to Holder. Skipper, Tagliacozzo, and Mauksch interviewed eighty-six patients of whom 65 percent rated presenting good explanations as one of the most important qualities of a good doctor, while 32 percent similarly categorized the answering of patients' questions. Almost every patient believed doctors and nurses were overworked, a belief which Skipper, Tagliacozzo, and Mauksch maintain is a major barrier to communication,[1] as well as the corollary--a lack of time which Skipper states is the most common barrier to good physician-patient communication.[2] Duff and Hollingshead document the fleetingness of patient-physician communications, finding that physicians spent an average of thirty seconds with private

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[1]James K. Skipper, Daisy L. Tagliacozzo, and Hans O. Mauksch, "What Communication Means to Patients," American Journal of Nursing 64 (April 1964) :103.

[2]James K. Skipper, "Communication and the Hospitalized Patient," in Social Interaction and Patient Care, ed.: James K. Skipper and Robert C. Leonard (Philadelphia: J. B. Lippincott Co., 1965), p. 71.

patients and twelve seconds with semiprivate patients during the observation periods.[1] Carlson and Vernon, in testing questionnaires to measure staff informativeness and patient informedness, found informativeness of staff members to be occupationally determined. Michaels interviewed twenty-two intensive care unit nurses regarding their anxiety and coping mechanisms, concluding that critical care nurses may not be able to provide psychological support to patients because they lack such support themselves. Skipper[2] and Coser[3] both indicate patients learn that nurses are a poor source of information which may have prompted Minckley's recovery room patients to ask the nurses their prognoses but not the surgeons, even if one was present shortly after the interchange with the nurse.

Most of the literature criticizing nurse-patient communication is in the area of feelings about health or its negative aspect, that of impending death. Studies by Kübler-Ross[4] and Glaser and Strauss[5] document the isolation of the patient and denial of death by the staff from the standpoint

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[1]Raymond S. Duff and August B. Hollingshead, Sickness and Society (New York: Harper and Row, Publishers, 1968) p. 277.

[2]Skipper, "Communication and the Hospitalized Patient," p. 71.

[3]Rose Laub Coser, Life in the Ward (East Lansing: Michigan State University Press, 1962), p. 77.

[4]Elisabeth Kübler-Ross, On Death and Dying (New York: Macmillan Co., 1969).

[5]Barney G. Glaser and Anselm L. Strauss, Awareness of Dying (Chicago: Aldine Publishing Co., 1965).

of an objective researcher. Guimond's appeal[1] is for honesty and openness from the critical care nurses whose behavior denied the inevitability of the child's death.

## Communication Networks

Hospital communication networks have been the subject of several studies. Duff and Hollingshead intensively studied 161 patients, their families, physicians, and nurses, finding communications between physicians and patients incomplete, especially regarding emotional aspects of illness, and evasive particularly with the terminally ill,[2] but more adequate with high status than with low status patients.[3] Additionally the researchers characterize nurse-patient relationships as task rather than person oriented,[4] and report widespread inability among nursing personnel, selected for their extensive contacts with the patients being studied, to correctly identify the patient while he was still on the nursing unit or the day following his discharge.[5] Of the 161 patients, 63 percent gave no indication of their feelings to their physicians[6] which undoubtedly influenced the finding that only 53 percent of the physicians at least partially perceived the emotional state of their patients.[7] Surgical patients displayed greater fear of illness than did medical patients,[8]

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[1]Joyce Guimond, "We Knew Our Child Was Dying," American Journal of Nursing 74 (February 1974) :248-49.

[2]Duff and Hollingshead, Sickness and Society, p. 369.

[3]Ibid., p. 371. [4]Ibid., p. 374. [5]Ibid., p. 226.

[6]Ibid., p. 208. [7]Ibid., p. 207. [8]Ibid., p. 276.

but medical patients were more likely than surgical patients to have emotional etiological components to their diseases.[1] The emotional state of the patients was perceived at least partially by licensed practical nurses with 80 percent of the patients, by registered nurses with 34 percent, and by nursing aides with 25 percent,[2] compared with 97 percent of the patients and 96 percent of their spouses who were aware of the patient's emotional state.[3] Lack of empathy with the patient was conspicuous among families of ward, or charity, patients.[4]

The patients were unable to differentiate among the various categories of nursing personnel,[5] but all nursing personnel displayed great ability to perceive the patient's social status, markedly greater ability here than regarding the patient's emotional state.[6] Female patients reported greater dissatisfaction with the hospital than did male patients regardless of accomodation or service.[7]

Coser's sociological analysis of interactions on the public wards found the best socialization agent for new patients to be the veteran patient, but that all patients enforced staff norms prohibiting complaining.[8] Duff and Hollingshead's findings concur with Coser's regarding orientation to the hospital and semiprivate and ward accomodations,

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[1]Ibid., p. 298. [2]Ibid., p. 208. [3]Ibid., p. 212.

[4]Ibid., p. 254. [5]Ibid., p. 229. [6]Ibid., p. 232.

[7]Ibid., p. 287.

[8]Coser, Life in the Ward, Chap. 6

but found patients occupying private accomodations more likely than the others to be oriented by the staff.[1] Skipper indicates the replacement of open wards with semiprivate rooms interferes with the patient's interpersonal communication with his acquisition of pertinent information.[2] Cohler and Shapiro, studying staff-patient communication on a research schizophrenic ward, found no differences in interaction rates on the day or evening shifts, significantly greater staff-staff than staff-patient interaction, and significantly more instrumental than socioemotional statements from staff to patients with the reverse distribution in staff-staff interactions. Spitzer and Folta reconstructed the communication networks carrying news of a death in the hospital in twenty-five anticipated and thirteen unanticipated deaths, finding minimal interaction in the former and increased interaction with interconnected, unprecedented, and often unnecessary channels in the latter.

## Nonverbal Communication

Nonverbal communication in health care has been studied by several research teams. Barnett observed 900 randomly selected incidents of non-procedural use of touch by health team personnel, finding greater use of touch at the public hospital, by registered nurses, by health team members under

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[1] Duff and Hollingshead, Sickness and Society, p. 270.

[2] Skipper, "Communication and the Hospitalized Patient," p. 73.

twenty-five years old, by females, and by Caucasians. Freedman, studying patient, nurse, and physician judgments of identical phenomena, found in all twenty-one cases the ratings of the physicians and nurses correlated higher than did either of their ratings with those of the patients. Baer, Davitz, and Lieb after presenting vignettes portraying patients expressing themselves verbally and nonverbally, found nurses, physicians, and social workers all inferred greater physical pain from the patient's verbal expressions and greater psychological distress from the described nonverbal situations. Lenburg, Glass, and Davitz, presenting vignettes portraying patients in the onset, treatment, and prognosis stages of illness to nuns, teachers, physicians, and nurses, found the onset of illness prompted the highest inferences of pain and distress followed by the treatment and prognosis stages. Lenburg, Burnside, and Davitz, after presenting vignettes portraying physical pain and psychological distress to first and second year community college nursing students, reported all students inferred greater distress than pain. Allekian used a hypothetical situation instrument to question seventy-six adult patients regarding intrusions of territory and personal space in the hospital, finding no significant differences between anxiety scores and type of hospital, length of hospitalization, or sex of the patient. Aguilera's case study reports spectacular results from the use of dignifying verbal and nonverbal civilities with a psychiatric patient. Minckley's observation of 644 recovery room patients indicated to her that the recovery

room retards the return of the patient's sense of identity by preventing the return of his sense of territoriality.

## Cross Cultural Communication

Cross cultural communication of health information was the subject of fewer studies. Hanson and Beech, comparing the health validations or reasons given to follow a health prescription, of public health nurses and Spanish speaking villagers in New Mexico, found both groups used similar criteria of appropriateness of validations. Roberts, Mico, and Clark, using two experimental groups, which received face-to-face or interposed messages, and a control group, all of American Indian postpartum patients, reported both experimental groups were significantly better in achieving the desired behavior than the control group but that the experimental groups did not differ significantly from each other.

## Mass Communication

Mass communication variables in health communication have not been studied extensively. Swinehart found the viewing of network television programs on health is not systematically related to the income, education, or occupation of the head of the household. Swinehart, after manipulating headlines over health information articles of identical content, found his senior citizen subjects preferred the high threat topic even under the high fear headline. Mohammed, after constructing health information paragraphs at convential reading grade levels, tested them on 300 diabetes clinic patients, finding 43 percent of the patients could not be

reached by written materials and 78 percent could not be reached by the handout materials used by the clinic studied.

## CHAPTER II

## DESIGN AND IMPLEMENTATION OF THE STUDY

### Basic Assumptions

Essential to the use of patient interviews as a means of data gathering is the first assumption that the patient will tell the interviwer the truth as he sees it.

Selection of the days of the week to interview was arbitrarily established by the nursing office in Hospital A. In Hospital B the day of the week was changed within the study to suit the researcher's convenience. The second assumption is that the patients would not systematically vary with the day of the week chosen to visit the hospital.

The third assumption is that the eligible patients in Hospital A would not systematically vary on the five medical surgical units from week to week.

### Design of the Interview Guide

An earlier field study by the writer to test a first draft of a nurse-patient communication interview guide indicated that the patients were not only unaware of nurses as persons occupying positions in the hospital hierarchy, but also were unconcerned with the nursing hierarchy as long as their physical needs were being met satisfactorily. The present interview guide was designed to permit open-ended questions as to with whom the patient communicated most in

volume and in importance in his own perception but to narrow the focus to specific aspects of his communication after he has named the other party. As indicated by Selltiz, open-ended questions, by permitting the respondent to answer within his own frame of reference, can be useful in exploratory studies where the relevant dimensions of the subject under study are unknown.[1] Specific questions regarding setting, method of communication, frequency, length, and satisfaction with each of them were included to avoid the severe rounding off of self-reported data, stated to be a common tendency by Johnson and Jackson,[2] and to direct the patient's attention to the dimensions of communication relevant to the interviewer, dominance, load, initiation, and functions of communication as suggested by Farace and MacDonald. Rather than expecting the patient to analyze his communications, the interview guide was intended to ask him to name his contacts and to provide bits of factual information about the exchanges so that the researcher could analyze his communications. The interview guide appears in Appendix A.

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[1]Claire Selltiz and others, Research Methods in Social Relations (New York: Holt, Rinehart, and Winston, 1959).

[2]Palmer O. Johnson and Robert W. B. Jackson, Introduction to Statistical Methods (New York: Prentice-Hall, 1953), Chap. 2.

## Hospitals Utilized

A letter requesting participation was sent to the five general hospitals within twenty miles of the researcher's home. Two osteopathic hospitals and one church related hospital failed to reply to the initial letter. The other two hospitals subsequently granted permission to interview patients. The initial letter content is reproduced in Appendix B.

Hospital A is located in a lake port and manufacturing city of 44,377 in a county of 156,077. It is a private institution of 360 beds, containing five medical-surgical units. In this institution the research study was approved with the stipulation that each eligible patient's physician be contacted by the researcher for permission to interview the patient.

Hospital B is located in a resort and industrial city of 11,834 in a county of 127,468. Its tax support is derived from five governmental units. It contains 116 beds with one permanent medical-surgical unit, one occasionally used medical-surgical unit and one four-bed ward on the obstetrical unit occasionally used for clean medical-surgical female patients. The medical staff at Hospital B approved the study as described in the initial letter so patients eligible for inclusion were selected by the researcher and the clinical care specialist nurse from a list of patients never before hospitalized in Hospital B prepared by the admitting officer.

## Selection of Patients

Following Selltiz's suggestion that the reactions of strangers or newcomers to a social system offer insight into the operation of the system,[1] medical-surgical patients never before hospitalized or employed in the given institution were sought between their third and tenth hospital days. The first hospital day is designated as the calendar date following the date of admission, so that a patient's first hospital day may begin a few minutes after admission if he is admitted shortly before midnight or may begin nearly twenty-four hours after admission if he is admitted shortly after midnight.

Other criteria for inclusion were that the patients not be acutely ill and be willing to be interviewed.

In Hospital A during the first week of interviews the nursing supervisors found the patients on their units who fit the criteria. Because of a delay in getting the lists to the nursing office, permission to interview was obtained from physicians for two patients on one unit before the remainder of the patients' names were received. The second week a nursing supervisor and the researcher examined charts on another unit, finding three patients who met the criteria for inclusion. Thereafter the researcher went through the charts alone or after consulting with the head nurse or charge nurse. After seeming to find sufficient patients on a single unit each of the first two weeks, it was decided to utilize one

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[1]Selltiz, Research Methods in Social Relations, p. 61.

unit per week. The remaining units were visited in a sequence selected by lot. The one unit which failed to produce any usable interviews on the first visit was revisited the sixth week. The sequence of searching the five units for eligible patients for the final two weeks was determined by lot.

In Hospital B the admitting clerk prepared a list of patients never before admitted to that hospital. The clinical care specialist nurse and the researcher then checked the hospital day and the condition of the patient.

## Procedures

Data were collected from the two hospitals over an eight week period in mid-winter.

The researcher, wearing street clothes with a laboratory coat, and a name plate bearing her given and surnames followed by "R.N.," introduced herself to each patient as a registered nurse studying communication at Michigan State University. Patients were told they would not be identified in the study, nor would any of their contacts. That their participation was voluntary was stressed, as was their right not to answer any questions they found objectionable.

One patient prefaced her answer to a demographic question with, "I was afraid you'd ask that," but she provided the data in spite of her feelings. Nevertheless, to guard against the Milgram response to white coats, thereafter patients were reminded before the demographic questions of their right to decline to answer.

The first two interviews in Hospital A took place in the head nurse's office, but the second of those was interrupted by a physician wishing to dictate records. That interview was finished in the patient's room and all subsequent interviews at both hospitals took place at the patient's bedside, sometimes with comments from the patient's roommate or roommates, depending upon their preoccupations with other entertainments.

Notes taken during each interview were expanded and clarified before another day of the interviews began. After the interviews were completed the notes were reviewed and categories for each question established. The information from the interviews was then coded by categories and transferred to five-by-eight inch cards for ease in sorting and tabulating.

# CHAPTER III

# FINDINGS OF THE STUDY

## The Sample

Thirty-five usable interviews[1] were obtained, eighteen at Hospital A and seventeen at Hospital B. Of the thirty-five patients, eighteen were female and seventeen male.

## Personal Characteristics

### Age and Sex

The ages of the thirty-five patients ranged from 15 to 77, with a mean of 52.3 and a median of 57. The ages reported are age at last birthday.[2] The seventeen males ranged in age from 19 to 75 with a mean of 54.1 and a median of 58. The eighteen females ranged in age from 15 to 77 with a mean of 50.6 and a median of 55. Patients interviewed at Hospital A ranged in age from 15 to 77, with a mean of 52.7 and a median of 59.5; those at Hospital B ranged in age from 22 to 71 with a mean of 51.9 and a median of 54. See Table 1.

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[1]For information on unusable interviews and unselected eligible patients, see Chapter 4.

[2]Only one patient, the fifteen year old girl, qualified her answer as "almost sixteen."

TABLE I

AGE (LAST BIRTHDAY IN YEARS) OF INTERVIEWED PATIENTS BY HOSPITAL AND SEX

| | Number | Mean Age | Median Age |
|---|---|---|---|
| Hospital A | | | |
| Male | 10 | 60.0 | 61.5 |
| Female | 8 | 43.6 | 42.0 |
| All Patients | 18 | 52.7 | 59.5 |
| Hospital B | | | |
| Male | 7 | 45.7 | 51.0 |
| Female | 10 | 56.2 | 58.5 |
| All Patients | 17 | 51.9 | 54.0 |
| Both Hospitals | | | |
| Male | 17 | 54.1 | 58.0 |
| Female | 18 | 50.6 | 55.0 |

Race

All but one patient were white. The exception was a fifty-one year old black male, interviewed at Hospital A.

Marital Status

Twenty-three patients were married, six were widowed; five were single; and one was separated. Table 2 summarizes the marital status data by hospital and sex.

TABLE 2

MARITAL STATUS OF INTERVIEWED PATIENTS
BY HOSPITAL AND SEX

| | Married | Widowed | Single | Separated | Total |
|---|---|---|---|---|---|
| Hospital A | | | | | |
| Male | 8 | 2 | ... | ... | 10 |
| Female | 4 | 1 | 3 | ... | 8 |
| Hospital B | | | | | |
| Male | 6 | ... | 1 | ... | 7 |
| Female | 5 | 3 | 1 | 1 | 10 |
| Total | 23 | 6 | 5 | 1 | 35 |

## Socioeconomic Status

### Occupation

Occupations were categorized as white collar, blue collar, service, and farm with the addition of three categories not used by the Department of Labor to designate housewives, students, and disabled persons. Persons who were self-employed were categorized as white collar by virtue of their proprietorship even though they perform the same tasks as their blue collar or service employees. A list of the responses and their categorization appears in Appendix D. Occupational classifications of the respondents and those of their parents and spouses appear in Table 3.

TABLE 3

OCCUPATIONS OF RESPONDENTS, PARENTS, AND SPOUSES

| | Patient | Spouse | Father | Mother |
|---|---|---|---|---|
| Hospital A | | | | |
| White Collar | 3 | 4 | 1 | 1 |
| Blue Collar | 7 | 4 | 10 | 3 |
| Service | 2 | ... | 1 | ... |
| Farm | 1 | ... | 6 | ... |
| Housewife | 3 | 5 | ... | 13 |
| Student | 2 | ... | ... | ... |
| Disabled | ... | 2 | ... | ... |
| Unknown | ... | ... | ... | 1 |
| Patient Unmarried | ... | 3 | ... | ... |
| Total | 18 | 18 | 18 | 18 |
| | Patient | Spouse | Father | Mother |
| Hospital B | | | | |
| White Collar | 7 | 4 | 3 | 5 |
| Blue Collar | 5 | 5 | 7 | 1 |
| Service | 1 | 1 | ... | ... |
| Farm | ... | ... | 5 | ... |
| Housewife | 4 | 4 | ... | 11 |
| Student | ... | ... | ... | ... |
| Disabled | ... | ... | ... | ... |
| Unknown | ... | 1 | 2 | ... |
| Patient Unmarried | ... | 2 | ... | ... |
| Total | 17 | 17 | 17 | 17 |

Education

Patients were asked their highest grade completed. The patients interviewed at Hospital A included two females still in school who are excluded from these figures. The other eight females at Hospital A completed from eight to fourteen years of schooling with a mean of nine. The males at Hospital A completed from five to twelve years with a mean of eleven.

Female patients at Hospital B completed between seven and eighteen years of schooling; males between eight and twelve. The mean for the females is 12.9; for the males, 10.7.

The female patients excluding the two still in school completed between seven and eighteen years of schooling with a mean of 10.6. The male patients completed between five and twelve years of schooling with a mean of 10.2.

## Geographic Data

Patients' places of birth and present residence were categorized as: 1) the county containing the hospital treating him, 2) a county adjacent to it, 3) another Michigan county, 4) another state, or 5) a foreign country. Patients' places of birth by hospital and sex appear in Table 4. Their counties of present residence by hospital and sex appear in Table 5.

The patients were asked the number of years he or she has lived in the county of his present residence. The ten male patients at Hospital A had lived there from 24 to

63 years, with a mean of 43.1. The eight female patients at Hospital A had lived in the county of their present residence from 0.3 to 47 years, with a mean of 26.2. The seven male patients at Hospital B had lived in their present county from 1 to 55 years, with a mean of 31.7; the females from 2 to 30 years, with a mean of 12.5.

TABLE 4

PATIENTS' PLACES OF BIRTH BY HOSPITAL AND SEX

| | County of Hospital | Adjoining County | Other Michigan County | Another State | Foreign Country |
|---|---|---|---|---|---|
| Hospital A | | | | | |
| Male | 3 | 1 | 2 | 3 | 1 |
| Female | 3 | 2 | 3 | ... | ... |
| Hospital B | | | | | |
| Male | 3 | 1 | 1 | 2 | ... |
| Female | ... | 4 | 3 | 3 | ... |
| Total | 9 | 8 | 9 | 8 | 1 |

## Hospitalization Data

### Major Medical Classification

Interviewed patients included seventeen medical patients and eighteen surgical patients. The medical and surgical patients were not divided evenly between the two hospitals, however, since twelve of the medical patients were interviewed at Hospital A, and twelve of the surgical

patients at Hospital B. The number of medical and surgical patients interviewed by hospital and sex is shown in Table 6.

TABLE 5

PATIENTS' PLACES OF PRESENT RESIDENCE BY HOSPITAL AND SEX

| | County of Hospital | Adjoining County | Other Michigan County |
|---|---|---|---|
| Hospital A | | | |
| Male | 7 | 2 | 1 |
| Female | 6 | 2 | ... |
| Hospital B | | | |
| Male | 5 | 2 | ... |
| Female | 6 | 3 | 1 |
| Total | 24 | 9 | 2 |

TABLE 6

MEDICAL AND SURGICAL PATIENTS INTERVIEWED BY HOSPITAL AND SEX

| | | Medical | Surgical | Total |
|---|---|---|---|---|
| Hospital A | Male | 8 | 2 | 10 |
| | Female | 4 | 4 | 8 |
| Hospital B | Male | 2 | 5 | 7 |
| | Female | 3 | 7 | 10 |
| Total | | 17 | 18 | 35 |

## Stage of Illness

Patients were classified to stage of illness according to their admitting diagnosis and information given during the interview. Preoperative patients were categorized in the treatment stage; postoperative ones in the prognostic stage, unless they anticipated additional operative procedures during this hospitalization. Medical patients not anticipating immediate discharge were classified in the treatment stage. The stages of illness of the patients by hospital and major medical category are shown in Table 7. The patients' admitting diagnoses with the classification given each appear in Appendix E.

TABLE 7

PATIENTS' STAGES OF ILLNESS BY HOSPITAL AND MAJOR MEDICAL CATEGORY

| | | Diagnostic | Treatment | Prognostic |
|---|---|---|---|---|
| Hospital A | Medical | 6 | 6 | 0 |
| | Surgical | 3 | 1 | 2 |
| Hospital B | Medical | 2 | 3 | 0 |
| | Surgical | 0 | 2 | 10 |
| Total | | 11 | 12 | 12 |

## Previous Hospitalizations

Of the thirty-five patients, twelve or 34.3 percent had been hospitalized before. Ten of the thirty-five, or 28.6 percent had been hospitalized just once before which occurred from 1 to 29 years ago with a mean of 7.6 years.

The number of previous hospitalizations for each patient classified by hospital and major medical category is shown in Table 8.

TABLE 8

PATIENTS EXPERIENCING PREVIOUS HOSPITALIZATION BY HOSPITAL AND MAJOR MEDICAL CATEGORY

| Previous Hospitalization | 0 | 1 | 2 | 3 | 4 | 9 | Total |
|---|---|---|---|---|---|---|---|
| Hospital A | | | | | | | |
| Medical | 5 | 3 | 1 | 1 | 1 | 1 | 12 |
| Surgical | ... | 2 | 3 | 1 | ... | ... | 6 |
| Hospital B | | | | | | | |
| Medical | 2 | 1 | 1 | 1 | ... | ... | 5 |
| Surgical | 5 | 4 | 2 | ... | 1 | ... | 12 |
| Total | 12 | 10 | 7 | 3 | 2 | 1 | 35 |

To demonstrate the extent to which previous hospitalization experiences of the patients are related to age or sex, Table 9 was prepared. It shows the distribution of age commonly used by the Department of Labor with the category of sixty-five and over subdivided to distinguish among the twelve patients who otherwise would have occupied one category.

## Ambulation

Because a patient's ability to move freely on the nursing unit might influence his reported communication networks, ambulatory for this study was defined as "the ability to ambulate unassisted outside of one's room." Using that

TABLE 9

PATIENTS EXPERIENCING PREVIOUS HOSPITALIZATION
BY SEX AND AGE

| Previous Hospitalizations | 0 | 1 | 2 | 3-9 | Total |
|---|---|---|---|---|---|
| **Males** | | | | | |
| 15-19 years old | 1 | ... | ... | ... | 1 |
| 20-24 | ... | ... | ... | 1 | 1 |
| 25-34 | 1 | ... | ... | ... | 1 |
| 35-44 | ... | ... | 1 | ... | 1 |
| 45-54 | 2 | 1 | ... | ... | 3 |
| 55-64 | 4 | ... | ... | 1 | 5 |
| 65-74 | 2 | 1 | 1 | ... | 4 |
| 75+ | 1 | ... | ... | ... | 1 |
| Total | 11 | 2 | 2 | 2 | 17 |
| **Females** | | | | | |
| 15-19 years old | 1 | ... | ... | ... | 1 |
| 20-24 | ... | 2 | ... | 1 | 3 |
| 25-34 | ... | ... | ... | ... | ... |
| 35-44 | ... | 1 | 1 | 1 | 3 |
| 45-54 | ... | 1 | 1 | ... | 2 |
| 55-64 | ... | 1 | 1 | ... | 2 |
| 65-74 | ... | 1 | 1 | 2 | 4 |
| 75+ | 1 | 2 | ... | ... | 3 |
| Total | 2 | 8 | 4 | 4 | 18 |

definition, eighteen of the patients were ambulatory and seventeen were not. The patients' mobility potentials are categorized by hospital and major medical classification in Table 10 and by hospital and sex in Table 11.

TABLE 10

AMBULATION BY HOSPITAL AND MAJOR MEDICAL CATEGORY

| | | Ambulatory | Not Ambulatory | Total |
|---|---|---|---|---|
| Hospital A | Medical | 6 | 6 | 12 |
| | Surgical | 4 | 2 | 6 |
| Hospital B | Medical | 2 | 3 | 5 |
| | Surgical | 6 | 6 | 12 |
| Total | | 18 | 17 | 35 |

TABLE 11

PATIENTS' AMBULATION BY HOSPITAL AND SEX

| | | Ambulatory | Not Ambulatory | Total |
|---|---|---|---|---|
| Hospital A | Male | 4 | 6 | 10 |
| | Female | 6 | 2 | 8 |
| Hospital B | Male | 6 | 1 | 7 |
| | Female | 2 | 8 | 10 |
| Total | | 18 | 17 | 35 |

Hospital Day

To examine communication patterns early in initial hospitalization in a specific institution, patients were sought between their third and tenth hospital day. The

hospital day on which the interview occurred ranged from three to ten with a mean of 5.7. The range and mean of the hospital day the interview occurred as classified by hospital, sex, and major medical classification appear in Table 12.

TABLE 12

HOSPITAL DAY INTERVIEW OCCURRED BY HOSPITAL, SEX, AND MAJOR MEDICAL CLASSIFICATION

| | Number | Range | Mean |
|---|---|---|---|
| Hospital A | | | |
| Male | 10 | 3-10 | 6.3 |
| Female | 8 | 4-9 | 6.3 |
| Medical | 12 | 3-9 | 6.2 |
| Surgical | 6 | 4-9 | 6.5 |
| Hospital B | | | |
| Male | 7 | 3-9 | 5.4 |
| Female | 10 | 3-9 | 4.9 |
| Medical | 5 | 3-7 | 4.8 |
| Surgical | 12 | 3-9 | 5.3 |

Accomodations

All seventeen patients at Hospital B occupied semi-private rooms. Thirteen of the eighteen patients at Hospital A were in semi-private rooms. The other five patients occupied four-bed wards. Those five patients had the following characteristics: 1) two were male, three female; 2) four

were white, one Negro; 3) two were students, two blue collar workers, and one a housewife; 4) two were married, two single, and one widowed; and 5) ranged in age from 15 to 74 with a mean of 45.2.

## Communication Variables

### Background Information

#### Health Field Contact

Patients were asked how much contact they had had with hospitals before being admitted to the present one. Responses were categorized as: 1) low, if the patient had no contact or contact as an outpatient; 2) medium if a close relative had been hospitalized; or 3) high, if the patient had been hospitalized or employed by a health agency in the past. The various amounts of hospital contact appear in Table 13.

TABLE 13

PATIENTS' PREVIOUS HOSPITAL CONTACTS BY HOSPITAL AND SEX

| | | Low | Medium | High |
|---|---|---|---|---|
| Hospital A | Male | 1 | 1 | 8 |
| | Female | ... | 2 | 6 |
| Hospital B | Male | 2 | 5 | ... |
| | Female | 1 | ... | 9 |
| Total | | 4 | 8 | 23 |

The patients were asked when the hospital contact occurred. The length of time since the last hospitalization for the patients categorized as having high contact ranged from 0.75 to 29 years for the males at Hospital A with a mean of 8.2; from 1.0 to 7.5 years for the females at Hospital A with a mean of 3. For the females at Hospital B the length of time since the previous hospitalization ranged from 0.5 to 23 years with a mean of 6.3.

At Hospital A three patients indicated they had had no previous contact with health workers; one had been employed by a health agency ten years ago. The other fourteen patients indicated the physician was their only contact in the health field. Four said the contact was irregular. Ten had regular contacts, with a mean elapsed time since the most recent of 0.5 years.

At Hospital B five patients said they had had no contact with health workers before admission; one had been an employee of a health agency; and one had a daughter who was a licensed practical nurse. The other ten patients mentioned the physician as their only contact in the health field, one reporting irregular contact and nine claiming regular contact, with a mean time since the previous contact of 0.8 years.

Numbers of patients expressing positive, negative, or neutral opinions of hospitals are shown in Table 14. Patients categorized as divided held strong negative opinions of one group of health workers only.

TABLE 14

PREHOSPITALIZATION AND PRESENT OPINIONS OF HOSPITALS AND HEALTH WORKERS

| | Hospital A | | | |
|---|---|---|---|---|
| | Before Admission | Present | Before Admission | Present |
| **Hospitals** | | | | |
| Positive | 3 | 12 | 7 | 15 |
| Negative | 6 | 3 | 4 | ... |
| Neutral | 2 | 3 | 2 | 2 |
| No Opinion | 7 | ... | 4 | ... |
| Total | 18 | 18 | 17 | 17 |
| **Health Workers** | | | | |
| Positive | 6 | 17 | 2 | 14 |
| Negative | 1 | 1 | 2 | ... |
| Neutral | 1 | ... | 2 | 1 |
| Divided | 1 | ... | 2 | 2 |
| No Opinion | 9 | ... | 9 | ... |
| Total | 18 | 18 | 17 | 17 |

Ten patients at Hospital A mentioned no exceptions to their generalizations about health workers. Of those who did mention exceptions, three referred with displeasure to nurses, two to physicians, and three generalized without mentioning categories. Eleven patients at Hospital B mentioned no exceptions to their opinions of health workers. Two expressed displeasure with nurses and four offered generalizations.

Talkativeness

Patients were asked if they were naturally talkative. All of the responses easily fit into low, medium, and highly talkative categories. Then they were asked if they ever used the telephone just to visit. Those who did so were categorized as highly talkative if they used the telephone for daily visits, as medium if they telephoned weekly, and as low if they would call somone to visit less than once a week. The self-reported talkativeness of patients is shown in Table 15 with the usual time in minutes each one estimated his telephone visits last. A response of "five to ten minutes," is listed as 7.5.

Patients were asked who does the most talking at their dinner tables at home. Responses are shown in Table 16 according to sex.

Excluding the eight patients who live or eat alone or in silence, twenty-five patients indicated in their first responses that their own family's activities and interests

dominate mealtime conversation. Two patients mentioned world affairs as dominant.

TABLE 15

SELF-RATED TALKATIVENESS AND INITIATED TELEPHONE VISITS

| Talkativeness | Would Not Initiate | Would Initiate | Frequency Of Calling | | Length In Minutes |
|---|---|---|---|---|---|
| High | 11 | 8 | High | 3 | 5 |
| | | | Med. | 3 | 15-30 |
| | | | Low | 2 | Unknown-30 |
| Medium | 2 | 6 | High | 2 | 7.5-22.5 |
| | | | Med. | 2 | 7.5 |
| | | | Low | 1 | 10 |
| Low | 3 | 5 | High | 2 | Unknown-10 |
| | | | Med. | 2 | 5-30 |
| | | | Low | 1 | 5 |
| Total | 16 | 19 | | | |

Dividing the telephone and dinner table responses by sex, eight males admitted using the telephone to visit while nine did not; ten females admitted to telephone visits and eight did not. Dominance at the dinner table divided by sex, omitting the children whose sex is unknown and who perhaps have not been completely socialized as to sex roles, shows they think of males as dominating in two families and females as dominating in eight families.

TABLE 16

SELF-REPORTED DOMINANCE OF CONVERSATION AT DINNER

| | Male Patients | Female Patients |
|---|---|---|
| Patient dominates | 2 | 4 |
| Spouse dominates | 4 | 0 |
| Children dominate | 0 | 1 |
| Equally divided | 7 | 6 |
| Divided without patient's participation | 1 | 1 |
| Divided with patient's participation | 1 | 0 |
| Silence | 1 | 1 |
| Lives or eats alone | 1 | 5 |
| Total | 17 | 18 |

Most Extensive Communication Since Hospitalization

Hospital A permitted visitors on the medical-surgical units from one to nine o'clock. Hospital B restricted visiting to two to four o'clock and seven to eight o'clock. Because differences in visiting hours may influence communication contacts, the data from the two hospitals are reported separately.

One patient at Hospital A and two patients at Hospital B could name no one with whom he communicated most since being hospitalized. In addition, six patients at Hospital A and three patients at Hospital B were unable to name a singular person, but persisted in answering the question with a group or category of individuals. Individuals with whom patients communicated most and the lengths of time the patient has known the individual are shown in Table 17.

TABLE 17

MOST EXTENSIVE COMMUNICATION CONTACT SINCE HOSPITALIZATION

| | Hospital A | | Hospital B | |
|---|---|---|---|---|
| | Number of Patients | Range of Time Known | Number of Patients | Range of Time Known |
| Roommate | 6 | 3-8 Da. | 6 | 0-9 Da. |
| Spouse | 2 | 38-44 Yr. | 2 | 18-42 Yr. |
| Parent | ... | ... | 2 | 19-20 Yr. |
| Child | 2 | 27-41 Yr. | 1 | 45 Yr. |
| Nurse | 1 | 6 Mo. | 1 | 5 Da. |
| No One | 1 | ... | 2 | ... |
| Plural Answer | 6 | ... | 3 | ... |
| Total | 18 | | 17 | |

Method of Communication

All eleven patients at Hospital A indicated their communications with their most extensive contacts were face-to-face. Eleven of the patients at Hospital B indicated their communications with their most extensive contacts were face-to-face and ten were satisfied. The one who was not satisfied with her communications with the nurse was having personal problems and said, "Every time they see a tear or hear a groan, they hit me with another shot." One patient's method of communication was the telephone which was satisfactory.

## Setting for Communication

All the patients said their communications with their most extensive contacts usually occurred in their rooms. Ten patients at Hospital A said they were satisfied with the setting; one said, "I have to be." All twelve patients at Hospital B were satisfied with the setting.[1]

## Initiation of Subjects

The patients' perceptions of the individual initiating the conversations with their most extensive contacts are listed in Table 18. All expressed satisfaction with the way subjects were initiated.

## Subjects Discussed

The patients were asked the kinds of subjects they discussed with their most extensive contacts. These responses, categorized as to health relatedness, are listed in Table 19. The patient who answered, "It depends on what's on my mind," was categorized noncommital. All twenty-three patients expressed satisfaction with the subjects discussed.

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[1]One patient said she thought it was strange there were only three chairs in each room when each patient was permitted two visitors, a complaint phrased in different terms by another patient's roommate who thought two easy chairs would be appropriate when both occupants of a room are ambulatory.

TABLE 18

INITIATION OF SUBJECTS WITH MOST EXTENSIVE CONTACT

| | Patient Initiates | Other Initiates | Equal Initiation |
|---|---|---|---|
| Hospital A | | | |
| Roommate | 1 | ... | 5 |
| Spouse | 1 | 1 | ... |
| Parent | ... | ... | ... |
| Child | ... | ... | 2 |
| Nurse | 1 | ... | ... |
| Hospital B | | | |
| Roommate | 2 | 1 | 3 |
| Spouse | ... | ... | 2 |
| Parent | ... | 1 | 1 |
| Child | ... | 1 | ... |
| Nurse | 1 | ... | ... |

Frequency of Communication

Patients were asked how often they communicated with their most extensive contacts. The number of patients indicating each frequency is listed in Table 20 with the category of contact.

TABLE 19

SUBJECTS DISCUSSED WITH MOST EXTENSIVE CONTACT

| | Roommate | Spouse | Parent | Child | Nurse |
|---|---|---|---|---|---|
| Hospital A | | | | | |
| Health related | 2 | 1 | ... | 1 | 1 |
| Nonhealth related | 3 | 1 | ... | 1 | ... |
| Noncommital | 1 | ... | ... | ... | ... |
| Hospital B | | | | | |
| Health related | 2 | 2 | 1 | 1 | 1 |
| Nonhealth related | 4 | ... | 1 | ... | ... |

TABLE 20

FREQUENCY OF COMMUNICATION WITH MOST EXTENSIVE CONTACT

| | All Day | 2-10 x Day | 1 x Day | Less |
|---|---|---|---|---|
| Hospital A | | | | |
| Roommate | 4 | 2 | ... | ... |
| Spouse | ... | ... | ... | 2 |
| Parent | ... | ... | ... | ... |
| Child | ... | ... | 2 | ... |
| Nurse | ... | 1 | ... | ... |
| Hospital B | | | | |
| Roommate | 5 | 1 | ... | ... |
| Spouse | ... | 1 | 1 | ... |
| Parent | ... | 2 | ... | ... |
| Child | ... | ... | 1 | ... |
| Nurse | ... | ... | ... | 1 |

Ten patients at Hospital A expressed satisfaction with the frequency of communication. The one patient not satisfied had named his wife as most extensive contact but she visited less than once a day because they lived in a county categorized as "C." All the patients at Hospital B were satisfied with the frequency of communication with their most extensive contact.

Length of Communication

Patients were asked how long at a time they communicated with their most extensive contacts. The number of patients indicating each frequency is listed in Table 21 with the category of contact.

Ten of the eleven patients at Hospital A expressed satisfaction with the amount of time they spend with their most extensive contact. The one dissatisfied patient was the same man dissatisfied with the frequency of communication with his spouse mentioned above. Eleven patients at Hospital B were satisfied with the amount of time spent with their most extensive contact. The one patient not satisfied wanted more time with the nurse. This patient, living in a "B" county, is the same one expressing dissatisfaction with her face-to-face communication with the nurse.[1]

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[1]See page 37.

TABLE 21

LENGTH OF COMMUNICATION WITH MOST EXTENSIVE CONTACT

| | All Day | 1 Hour Or More | 11-59 Minutes | 1-10 Minutes |
|---|---|---|---|---|
| Hospital A | | | | |
| Roommate | 2 | ... | ... | 4 |
| Spouse | ... | 2 | ... | ... |
| Parent | ... | ... | ... | ... |
| Child | ... | ... | 2 | ... |
| Nurse | ... | ... | 1 | ... |
| Hospital B | | | | |
| Roommate | 1 | ... | 3 | 2 |
| Spouse | ... | 2 | ... | ... |
| Parent | ... | ... | 2 | ... |
| Child | ... | ... | 1 | ... |
| Nurse | ... | ... | ... | 1 |

NOTE: All the times given throughout this paper are patients' estimates. The structure of the categories may give an impression of a more objective measure, however, all the patients answered in minutes or hours.

Disagreement

Nine patients at Hospital A indicated they have never disagreed with their most extensive contact. Two said they had disagreed once or on one subject; one patient disagreed with the nurse whose verbal instructions contradicted the book he had given the patient; the other disagreed with his

spouse about the need for staying in the hospital. Ten patients at Hospital B said they had not disagreed with their most extensive communication contact. One patient disagreed once with the nurse giving her a medication the patient thought would make her sick; the other disagreed with his parent oftener than once or on one subject.

## General Health Matters

### Most Extensive Contact

Fourteen patients at Hospital A and fifteen at Hospital B denied discussing general health matters such as smoking or nutrition with anyone since admission.

Of the four patients at Hospital A who had discussed general health matters, two did so with roommates, one with a nursing student, and one with his child. Neither the roommates nor the nurse were known before hospitalization; the child was known forty years.

The three satisfied patients are reported separately from the dissatisfied one. These three patients reported their exchanges with the roommate, nurse, and child were face-to-face, took place in the patient's room, and consisted of subjects equally initiated. Their communications ranged in frequency from less than once a day to all day, lasted up to an hour, and about half consisted of subjects related to hospitalization. The patients were satisfied on all these dimensions. None had difficulty understanding the terminology of his contact or disagreed with him.

The exceptional patient communicated with her roommate face-to-face but "would just as soon close the curtain" between their beds.[1] The exchanges took place in the room they shared but the patient expressed dissatisfaction with her roommate's 9:30 P.M. visitors. This patient, too, reported about half her conversations with her roommate were hospitalization-related and all were equally initiated, but she thought her roommate was too demanding with the hospital staff and with herself since she wanted to be undisturbed. "She is young and spoiled," is the patient's description of the roommate.[2] This patient estimated she communicated with her roommate six or seven times a day for three to four minutes at a time which she thought excessive. She did have difficulty understanding the roommate's terminology[3] and asked for an explanation immediately. She disagreed with her roommate about six times, four or five times openly, since the other occasion concerned "a touchy subject."

Only two patients at Hospital B said they had discussed general health matters with someone since admission. One

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[1]A patient at Hospital B was on the opposite side of this dispute, dissatisfied because her roommate kept the curtain drawn and the interviewed patient could not see out the window.

[2]The patient was twenty-one years old; the roommate, eighteen.

[3]The roommate was black, the interviewed patient, white.

patient's contact was a licensed practical nurse.[1] The patient had known the nurse two days, communicated face-to-face, in his room, 10 percent on health, equally initiated the subjects, communicated four or five times a day for fifteen or twenty minutes, and was satisfied with these aspects of communication. The patient had no difficulty understanding the nurse's terminology and disagreed with her on one subject, smoking. He told her of his disagreement and disclosed that the nurse admitted she also smoked, but had told the patient it was unhealthy.

The other patient's contact was a friend of the same sex whom the patient knew for eight years. Their chief method of communication was the telephone which satisfied the patient. She was not satisfied with her room as a setting, however, but felt her roommate interferred with her communication with her friend. The conversations with her friend were solely concerned with the patient's health. The subject satisfied the patient but her friend's comments did not. The friend initiated the subjects which "more or less" satisfied the patient who felt she had little choice. She communicated with her friend once a day for fifteen minutes by long distance telephone which was unsatisfactory since she wanted more frequent and longer contacts. She had no difficulty understanding the friend's terminology,

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[1]The patient did not know the nurse's category. Since he answered "neither," when asked if she had been a registered or licensed practical nurse, but he described her cap accurately enough to indicate the latter.

and disagreed with her friend about half the time. She told her friend of her disagreement because the patient felt the friend didn't understand the situation.

Most Important Contact

Three patients at Hospital A named a most important contact on general health matters. The physician and roommate were known six and seven days, respectively, the patient's child, forty years. All the communications were face-to-face and took place in the patients' rooms which satisfied them. Ninety percent of the subjects discussed with the physician and 50 percent of those discussed with the child were related to the patient's hospitalization; none of those discussed with the roommate were so related. The patient initiated the subjects in conversation with the physician; the child did so with one patient; and the third patient equally initiated with the roommate. The physician was seen once a day which did not satisfy the patient who sometimes would have preferred a different time of day. The roommate was available all day which was satisfactory. The child was available for ten to fifteen minutes on two days out of the six the patient had been hospitalized, but the patient expressed satisfaction with the frequency and length of contact. The patient naming the physician said he had difficulty understanding the terminology used and asked for an explanation immediately. The patient disagreed with the physician on the subject of staying in the hospital and told him of her feelings. The patients naming the

roommate and the child had no difficulty with terminology and had no disagreements with the contact.

Hospital B patients denied having a most important communication with anyone on general health matters.

## Communication on the Patient's Health

### Most Extensive Contact

Fifteen patients at Hospital A and fourteen at Hospital B named an individual with whom he spent the most time communicating about his own health since hospitalization. The number of patients naming each category of contact and the length of time the person was known appear in Table 22. All fifteen patients at Hospital A and thirteen at Hospital B indicated the communications took place face-to-face and in their rooms which was satisfactory. The other patient at Hospital B used face-to-face communication but preferred not to comment on her satisfaction. The exchanges took place in the patient's room which dissatisfied the patient because her roommate could overhear their conversations.

### Subjects Discussed

At Hospital A two patients indicated 25 percent or less of their communication with their spouses was hospitalization-related. Three patients naming spouses and one naming a child said 25 to 50 percent of their communication was hospitalization-related. Five patients naming a physician and one each naming a parent or a child indicated

between 75 and 100 percent of their communication with the individual was hospitalization-related. All were satisfied with the subjects. For two patients, naming a spouse and a child, hospitalization-related subject data are unknown.

TABLE 22

MOST EXTENSIVE COMMUNICATION CONTACT ON OWN HEALTH SINCE HOSPITALIZATION

| | Hospital A | | Hospital B | |
|---|---|---|---|---|
| | Number Of Patients | Range Of Time Known | Number Of Patients | Range Of Time Known |
| Spouse | 6 | 3-38 Yr. | 6 | 5-50 Yr. |
| Physician | 5 | 3 day-10 Yr. | 4 | 5 day-7 Yr. |
| Child | 3 | 31-40 Yr. | 1 | 45 Yr. |
| Parent | 1 | 15 Yr. | ... | ... |
| Sibling | ... | ... | 1 | 67 Yr. |
| Friend | ... | ... | 1 | 6 Mo. |
| Roommate | ... | ... | 1 | 3 Da. |
| No One | 2 | ... | ... | ... |
| Plural Answer | 1 | ... | 3 | ... |
| Total | 18 | | 17 | |

At Hospital B, three patients naming spouses, and one each naming a sibling and a roommate indicated 25 percent or less of their communication was hospitalization-related. Two patients naming spouses said 26 to 50 percent of their communication was hospitalization-related. Five patients

naming physicians and one naming a friend said 76 to 100 percent of their communication was hospitalization-related. All were satisfied except the patient communicating with a friend who would have preferred other subjects. For two patients naming a spouse and a child, hospitalization-related subject data are unknown.

The patients' reports of the major initiator of subjects discussed with their most extensive contacts on their own health are listed in Table 23. All but one patient were satisfied with the initiation process. That patient at Hospital A was dissatisfied because his physician had no answers for him yet.

Six patients at Hospital A indicated their most extensive contacts on their health had never asked for their opinions, suggestions, or decisions regarding their health care. Of the six patients who said the individual had asked for his opinion, two named spouses, two physicians, and one each, a parent and a child. One patient said his opinion was asked once, one said several times, and four oftener than that. Those four contacts were two spouses, one physician, and one parent. For three patients, one naming a physician and two naming a child, the data on soliciting of opinions are unknown.

Nine patients at Hospital B indicated their most extensive contacts on their health had never asked for their opinions, suggestions, or decisions regarding their health care. Of the four patients whose opinions had been asked,

two said their opinions had been asked once, one several times, and one oftener. For one patient, naming a spouse, the data on soliciting of opinions are unknown.

TABLE 23

INITIATION OF SUBJECTS WITH MOST EXTENSIVE CONTACT ON OWN HEALTH

| | Patient Initiates | Other Initiates | Equal Initiation |
|---|---|---|---|
| Hospital A | | | |
| Spouse | 2 | 1 | 3 |
| Physician | 2 | 2 | 1 |
| Child | 1 | 1 | 1 |
| Parent | 1 | ... | ... |
| Sibling | ... | ... | ... |
| Friend | ... | ... | ... |
| Roommate | ... | ... | ... |
| Hospital B | | | |
| Spouse | 2 | ... | 4 |
| Physician | ... | 2 | 2 |
| Child | ... | ... | 1 |
| Parent | ... | ... | ... |
| Sibling | ... | ... | 1 |
| Friend | ... | 1 | ... |
| Roommate | ... | ... | 1 |
| Total patients | 8 | 7 | 14 |

Frequency of Communication

Frequencies of communication with the most extensive contact on the patient's health are listed in Table 24. Thirteen patients at Hospital A and twelve at Hospital B were satisfied with the frequency. Two patients at Hospital A, naming a spouse and a parent, and two at Hospital B, naming a physician and a friend, were dissatisfied and wanted more frequent contacts. The patient naming a physician said the physician had not visited him until his third hospital day.[1]

Length of Communication

Lengths of communication reported with the most extensive contact on the patient's health appear in Table 25. Twelve patients at each hospital were satisfied with the length of contact. Three patients at Hospital A, naming a spouse, a physician, and a parent, and two patients at Hospital B, naming a physician and a friend, wanted longer contact.

Terminology

Only one patient at either hospital had difficulty understanding his contact's terminology, a patient whose wife was a laboratory technician.[2] The patient said he

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[1]He was interviewed on his fifth hospital day.

[2]This person is categorized throughout as a nonprofessional, because the patient referred to her as his wife rather than his laboratory technician, and because laboratory technicians in general have little responsibility for communicating with patients regarding their health.

sometimes asked her to explain her terminology but sometimes he didn't because "there's some things she won't tell me."

TABLE 24

FREQUENCY OF COMMUNICATION WITH MOST EXTENSIVE CONTACT ON OWN HEALTH

| | All Day | 2-10 x Day | Once A Day | Less |
|---|---|---|---|---|
| Hospital A | | | | |
| Spouse | ... | 4 | 1 | 1 |
| Physician | ... | ... | 3 | 3 |
| Child | ... | ... | 2 | ... |
| Parent | ... | ... | 1 | ... |
| Hospital B | | | | |
| Spouse | ... | 5 | 1 | ... |
| Physician | ... | ... | 3 | 1 |
| Child | ... | ... | ... | 1 |
| Sibling | ... | ... | ... | 1 |
| Friend | ... | ... | 1 | ... |
| Roommate | 1 | ... | ... | ... |
| Total patients | 1 | 9 | 12 | 7 |

Disagreement

Thirteen patients at Hospital A and twelve at Hospital B said they had not disagreed recently with their most extensive contacts on their health. Two at Hospital A disagreed with their spouses oftener than once or on one subject. One, married three years, disagrees "at least once a day,"

and the other, married fourteen years, disagrees "all the time." Both tell their spouses when they disagree. Two patients at Hospital B also disagreed with their spouses, on one subject, and told them about it.

TABLE 25

LENGTH OF COMMUNICATION WITH MOST EXTENSIVE CONTACT ON OWN HEALTH

| | 1 Hour Or More | 11-59 Minutes | 1-10 Minutes | Less |
|---|---|---|---|---|
| Hospital A | | | | |
| Spouse | 4 | 1 | 1[a] | ... |
| Physician | ... | ... | 3 | 2 |
| Child | 1 | 2 | ... | ... |
| Parent | 1 | ... | ... | ... |
| Hospital B | | | | |
| Spouse | 6 | ... | ... | ... |
| Physician | ... | 1 | 3 | ... |
| Child | ... | 1 | ... | ... |
| Sibling | ... | 1 | ... | ... |
| Friend | 1 | ... | ... | ... |
| Roommate | ... | 1 | ... | ... |
| Total patients | 13 | 7 | 7 | 2 |

[a]This patient's wife was employed at the hospital and made several short visits daily.

Most Important Contact

Seventeen patients at Hospital A and sixteen at Hospital B named a most important contact on his own health. The number of patients naming each category of contact and the length of time the person was known appear in Table 26. All the patients reported the communications took place face-to-face and in their rooms which satisfied all but one patient at Hospital B who resented her roommate overhearing her conversations with her physician.[1]

TABLE 26

MOST IMPORTANT COMMUNICATION CONTACT ON OWN HEALTH SINCE HOSPITALIZATION

| | Hospital A | | Hospital B | |
|---|---|---|---|---|
| | Number Of Patients | Range Of Time Known | Number Of Patients | Range Of Time Known |
| Physician | 11 | 4 Da.-37 Yr. | 13 | 4 Da.-7 Yr. |
| Spouse | 5 | 14-44 Yr. | 3 | 3-50 Yr. |
| Nurse | 1 | 3 Da. | ... | ... |
| No One | 1 | ... | ... | ... |
| Plural | ... | ... | 1 | ... |
| Total | 18 | | 17 | |

[1] This is the same patient mentioned on pages 45 and 47 in the same context.

Subjects Discussed

At Hospital A two patients, naming a physician and a spouse, reported 25 percent or less of their communication was hospitalization-related. One patient naming a spouse reported 26 to 50 percent of their communication was hospitalization-related. Twelve patient, ten naming physicians, one a nurse, and one a spouse, reported 76 to 100 percent of their communication was hospitalization-related. All of the patients were satisfied with the subjects. Subject data for two patients are unknown.

At Hospital B two patients naming spouses reported 25 percent or less of their communication was hospitalization-related; one patient naming a spouse reported 26 to 50 percent was hospitalization-related; and thirteen patients naming physicians reported 76 to 100 percent was hospitalization-related. All of the patients were satisfied with the subjects.

Patients' perceptions of the major initiator of subjects discussed with their most important communication contacts on their health are listed in Table 27. Sixteen patients at Hospital A and fifteen at Hospital B were satisfied with the initiation process. One dissatisfied patient at Hospital A said his doctor "has no answers yet." One patient at Hospital B said he had to be satisfied because the doctor "has to see a lot of patients."

Twelve patients at Hospital A and seven at Hospital B said their most important contacts on their health had never

asked for their opinions, suggestions, or decisions regarding their health care. At Hospital A two patients said their physicians asked their opinions one time or on one subject; one patient said the nurse asked his opinion several times; and two patients naming a physician and a spouse said oftener than several times. At Hospital B nine patients said their physicians solicited their opinions; seven said once or on one subject; one said several times; and one oftener.

TABLE 27

INITIATION OF SUBJECTS WITH MOST IMPORTANT CONTACT ON OWN HEALTH

| | Physician | Spouse | Nurse |
|---|---|---|---|
| Hospital A | | | |
| Patient Initiates | 3 | 3 | 1 |
| Other Initiates | 6 | 1 | ... |
| Equal Initiation | 2 | 1 | ... |
| Hospital B | | | |
| Patient Initiates | 1 | 2 | ... |
| Other Initiates | 9 | ... | ... |
| Equal Initiation | 3 | 1 | ... |
| Total Patients | 24 | 8 | 1 |

Frequency of Communication

Frequencies of communication with the most important contact on the patient's health are listed in Table 28. Fifteen of the patients at each hospital were satisfied with

the frequencies. The two dissatisfied patients at Hospital A named their spouses; the one dissatisfied at Hospital B named the physician. All desired more frequent contact.

TABLE 28

FREQUENCY OF COMMUNICATION WITH MOST IMPORTANT CONTACT ON OWN HEALTH

| | Physician | Spouse | Nurse |
|---|---|---|---|
| Hospital A | | | |
| 2-10 x Day | ... | 3 | 1 |
| Everyday | 9 | ... | ... |
| Less Than Daily | 2 | 2 | ... |
| Hospital B | | | |
| 2-10 x Day | 1 | 2 | ... |
| Everyday | 8 | 1 | ... |
| Less Than Daily | 4 | ... | ... |
| Total Patients | 24 | 8 | 1 |

Length of Communication

Lengths of communication reported with the most important contacts on the patient's health appear in Table 29. Thirteen of the patients at Hospital A and fourteen at Hospital B were satisfied with the length of communication. At Hospital A two patients naming their spouses and two

naming their physicians wanted longer contacts.[1] At Hospital B the two dissatisfied patients named their physians as most important contacts on their health. One usually communicated for less than one minute and one for fifteen minutes.[2]

TABLE 29

LENGTH OF COMMUNICATION WITH MOST IMPORTANT CONTACT ON OWN HEALTH

| | Physician | Spouse | Nurse |
|---|---|---|---|
| Hospital A | | | |
| One Hour or More Daily | ... | 5 | ... |
| 11-59 Minutes | 1 | ... | ... |
| 1-10 Minutes | 8 | ... | 1 |
| One Minute or Less | 2 | ... | ... |
| Hospital B | | | |
| One Hour or More Daily | ... | 3 | ... |
| 11-59 Minutes | 3 | ... | ... |
| 1-10 Minutes | 9 | ... | ... |
| One Minute or Less | 1 | ... | ... |
| Total Patients | 24 | 8 | 1 |

[1] Only one dissatisfied patient naming his physician said the latter contact lasted less than one minute.

[2] The last patient is the same one mentioned on page 51 who had not seen his physician until the third hospital day.

Terminology

Fourteen patients at Hospital A and all sixteen at Hospital B said they had no difficulty understanding the terminology used by their most important contacts on their health. Three at Hospital A had difficulty understanding the physician; one did not ask for an explanation; one asked some of the time; and one asked immediately whenever he did not understand.

Disagreement

Fourteen patients at each hospital said they never disagreed with their most important contacts on their health. Two patients at Hospital A disagreed one time or on one subject with a spouse and a nurse and said they told the contact of their disagreement. One patient disagreed with his spouse oftener than once or on one subject and told her about it. At Hospital B two patients disagreed with the physician one time or on one subject; one patient told the physician of his disagreement and one did not.

## Communication on Patients' Feelings About Their Health

Most Extensive Contact

The question "With whom have you spent the most time communicating about your feelings about your health since you have been hospitalized?" was clarified by adding the researcher was not asking with whom the patient communicates about how he feels physically, but about how he feels about being in the hospital rather than at home. The

contacts named as most extensive on the patient's feelings and the range of time the patient had known the person are listed in Table 30. Ten of the patients at Hospital A and nine at Hospital B indicated the exchanges were face-to-face. Eight of the patients at Hospital A were satisfied. one was satisfied under the circumstances, and one patient's attitude is unknown. One patient at Hospital A used the telephone to communicate which was satisfactory.

Ten of the patients at Hospital A indicated these communications occurred in their rooms. Nine were satisfied; one's satisfaction is unknown. One patient communicated with her friend in the ward lounge with which she would have been better satisfied had the hospital provided some games. At Hospital B, eight patients indicated the exchanges took place in their rooms; all but the one who resented her roommate overhearing her conversations were satisfied.[1] One patient's communications took place in his brother's room with which he was satisfied.[2]

Frequency of Communication

Frequencies of communication with the most extensive contact on feelings about health are listed in Table 31. Eight of the Hospital A patients and all of the Hospital B

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[1]See pages 45, 47, and 54.

[2]The brother was a patient on the same nursing unit.

patients were satisfied with the frequencies. Two patients at Hospital A, naming a spouse and a parent, wanted more frequent contact.

TABLE 30

MOST EXTENSIVE COMMUNICATION CONTACT ON FEELINGS ABOUT HEALTH SINCE HOSPITALIZATION

| | Hospital A | | Hospital B | |
|---|---|---|---|---|
| | Number Of Patients | Range Of Time Known | Number Of Patients | Range Of Time Known |
| Spouse | 5 | 3-44 Yr. | 6 | 5-50 Yr. |
| Physician | 1 | 6 Da. | ... | ... |
| Child | 1 | 27 Yr. | 1 | 45 Yr. |
| Parent | 1 | 15 Yr. | 1 | 22 Yr. |
| Friend | 1[a] | 3 Yr. | ... | ... |
| Sibling | 1[b] | 22 Yr. | 1 | 46 Yr. |
| Researcher | 1[c] | 1 Hr. | ... | ... |
| No One | 6 | ... | 6 | ... |
| Plural Answer | 1 | ... | 2 | ... |
| Total | 18 | | 17 | |

[a]This same sex friend shares the house in which the patient lives.

[b]This individual is related to the patient by marriage.

[c]The objective data from this exchange are recorded; the patient was not asked his satisfaction on any of the dimensions.

TABLE 31

FREQUENCY OF COMMUNICATION WITH MOST EXTENSIVE CONTACT ON FEELINGS ABOUT HEALTH

| | Hospital A | | | Hospital B | | |
|---|---|---|---|---|---|---|
| | 2-10 x A Day | Once A Day | Less Than Once A Day | 2-10 x A Day | Once A Day | Less Than Once A Day |
| Spouse | 2 | 1 | 2 | 3 | 3 | ... |
| Physician | ... | ... | 1 | ... | ... | ... |
| Child | ... | 1 | ... | ... | 1 | ... |
| Parent | ... | 1 | ... | ... | 1 | ... |
| Sibling | 1 | ... | ... | 1 | ... | ... |
| Friend | ... | 1 | ... | ... | ... | ... |
| Researcher | ... | ... | 1 | ... | ... | ... |
| Total | 3 | 4 | 4 | 4 | 5 | 0 |

Initiation

The persons reported to initiate communication on the patient's feelings about his health are listed in Table 32. Seven of the patients at Hospital A and five at Hospital B were satisfied with the initiation process. The satisfaction of four patients in each hospital is unknown.

Length of Communication

Lengths of communication with the most extensive contacts on feelings about health appear in Table 33. Seven of the patients at Hospital A and eight at Hospital B were satisfied with the length of the exchanges. Two at Hospital A, naming a spouse and a parent, and one at

Hospital B naming a parent desired longer contacts; one at Hospital A desired shorter contacts with the friend.

TABLE 32

INITIATION OF SUBJECT OF FEELINGS ABOUT HEALTH WITH MOST EXTENSIVE CONTACT

| | Patient Initiates | Other Initiates | Equal Initiation | Unknown |
|---|---|---|---|---|
| **Hospital A** | | | | |
| Spouse | 1 | 2 | ... | 2 |
| Physician | ... | 1 | ... | ... |
| Child | ... | ... | ... | 1 |
| Parent | 1 | ... | ... | ... |
| Sibling | 1 | ... | ... | ... |
| Friend | 1 | ... | ... | ... |
| Researcher | ... | 1 | ... | ... |
| **Hospital B** | | | | |
| Spouse | 1 | 1 | 1 | 3 |
| Child | ... | ... | ... | 1 |
| Parent | ... | 1 | ... | ... |
| Sibling | ... | ... | 1 | ... |
| Total patients | 5 | 6 | 2 | 7 |

## Most Important Contact

Ten patients at Hospital A and eight patients at Hospital B specified individuals as their most important contacts on their feelings about health. This information appears in Table 34. Nine of the patients at Hospital A indicated

TABLE 33

LENGTH OF COMMUNICATION WITH MOST EXTENSIVE CONTACT ON FEELINGS ABOUT HEALTH

| | 1 Hour Or More | 11-59 Minutes | 1-10 Minutes |
|---|---|---|---|
| **Hospital A** | | | |
| Spouse | 5 | ... | ... |
| Physician | ... | ... | 1 |
| Child | ... | 1 | ... |
| Parent | 1 | ... | ... |
| Sibling | ... | 1 | ... |
| Friend | 1 | ... | ... |
| Researcher | 1 | ... | ... |
| **Hospital B** | | | |
| Spouse | 5 | 1 | ... |
| Child | ... | 1 | ... |
| Parent | ... | 1 | ... |
| Sibling | ... | 1 | ... |
| Total patients | 13 | 6 | 1 |

this communication took place face-to-face, one by telephone, and all were satisfied. All eight Hospital B patients communicated face-to-face; seven were satisfied and one did not want to comment on her communications with her friend. Nine of the patients at Hospital A and eight at Hospital B reported these exchanges took place in their rooms with which they were satisfied. One patient at Hospital A communicated with her friend in the lounge with which she was dissatisfied because of lack of diversion.[1]

Frequency of Communication

Frequencies of communication with the most important contacts on feelings about health appear in Table 35. Eight of the patients at Hospital A and seven at Hospital B were satisfied. Two patients at Hospital A wanted more frequent contact with a spouse and a parent; one at Hospital B wanted more frequent contact with the friend.

Length of Communication

Lengths of communication with the most important contacts on feelings about health appear in Table 36. Seven patients at each hospital were satisfied with the length of contact. Two patients at Hospital A wanted longer contacts with a spouse and a parent; one sometimes wanted shorter contact with the friend. One patient at Hospital B wanted longer contact with the friend.

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[1]This is the same patient mentioned on page 60 in the same context.

TABLE 34

MOST IMPORTANT COMMUNICATION CONTACT ON FEELINGS ABOUT HEALTH SINCE HOSPITALIZATION

| | Hospital A | | Hospital B | |
|---|---|---|---|---|
| | Number Of Patients | Range Of Time Known | Number Of Patients | Range Of Time Known |
| Spouse | 6 | 3-44 Yrs. | 6 | 18-50 Yrs. |
| Physician | 1 | 2 Yrs. | ... | ... |
| Child | ... | ... | 1 | 45 Yrs. |
| Parent | 1 | 15 Yrs. | ... | ... |
| Sibling | 1 | 22 Yrs. | ... | ... |
| Friend | 1 | 3 Yrs. | 1 | 6 Mo. |
| No One | 8 | ... | 8 | ... |
| Plural | ... | ... | 1 | ... |
| Total | 18 | | 17 | |

TABLE 35

FREQUENCY OF COMMUNICATION WITH MOST IMPORTANT CONTACT ON FEELINGS ABOUT HEALTH

| | Hospital A | | | Hospital B | | |
|---|---|---|---|---|---|---|
| | 2-10 x A Day | Once A Day | Less Than Once A Day | 2-10 x A Day | Once A Day | Less Than Once A Day |
| Spouse | 3 | 1 | 2 | 3 | 3 | ... |
| Physician | ... | 1 | ... | ... | ... | ... |
| Child | ... | ... | ... | ... | 1 | ... |
| Parent | ... | 1 | ... | ... | ... | ... |
| Sibling | 1 | ... | ... | ... | ... | ... |
| Friend | ... | 1 | ... | ... | 1 | ... |
| Total | 4 | 4 | 2 | 3 | 5 | 0 |

Initiation

Data are available on only four patients at each hospital. In four cases patients initiated communication about feelings and in four cases the other person did so.

TABLE 36

LENGTH OF COMMUNICATION WITH MOST IMPORTANT CONTACT ON FEELINGS ABOUT HEALTH

| | One Hour Or More | 11-59 Minutes | 1-10 Minutes |
|---|---|---|---|
| Hospital A | | | |
| Spouse | 6 | ... | ... |
| Physician | ... | ... | 1 |
| Parent | 1 | ... | ... |
| Sibling | ... | 1 | ... |
| Friend | 1 | ... | ... |
| Hospital B | | | |
| Spouse | 6 | ... | ... |
| Child | ... | 1 | ... |
| Friend | 1 | ... | ... |
| Total patients | 15 | 2 | 1 |

Hospital Organization

Eleven patients at each hospital said they communicated with no one regarding the way the hospital operates and how they fit into the system; two patients at Hospital A and three at Hospital B gave plural answers. The contacts named and the length of time the person was known to the

patient are listed in Table 37. All communication exchanges were face-to-face which satisfied the patients.

TABLE 37

MOST EXTENSIVE COMMUNICATION CONTACT ON HOSPITAL ORGANIZATION

| | Hospital A | | Hospital B | |
|---|---|---|---|---|
| | Number Of Patients | Range Of Time Known | Number Of Patients | Range Of Time Known |
| Roommate | 2 | 3-6 Da. | 2 | 0-7 Da. |
| Spouse | 2 | 3-38 Da. | 1 | 11 Yr. |
| Parent | 1 | 15 Yr. | ... | ... |
| No One | 11 | ... | 11 | ... |
| Plural Answer | 2 | ... | 3 | ... |
| Total patients | 18 | | 17 | |

Subjects discussed included hospital food, diagnostic tests, kind of care, and hospital routines. All patients were satisfied with the subjects.

Patients initiated communication on hospital operations in two cases, the other person in two cases, and each equally initiated in four cases. All expressed satisfaction with the initiation process.

Patients communicated with their most extensive contacts on hospital organization: all day with three roommates; two to ten times a day with one roommate; once a day with two spouses and a parent; and less than once a day with one spouse. All patients were satisfied with the frequency

except the one communicating less than once a day who desired more frequent contact.

The patients communicated with their most extensive contacts on hospital organization: all day with one roommate; one hour or more with three spouses and a parent; eleven to fifty-nine minutes with a roommate; and one to ten minutes with two roommates. All patients were satisfied except the one communicating less than once a day with a spouse who wanted more time.

None of the patients had difficulty understanding the contact's terminology. None of them disagreed with his most extensive contact on hospital organization.

## Communication Load

Only two patients admitted having a communication overload in connection with their present illnesses. One patient was overloaded with personal problems by a friend before hospitalization and by her employer during this hospitalization.

Six Hospital A patients and five Hospital B patients said they had felt underloaded at some time during this hospitalization. The subjects on which they would have liked additional information are listed in Table 38. Three patients who did not admit to being underloaded volunteered

the information that if they had been, they would have asked someone for the desired information.[1]

## Interruptions

Only two patients at Hospital A and three at Hospital B said their communications had been interrupted: one patient once, two several times, and two, both at Hospital B, oftener than that. All of the patients indicated the interruptions were caused by someone other than themselves, a visitor or a nurse usually. One patient at each hospital said he could not resume the interrupted communication satisfactorily. One patient at Hospital A and two at Hospital B said it could be done sometimes. The reasons given by all for failure to resume communication is that the visitor left or the nurse did not return.

Interruptions during the interviews were tallied. Only intentional intrusions into the patient-researcher conversation were counted, not brief breaks caused by squawks on the intercom or pagings of other people. The interviews with thirteen patients at Hospital A and seven patients at Hospital B were interrupted between one and three times each. Mean interruptions per patient interrupted were 1.8 at Hospital A and 1.9 at Hospital B.

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[1]They apparently expected more effective responses than one patient related. Although she did not admit to an underload, she related earlier in the interview that she had asked a nurse about the erythema surrounding her tuberculin test. The nurse told her to "ask your doctor." The patient was less concerned at the time of the interview because "Now it's going away," but such handling by the nurse causes one to question her understanding of the principles of intradermal testing.

TABLE 38

SUBJECTS OF COMMUNICATION UNDERLOAD SINCE HOSPITALIZATION

| | Hospital A | Hospital B |
|---|---|---|
| Changes in Physician's Orders | 1 | ... |
| Diagnosis | 1 | 1 |
| Length of Hospitalization | ... | 1 |
| Medications | 1 | 1 |
| Operative Procedure | 1 | ... |
| Test Results | 1 | 1 |
| Vital Signs | ... | 1 |
| World News | 1[a] | ... |
| None | 12 | 12 |
| Total patients | 18 | 17 |

[a]This patient said she had access to television and newspapers but wasn't able to get much out of them in the hospital.

## Nonverbal Communication

Nine patients[1] at Hospital A and fourteen at Hospital B could not recall communicating through such actions as shaking hands, pointing, or hushing someone. Nine patients at Hospital A and two at Hospital B mentioned one type of nonverbal communication; two patients at Hospital A mentioned two or more types.

[1]One of these patients could not see adequately to discern another's gestures, but she recalled both of her physicians touching her by shaking hands or pinching her toe during their visits.

Communication Through Touch

Four patients at each hospital could not recall any instances of communication through touch, such as holding hands or kissing. Ten patients at Hospital A and nine at Hospital B recalled such instances which were limited to greetings. Four patients at each hospital cited instances occurring oftener than in greeting. The persons most likely to communicate through touch are listed in Table 39. Among the individuals mentioned who do not appear in the table because their communications by touch were not the most frequent received by the patient are: 1) nurses, mentioned by three patients at Hospital A and one at Hospital B, and 2) ministers, mentioned by two patients at Hospital B. One patient at Hospital A said an unrelated nursing student hugged and kissed her; another patient said he refused backrubs because he wants only his wife's hands touching him.

Ten patients at Hospital A and eight at Hospital B were satisfied with their communications through touch. One at each hospital was noncommital. Two patients at Hospital B wanted more of this communication with their spouses.

Call Signal

The frequencies with which the patients reported using the call signal appear in Table 40.

The call signal was answered over the intercom most often according to five patients at Hospital A and ten at Hospital B. A nurse came to answer most frequently according

TABLE 39

PERSONS MOST LIKELY TO COMMUNICATE WITH PATIENTS THROUGH TOUCH

| | Hospital A | Hospital B |
|---|---|---|
| Spouse | 8 | 7 |
| Child | ... | 1 |
| Other Family Members | 5[a] | 3 |
| Physician | 1 | ... |
| Friend | ... | 1 |
| Physical Therapist | ... | 1[b] |
| None | 4 | 4 |
| Total patients | 18 | 17 |

[a]Includes one patient who answered "outsiders--visitors."

[b]This seventy-six year old patient said the physical therapy staff tweaked her nose and that "they treat me like a child." Her reply to the satisfaction question was non-commital.

TABLE 40

USE OF CALL SIGNAL

| | Hospital A | Hospital B |
|---|---|---|
| Never or Accidental | 3 | 4 |
| 1-3 x total | 7 | 4 |
| 1-2 x per day | 7 | 7 |
| 3-6 x per day | 1 | 1 |
| Oftener | ... | 1 |
| Total patients | 18 | 17 |

to nine patients[1] at Hospital A and three patients at Hospital B. One patient at Hospital A was uncertain of which method was used most frequently.

Ten patients at Hospital A and thirteen at Hospital B said the persons answering their call signals usually are able to provide the needed help. Three patients at Hospital A answered "Sometimes." One at each hospital said the person usually is not able to help them.

Other Signals and Gestures

Twelve patients at Hospital A and eleven at Hospital B said they had not used gestures and signals other than the call signal. Such instances are indicated in Table 41 with the direction of the signal. The other persons involved in these exchanges are listed in Table 42.

## Interposed Verbal Communication

Written Communication

Four patients at Hospital A and three at Hospital B denied using written communication since being hospitalized. Seven patients at Hospital A and nine at Hospital B recalled one type; seven at Hospital A and five at Hospital B recalled two or more types. Most often mentioned were greeting cards and menu choice slips. Twelve patients at Hospital A received

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[1]One patient's room number did not light on the console at the nurses' station on the day of the interview, although the light above the patient's door was operating.

TABLE 41

USE OF SIGNALS OTHER THAN CALL SIGNAL

| | None | Once | Oftener |
|---|---|---|---|
| Hospital A | 12 | | |
| Sent | | 1 | 3 |
| Received | | 1 | 1 |
| Hospital B | 11 | | |
| Sent | | 2 | 1 |
| Received | | 3 | ... |
| Total patients | 23 | 7 | 5 |

TABLE 42

CONTACTS INVOLVED IN SIGNAL EXCHANGE

| | Hospital A | Hospital B |
|---|---|---|
| Nurses | 2 | 4 |
| Other Patients | 2 | ... |
| Roommate | 1 | ... |
| Housekeeper | ... | 1 |
| Visitor | ... | 1 |
| Unknown | 1 | ... |
| Total patients | 6 | 6 |

more messages than they sent; two sent more than they received. All fourteen patients at Hospital B received more messages than they sent. All the patients except two at Hospital B named friends and relatives as the other parties to the written exchange. Those patients named a physician and a nurse.

Messages Through Humans

Nine patients at Hospital A and eleven patients at Hospital B could not recall sending or receiving a message through another person. Those who could recall such instances are listed in Table 43.

TABLE 43

HUMAN-INTERPOSED COMMUNICATIONS

| | None | Once | Oftener |
|---|---|---|---|
| Hospital A | 9 | ... | ... |
| Sent | | 3 | 3 |
| Received | ... | 1 | 1 |
| Unknown | ... | ... | 1 |
| Hospital B | 11 | ... | ... |
| Sent | | 1 | 3 |
| Received | ... | ... | 1 |
| Unknown | ... | 1 | ... |
| Total patients | 20 | 6 | 9 |

The other parties to messages sent or received through another person were four physicians, one family group, one

one unknown, one researcher, and eight nurses; however not one of the latter was mentioned as a specific individual.

## Intercom System

In both hospitals staff members rather than patients chose to activate the intercom system. The patient signals with his call light which may be answered over the intercom system or face-to-face.

Eight patients at Hospital A and three at Hospital B said they had never used the intercom system. Six at Hospital A and nine at Hospital B said it was used only in response to their calls. Four patients at Hospital A and five at Hospital B said the staff initiated communication with them through the intercom system.

## Telephone Communication

Only one patient said he had never used the telephone since being admitted to the hospital. Frequencies of telephone use approximated by the patients appear in Table 44.

Six patients at Hospital A and nine at Hospital B sent more messages than they received; six patients at Hospital A and five at Hospital B received more than they sent. Five at Hospital A and two at Hospital B estimated the sending and receiving was equally divided. The data for one patient at Hospital B are unknown.[1]

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[1]Another patient described her prehospitalization frustration with telephone use. After fracturing her ankle, she dragged herself to the telephone only to be told, "You may dial that number yourself," by the operator who then rang off.

TABLE 44

USE OF TELEPHONE DURING HOSPITALIZATION

| | Hospital A | Hospital B |
|---|---|---|
| None | 1 | ... |
| 1-3 x total | 9 | 4 |
| 1-3 x per day | 5 | 7 |
| 4-6 x per day | 1 | 2 |
| Oftener | ... | 1 |
| Unknown | 2[a] | 3[b] |
| Total patients | 18 | 17 |

[a]These patients answered 10 and 40 percent of their communications were by telephone.

[b]These patients answered 10,25, and 50 percent of their communications were by telephone.

### Other Methods of Communication

The patients could not recall other methods of communication they had used which were not mentioned in the interview guide.

### Patients' Perceptions of Hospital Personnel

Patients were asked how they categorized the various health workers with whom they came in contact during their hospitalizations. Their first responses were tabulated. Eight of the patients at Hospital A and five at Hospital B said they did not know how to categorize the workers; one additional patient at each hospital said he was unconcerned about it. Five patients at each hospital said they categorized workers by the uniforms they wore; three at

Hospital B by the worker's name tag; and one at Hospital B by the worker's deportment.

To a more specific question about differentiating a nurse from a housekeeper, fifteen patients at Hospital A and ten at Hospital B said their uniforms differentiated them, two at Hospital A and one at Hospital B said the worker's deportment; three at Hospital B said the tasks performed; and one patient at Hospital A and three at Hospital B said they could not differentiate a nurse from a housekeeper.

One patient at Hospital A and three at Hospital B said they thought they knew the head nurse on the unit by sight.

Patients reporting "just talking" by health workers, as opposed to talking while performing some task for the patient, are recorded in Table 45.

The patients at Hospital A reported their nontask-related conversations with the health workers consisted of health topics in two cases, nonhealth topics in three, and unknown in one. At Hospital B the conversations consisted of nonhealth topics in three cases and unknown in three. None of the patients was dissatisfied with the topics.

The patients at Hospital A said they initiated the subjects in two cases, the other person in one, equally in two, and unknown in one. At Hospital B the other person initiated in two cases, equally in one, and unknown in three. None of the patients expressed dissatisfaction with the initiation process.

TABLE 45

NONTASK-RELATED COMMUNICATIONS WITH HEALTH TEAM MEMBERS

| | Hospital A | | | Hospital B | | | |
|---|---|---|---|---|---|---|---|
| | 2-10 Per Day | Daily | Less Than 1 x Day | 2-10 Per Day | Daily | Less Than 1 x Day | Total |
| Physician | ... | ... | ... | ... | ... | 1[a] | 1 |
| Nursing Student[b] | 3 | ... | ... | ... | ... | ... | 3 |
| Nurse Aide | ... | ... | ... | ... | ... | 1 | 1 |
| Housekeeper | 1 | ... | ... | ... | ... | ... | 1 |
| Employee Not Assigned to Patient's Unit | ... | 1 | 1 | 1 | 2 | 1 | 6 |
| Total patients | 4 | 1 | 1 | 1 | 2 | 3 | 12 |

[a]This physician, a church comrade of the patient, made a social visit.

[b]No nursing students were on duty at Hospital B during the interview period.

The frequencies with which the nontask-related communication occurred at Hospital A are: two to ten times a day, four patients; less than once a day, one patient; and unknown, one patient. At Hospital B the frequencies with which nontask-related communications occurred are: from two to ten times a day, one patient; daily, two patients; less than once a day, one patient; and unknown, two patients. All the patients were satisfied with the frequency of communication.

The lengths of time spent on nontask-related communications at Hospital A are: eleven to fifty-nine minutes, one patient; one to ten minutes, three patients; and unknown, two patients. All were satisfied except one patient at Hospital B who desired more communication with the aide.

## The Good Patient

Although two patients at Hospital A and three at Hospital B could not describe a good patient in regard to communication with health workers, thirty-four were willing to rate themselves. Four patients at Hospital A and three at Hospital B described a good patient regarding communication along some dimension of openness and honesty with the health worker. Twelve patients at Hospital A and eleven at Hospital B described a good patient as undemanding in his communications.

Twelve patients at Hospital A rated themselves as good patients, six as medium. Eleven patients at Hospital B rated themselves good, five medium, and one would not commit himself.

# CHAPTER IV

## ANALYSIS AND INTERPRETATION

### Patients Eligible But Excluded From the Sample

This sample of patients is not a random one, in which any person in a given population has an equal chance to be included. Patients favoring any of the three hospitals whose administrators failed to answer the researcher's invitation to participate were thereby excluded. Although no item was included to test the patients' loyalty to a specific hospital, several patients volunteered information on such loyalties so that establishing a criteria of first time admission to the particular institution almost guarantees the sample of patients will not represent its typical population.

In addition, on many interview days more patients were available than could be interviewed in the time allotted. Patients judged likely not to have normal communication contacts in the hospital were excluded, for instance: a patient in protective isolation, one under sheriff's guard, an adult patient on the pediatrics unit, and one on the temporary medical-surgical unit in Hospital B. Three patients were excluded by the researcher because they

were in pain the morning the interview was scheduled.[1] Several patients who were otherwise eligible were excluded because they were sleeping, being discharged, or out of their rooms. The latter especially may have had different and more extensive communication contacts than the patients whom the researcher found "at home" in their rooms. Refusal to participate occurred in three instances. One physician would not permit a newly diagnosed cancer patient to be interviewed, and one patient at each hospital refused to participate. The patient who refused at Hospital A said he would be willing to be interviewed at another time; the one at Hospital B began the interview but was involved in litigation regarding her injury and apparently was nervous about talking to strangers. Two patients were excluded because of administrative failure. In one case the patient's chart failed to indicate she previously had been a patient in Hospital A. In the second case the physician's receptionist failed to relay the request for permission to interview his patient.

## The Sample

In addition to the above reservations, the sample may not reflect the population of the two hospitals because of

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[1] In the most striking case of discrepancy between the meaning assigned to "acutely ill" by the physician and the head nurse on one hand and the researcher and the patient on the other, one patient with three tubes protruding from various orfices replied to the researcher's "How do you feel?" by saying, "Like last year's tennis shoe." He was excluded.

the criteria that patients be well enough to tolerate the interview. The physician's refusal described above excluded one patient whose future may be changed as a result of communication she receives at the hospital. For many of the patients interviewed, hospitalization is not likely to change their life styles or outlook. The extent to which patients' lives are changed by hospitalization is unknown.

All the measurements of time are patients' estimates and may vary greatly from objective measurements. Nevertheless, if a patient perceives his physician spending fifteen minutes or less than a minute with him, his perception will color his response to the physician whether or not the perception is objectively correct. Regarding most important communication on various subjects, the patient is the only possible source of this information. Who but the patient could know what he considers most important?

## Personal Characteristics

The mean age for the males interviewed at Hospital A was 14.3 years greater than that of the males at Hospital B. The mean age for the females at Hospital A was 12.6 years less than that of the females at Hospital B. The large age differences between sexes are obscured by reporting a difference between mean ages of all patients at the two hospitals of 0.8 years, and between males and females as 3.5 years.

The present sample's marital status is compared with that of the population of the United States in 1967 in

Table 46. As is seen, the married and separated or divorced categories of patients are each within 0.2 percent of the corresponding categories throughout the country. The large discrepancies in the widowed and single categories may be a function of age since the median age of the sample was 57 years and of the United States population in 1970[1] was 27.8 years.

TABLE 46

MARITAL STATUS OF THE SAMPLE AND UNITED STATES POPULATION

| | Present Sample | United States, 1967[a] |
|---|---|---|
| Married | 65.7% | 65.5% |
| Widowed | 17.1 | 8.1 |
| Single | 14.3 | 23.7 |
| Separated or Divorced | 2.9 (Sep.) | 2.7 (Div.) |
| Total | 100.0% | 100.0% |

[a]World Book Encyclopedia, 1969, s.v. "Marriage," by Harold T. Christensen.

## Socioeconomic Status

The percentage of patients reporting their own occupations is compared with the distribution of employed

[1]Darlene R. Stille, "Census," 1972 World Book Year Book (Chicago: Field Enterprises Corp., 1972), p. 274.

persons in the United States in 1969 in Table 47. The categories of housewife and student are omitted from the sample data and the percentages are calculated on the basis of the twenty-six remaining patients as 100 percent.

TABLE 47

OCCUPATIONAL DISTRIBUTION OF THE SAMPLE AND UNITED STATES LABOR FORCE

| | Present Sample[a] | | | United States 1969[b] |
|---|---|---|---|---|
| | Hospital A | Hospital B | All Patients | |
| White Collar | 23.0% | 53.8% | 38.5% | 47.0% |
| Blue Collar | 53.9 | 38.5 | 46.2 | 36.0 |
| Service | 15.4 | 7.7 | 11.5 | 12.0 |
| Farm | 7.7 | ... | 3.8 | 5.0 |
| Total | 100.0% | 100.0% | 100.0% | 100.0% |

[a]Based on twenty-six patients reporting these occupations.

[b]Seymour Wolfbein, Work in American Society (Glenview, Illinois: Scott Foresman and Co., 1971), p. 46.

Hospital B's patients more closely approximate the national distribution of white and blue collar workers than do Hospital A's patients, but the reverse is true of service and farm workers.

The median years of schooling completed by the males in the sample was twelve, of the females excluding the two still enrolled in school, eight. The median years of schooling completed by members of the United States labor force is 12.3 for males and 12.4 for females,[1] however, since labor force participation varies directly with years os schooling,[2] the seven housewives skew the sample's median. When the housewives are excluded, the median for the females in the sample is twelve years of schooling completed, much closer to the national median of the labor force.

## Geographic Data

Of the thirty-five patients, 74.2 percent were Michigan natives. Of the Hospital A patients, 27.8 percent did not live in the Hospital's county, while 35.3 percent of Hospital B's patients lived beyond its county lines. The fact that 31.4 percent of the sample did not live in the county in which the hospital is located may have strongly influenced those patients' communication contacts.

## Hospitalization Data

As indicated in Chapter 3, two-thirds of the medical patients were interviewed at Hospital A and two-thirds of

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[1]Seymour Wolfbein, Work in American Society (Glenview, Illinois: Scott Foresman and Co., 1971) p. 58.

[2]Ibid.

the surgical patients at Hospital B, although medical patients comprise 48.6 percent and surgical patients 51.4 percent of the sample.

Roughly one-third of the patients were in each of the three stage of illness categories.

The sample met the criteria of newness to the hospital situation fairly well: 34.3 percent of the patients had never been hospitalized before; 28.6 percent had been hospitalized just once; and 37.1 percent had been hospitalized more than once but never in the hospital in which the interview took place.

The sample of patients is older than the average age of discharged patients in the United States.[1] Of the sample, 65.7 percent were under sixty-five years of age compared to 75.4 percent nationally. Patients over sixty-five represented 34.3 percent of the present sample and 24.3 percent of the national sample.[2]

Regarding ambulation outside of their rooms, 47.1 percent of the medical and 55.6 percent of the surgical patients were ambulatory; 58.9 percent of the males and 44.4 percent

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[1]U.S. Department of Health, Education, and Welfare, Inpatient Utilization of Short-stay Hospitals by Diagnosis, United States--1965 (Washington, D.C.: Government Printing Office, 1970), p. 31.

[2]The national sample included patients under fifteen years of age, comprising 14.2 percent of the 4,116 patients whose ages were stated.

of the females were ambulatory; and 44.4 percent of the Hospital A patients and 47.1 percent of the Hospital B patients were ambulatory.

The mean hospital day on which the interview was conducted varied between 5.5 and 5.9 by sex and major medical classification.

## Communication Variables

### Background Information

Patients' reports of their previous contact with hospitals indicated 11.4 percent had had very little contact; 22.9 percent had visited a close relative in a hospital; and 65.7 had been a patient at least once before.

Opinions of hospitals were reported as positive before hospitalization by 28.6 percent of the patients, and as positive when interviewed by 77.1 percent. Negative opinions of hospitals were reported by 28.6 percent of the patients recalling their prehospitalization thoughts, and by 8.6 percent of the patients on the day of the interview. Health workers fared even better than hospitals in the opinion survey. Positive prehospitalization opinions of health workers were reported by 22.9 percent of the patients in the sample; whereas positive opinions on the day of the interview were expressed by 88.6 percent. Negative opinions of health workers were held by 8.6 percent of the patients before hospitalization and 2.9 percent on the day

of the interview.[1] No attempt was made to assess the extent to which Coser's finding of patient enforcement of staff norms against complaining might have been operative at the two hospitals in this study.

Although nineteen of the patients characterized themselves as highly talkative, only 42.1 percent of them said they would initiate a telephone call just to visit, compared to 75 percent of those characterizing their talkativeness as medium, and 62.5 percent of those placing themselves in the low category. Only ten patients indicated a sexual difference to dominance of dinner table conversation with females indicated as dominant in eight of the ten families.

### Most Extensive Communication

Dividing the most extensive communication contacts since hospitalization into helping professionals[2] and non-professionals, only 8.7 percent of the patients naming such a contact mentioned professionals, both nurses. Both of the

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[1]The patients expressing neutral, divided and no opinions are not repeated here but the basis for the percentage is the total sample of thirty-five patients.

[2]Professional contacts for this purpose include anyone whose job is helping the patient as contrasted with incidental contacts such as roommates and family members. This study's purpose does not include answering the question, "Who is a professional?"

patients indicated they initiated subject matter more frequently than did the nurses, whereas the patients naming nonprofessional contacts said they initiated subjects in 19.0 percent of the cases, the other person did so in 19.0 percent of the cases, and both persons initiated equally in 61.9 percent of the cases. Both patients reported they discussed health-related subjects with the nurses compared to 50 percent of the patients naming nonprofessional contacts who said they discussed health-related subjects.

The two patients mentioning professionals as most extensive contact saw the individuals up to ten times or less than once a day. Of the patients reporting a most extensive contact, 52.2 percent named the individual probably most available for communication, a roommate. On the other hand, 13 percent of the patients naming a most extensive contact indicated that person was available for communication less than once a day. Combining that 13 percent with those who answered "No one," or gave plural answers, 42.9 percent of the thirty-five patients either could not name an individual with whom they had most extensive contact since hospitalization or named an individual whom they contacted less than once a day.

Of the twenty-three patients naming a most extensive contact, 13 percent said they talked all day to the person most available, the roommate. On the other hand, 30 percent of the twenty-three also named the roommate but said the most extensive contact consisted of one to ten minute

exchanges. Of the twenty-three patients naming a most extensive contact, only four, or 17.4 percent, indicated they had disagreed with the person at all, half with professionals and half with nonprofessionals.

## General Health Matters

Only six patients, or 17.1 percent of the sample, discussed general health matters with anyone since admission and only two of those named health professionals as the contact. Only three patients, or 8.6 percent of the sample, named a most important contact on general health matters, all of them at Hospital A; and only one of the three a health professional.

## Patients' Own Health

### Most Extensive Contact

Of the twenty-nine patients naming a most extensive contact on the subject of their own health, 31 percent named professionals, all physicians; 41.4 percent named spouses; 20.7 percent, other relatives; and 6.9 percent, unrelated persons.

Of the nine patients naming physicians as most extensive contacts on their own health, 22.2 percent said their communications were patient initiated, 44.4 percent said physician initiated, and 33.3 percent said equally initiated. The corresponding percentages for the patients naming nonprofessional most extensive contacts are 30 percent

patient initiated, 15 percent other initiated, and 55 percent equally initiated.

Of the nine patients naming physicians as most extensive contacts on their own health, two-thirds saw the physician daily and one-third less often. Of the twenty naming nonprofessional most extensive contacts on their health, 5 percent saw the person all day, 45 percent two to ten times a day, 30 percent once a day, and 20 percent less frequently. One of the nine patients naming physicians, or 11.1 percent, was dissatisfied with the frequency of communication, whereas three of the patients naming nonprofessionals, or 15 percent of that group, were dissatisfied with the frequency of communication.

Of the nine naming physicians as most extensive contacts on their own health, 11.1 percent said the physician's visit usually lasted from eleven to fifty-nine minutes, 66.7 percent said one to ten minutes, and 22.2 percent said less than one minute. Of those naming nonprofessional most extensive contacts, 65 percent said the visits lasted one hour or more, 30 percent said eleven to fifty-nine minutes, and 5 percent said one to ten minutes. Two of the patients naming physicians, or 22.2 percent, were dissatisfied with the length of contact. Three patients, or 15 percent of those naming nonprofessionals were dissatisfied with the length of contact. All four patients admitting to disagreements with the person named, or 13.8 percent of those naming most extensive contacts on their own health,

disagreed with nonprofessional contacts rather than professional ones.

Most Important Contact

Two of the thirty-five patients could name no one with whom they had the most important communication on their own health since admission. Of the remaining thirty-three patients, 75.8 percent named professional persons as the most important contact on their own health. Of those naming professional persons, 20 percent saw their communication as patient initiated, 60 percent as professional initiated, and 20 percent equally initiated. Twenty-four patients, or 96 percent, said 76 percent or more of their communication with the professionals was hospitalization-related. Those naming nonprofessional persons characterized their communication as 62.5 percent patient initiated, 12.5 percent other initiated, and 25 percent equally initiated.

To explore whether sex roles may influence initiation with physicians who were all male, the patient-professional initiation reports were divided by sex. More males than females reported equal initiation with the physician, but a slightly larger percentage of females than males reported patient initiation.[1]

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[1]Of the eleven males, 18.2 percent reported patient initiation, 54.6 percent physician initiation, and 27.2 percent equal initiation. Of the fourteen females, 21.4 percent reported patient initiation, 64.3 percent physician initiation, and 14.3 percent equal initiation.

Of the twenty-five patients naming professionals as their most important contacts on their own health, 8 percent saw the contact two to ten times a day, 68 percent once a day, and 24 percent less frequently. Of the patients naming nonprofessional contacts, 62.5 percent saw the person two to ten times a day, 12.5 percent once a day, and 25 percent less frequently. One patient, or 4 percent of those naming professionals was dissatisfied, whereas two patients, or 25 percent of those naming nonprofessionals, were dissatisfied with the frequency.

The length of contact with professionals was reported by 16 percent of the patients to be eleven to fifty-nine minutes, by 72 percent as one to ten minutes, and by 12 percent as less than one minute. All the patients naming nonprofessionals said the visits lasted one hour or more. Four patients, or 16 percent of those naming professionals, were dissatisfied with the length of the visits, compared with two patients representing 25 percent of those naming nonprofessionals who were dissatisfied with the length of the visits.

Three patients, or 12 percent of those naming professionals said they had difficulty understanding his terminology. Those naming nonprofessionals had no difficulty with terminology.

Three patients, or 12 percent of those naming professionals disagreed with the contact compared with two

of the patients, or 25 percent of those naming nonprofessionals who disagreed with the contact.

The present study found the physician was named by 68.6 percent of the patients as most important communication contact on the patient's own health. Of the patients naming physicians, 4.2 percent were dissatisfied with the frequency, 16.7 percent dissatisfied with the length of the visits, and 12.5 percent had difficulty understanding the physician's terminology. Korsch and Negrete found no correlation between the length of the visit and the parent's satisfaction, a confirmation of overuse of technical language by the physicians with 20 percent of the mothers uncertain of the child's diagnosis following the visit, and a direct relationship between the amount of nonmedical conversation and the parent's satisfaction. No attempt was made in the present study to validate the patient's estimates of time spent or proportion of conversation devoted to health or nonhealth subjects, but one physician was observed to comment on a toy animal on the patient's bed, whereas the patient in the interview said their communications were 100 percent health related. Small civilities may be selectively ignored by medical-surgical patients in their concern about topics of greater significance to them, however, Aguilera[1] advocates use of nonverbal modes of

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[1]Donna Conant Aguilera, "The Use of Physical Contact (Touch) as a Technique of Nonverbal Communication with Psychiatric Patients" in Exploring Progress in Psychiatric Nursing Practice (New York: American Nurses Association, 1966) p. 34.

communication such as shaking hands and establishing eye contact as means of establishing the psychiatric patient's sense of self-worth. Great differences exist between the situations and the physicians in the Korsch and Negrete study and those in the present one. A walk-in clinic is hardly comparable with a private practice situation in which patients are a more important reference group for the physicians than in a clinic situation. In spite of the fact that 45.8 percent of the patients in the present study naming the physician as most important contact on their own health knew the physician two years or longer, 33.3 percent knew him ten days or less which is somewhat similar to a walk-in clinic; but only 25 percent of those knowing the physician ten days or less expressed dissatisfaction with their communication, in both cases with the length of his visits, the longest of which was described as "a couple of minutes."

## Patients' Feelings About Health

More than half, or 57.1 percent, of the thirty-five patients named an individual with whom they had most extensive communication about their feelings about being ill. Only 5 percent of the twenty patients thus reporting named a professional, whereas 85 percent named a related nonprofessional and 10 percent an unrelated nonprofessional.[1]

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[1]The researcher is included as an unrelated nonprofessional since she was not accountable for the patient's nursing care or health instruction at the time of the interview. Her role regarding the patient's processing of his illness

The patient naming a professional as most extensive contact on health feelings saw that person less than once a day. Of the patients naming nonprofessionals, 36.8 percent saw the individual two to ten times a day, 47.4 percent once a day, and 15.8 percent less frequently, all at Hospital A. The two dissatisfied patients named nonprofessionals.

Eighteen, or 51.4 percent, of the thirty-five patients named a most important contact on feelings about health. Only one, or 5.6 percent of the eighteen, named a professional; 83.3 percent a related nonprofessional, and 11.1 percent an unrelated nonprofessional.

The patient naming the professional saw that person once a day. Of those naming the nonprofessionals, 41.2 percent saw the person two to ten times a day, 47.1 percent once a day, and 11.8 percent less frequently. Three patients or 18.8 percent of those naming nonprofessionals as most important contacts on health feelings were dissatisfied with frequency.

The patient naming the professional indicated the visit lasted from one to ten minutes. Of those naming nonprofessionals, 88.2 percent indicated the visits were one hour or

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was that of listener. That she represents half the units in this category is understood to be a contamination of the data by the research process, however, the patient clearly enunciated his feelings about this heart attack being a "warning," indicating he had thought about the matter and perhaps would have talked to someone else about it had the opportunity occurred before the interview.

more while 11.8 percent said eleven to fifty-nine minutes. Four of the patients, or 23.5 percent of those naming non-professionals, were dissatisfied.

## Hospital Organization

Only eight patients, or 22.9 percent of the sample, talked to any individual about the organization of the hospital. None of them talked to the providers of care as individuals, but only mentioned them as plural contacts. Four talked to roommates and four to relatives.

## Communication Load

Eleven, or 31.4 percent, of the thirty-five patients admitted communication underload since admission. The underloaded patients were evenly divided as to hospital and to stage of illness: four in the diagnostic stage, three in the treatment stage, and four in the prognostic stage. Of the underloaded patients, 63.6 percent were female and 54.5 percent were surgical patients. Their ages ranged from 15 to 66 years with a mean of 39.5. Ten of the eleven, or 90.9 percent, indicated the underload was hospitalization-related. All of the subjects specifically related to their own cases, however, and aside from the patient who discussed with a roommate "how we get out of here," none could have been answered by information usually given in a patient's handbook or introductory material.[1]

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[1]Hospital B gave such a booklet to the patients; Hospital A did not. The patient wondering about the discharge procedure was at Hospital B but apparently had not read the page in the booklet titled "Going Home."

## Interruptions

Interruptions occurred in 57.1 percent of the interviews, however, only 14.3 percent of the patients said their hospital communications had been interrupted. The length of the interview, rivaled only by reported lengths of communication with roommates and visitors, may explain the discrepancy between the patients' reports of previous interruptions and those occurring during the interviews.

## Nonverbal Communication

Twenty-seven, or 77.1 percent, of the patients indicated they had communicated through touch with someone since admission. Of the twenty-seven patients, 7.4 percent said the touches were received from professionals and 92.6 percent said from nonprofessionals. The preponderance of nonprofessional contacts seems consistent with Frank's observation that tactile communication usually involves only two persons and expresses affection of hostility.[1]

Of the total sample, 80 percent had used the call signal at least once, but only 8.6 percent admitted to using it three to six times a day or oftener. Two-thirds of the most frequent users of the call signal were not ambulatory on the day of the interview.

Twelve, or 34.3 percent, of the thirty-five patients recalled using gestures or signals other than the call signal.

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[1]Lawrence K. Frank, "Tactile Communication," in Communication and Culture, ed: Alfred G. Smith (New York: Holt, Rinehart and Winston, 1966), p. 203.

Of those using signals, 58.3 percent sent signals oftener than they received them and 41.7 percent received more than they sent. The other person involved in the signal exchange was a professional[2] with 58.3 percent of the patients, non-professional with 33.3 percent, and unknown with 8.3 percent.

## Interposed Verbal Communication

Twenty-eight, or 80 percent of the sample, said they had sent or received written messages since admission to the hospital, but only two, or 7.1 percent of the twenty-eight named a professional as the other party to the exchange.

Fifteen, or 42.9 percent, of the patients recalled sending or receiving a message through another human being. Of the fifteen, 66.7 percent sent more messages than they received, 20.0 percent received more than they sent, 6.7 percent sent and received equally, and 6.7 percent could not remember the details of the incident. Twelve, or 80 percent of the patients reporting human-interposed communication, indicated it occurred with professionals.

Only one patient, representing 2.9 percent of the sample, claimed to have had no telephone communication since admission to the hospital. Of the total sample, 71.4

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[1] The housekeeper is included in professional according to the definition on page 90.

percent used the telephone up to three times a day, 11.5 percent oftener, and 14.3 percent unknown.[1]

## Patients' Perceptions of Hospital Personnel

Four patients, or 11.4 percent of the sample, indicated they could not differentiate a nurse from a housekeeper, however, no validation was made of the correctness of the perceptions of the other thirty-one patients who did claim ability to differentiate nurses from housekeepers.

An equal number, 11.4 percent, said they knew the head nurse by sight and one volunteered that "her name starts with S," which was correct; but the same uncertainty regarding correctness obtains here as in the above instance.

Twelve, or 34.3 percent of the thirty-five patients, reported nontask-related communications with health professionals. Of the twelve, 58.3 percent reported their contacts were persons not assigned to their nursing units. Five of those seven persons were individuals with whom the patient had had some contact before admission; one was a former hospital roommate of the patient during this hospitalization, and one of the patients and her contact shared mutual friends. Of the patients naming individuals assigned to their nursing units, one had known the individual prior to admission, thus, only 11.4 percent of the thirty-five patients had nontask-related communications with health

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[1]See footnotes to Table 44, page 78.

professionals they neither knew before admission nor claimed with a special introduction.

## The Good Patient

Of the thirty patients willing and able to describe their ideas of good patients regarding communication with health workers, seven, or 23.3 percent, mentioned dimensions of openness or honesty in communications compared with 76.6 percent who described a good patient undemanding. Of the thirty-four patients willing to rate their behavior as patients, 67.6 percent said good, and 32.4 percent said medium.

## Number of Contacts Per Patient

Tallying the different individuals named by each patient in answer to the eight questions about most extensive communication, general health communication, his own health, his feelings about his health, and the hospital organization, the number of contacts of each patient were determined. The patients at Hospital A had between zero and five different contacts with a mean of 2.3 and a median of 2. Those at Hospital B had between zero and six different contacts with a mean of 2.4 and a median of 2.

Using the same method to examine professional contacts, the patients at each hospital reported between zero and two different professional contacts with a mean of 0.9 and a median of 1. Of the patients naming professional contacts, five, or 14.3 percent of the total sample, named particular

nurses, three at Hospital A, all nursing students, and two at Hospital B. Of the thirty-five patients, 11.4 percent claimed to know the head nurse by sight, 5.6 percent of the Hospital A patients and 17.6 percent of the Hospital B patients.

Using the two measures just described, the two hospitals which are of quite different size but of similar professional structure, staffed by private practice physicians, differed little in communication contacts reported by the patients except in the length of professional experience of the nurses named as individual contacts.

One patient at each hospital named no individual contacts. The patient at Hospital A lived in an adjoining county; the one at Hospital B lived in the hospital's county. Four patients at each hospital, or 22.9 percent of the sample, named no professional contacts. They ranged in age from 51 to 77 years with a mean of 64.1, were 62.5 percent male, fairly evenly divided by stage of illness, and 62.5 percent were medical patients.

Seven patients at Hospital A named plural contacts whom they could not narrow to a single individual. One of the seven named three different categories of individuals; the others, one each. Eight patients at Hospital B named plural contacts, all one each. One patient at Hospital A and three at Hospital B named personal contacts as plurals, one her family, one her children and two their friends. All the rest of the plural contacts named were nurses and

roommates. One patient naming no individual contacts also named no plural contacts; the other named one plural contact, her children.

Of the thirty-five patients, 65.7 percent named a most extensive contact since hospitalization, 17.1 percent named a most extensive contact on general health matters, and 8.6 percent named a most important contact on general health matters. On the subject of the patient's own health, 82 percent of the thirty-five patients named a most extensive contact; 94.3 percent named a most important contact; 57.1 percent named a most extensive contact on feelings about health; and 51.4 percent named a most important contact on feelings about health.

In every category except most important communication on the patient's health, less than one-third of the thirty-five patients named professional contacts. Of the thirty-five patients, 5.7 percent named a professional as most extensive contact since admission, 5.7 percent as most extensive contact on general health, 2.9 percent as most important contact on general health, 25.7 percent as most extensive contact on the patient's health, 71.4 percent as most important contact on his health, 14.3 percent as most extensive contact on his health feelings, and 2.9 percent as most important contact on health feelings.

More than one-fifth of the thirty-five patients named individuals whom they saw less than once a day as most extensive or most important communication contact on their

own health. Of the thirty-five patients, 8.6 percent named such an individual as their most extensive contact since hospitalization, 2.9 percent as both most extensive on general health matters and most important on general health, 20 percent as most extensive contact on his own health, 11.4 percent as most extensive contact on health feelings, and 5.7 percent as most important contact on health feelings.

Of the thirty-five patients, 2.9 percent named a professional seen less than once a day as most extensive contact since hospitalization, 11.4 percent named such a professional as most extensive contact on his own health, 17.1 percent as most important contact on his own health, and 2.9 percent as most extensive contact on health feelings. None of the patients named professionals they saw less than once a day in answer to the general health questions or the most important communication on health feelings question.

Three-fifths of the thirty-five patients named individuals whom they usually contacted for ten minutes or less as their most important contacts on their own health. Of the thirty-five patients, 20 percent named individuals with whom they communicated for ten minutes or less as their most extensive contacts since hospitalization, 5.7 percent as their most extensive contacts on general health, 25.7 percent as the most extensive contacts on their own health, 60 percent as the most important contact on their own health,

2.9 percent both as the most extensive and most important contacts on health feelings. No one named an individual seen for ten minutes or less as most important contact on general health matters.

Of the thirty-five patients, 2.9 percent named a professional seen for ten minutes or less as most extensive contact since admission, 22.9 percent named such a professional as most extensive contact on the patient's own health, 60 percent as the most important contact on their own health, 2.9 percent each as most extensive and most important contacts on health feelings. No one named a professional seen for ten minutes or less in answer to the general health questions.

## Channels and Settings

Nearly all the communications reported by the patients took place face-to-face. Although two patients used the telephone with persons they named as most extensive or most important contacts, they were not the dissatisfied patients on the dimension of method. All the patients except one indicated communication occurred in their rooms with which they were satisfied except for two twenty-one and twenty-two year old females who did not like their roommates overhearing their conversations.[1] Although both hospitals assigned

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[1]Nothing was reported similar to the incident in a different hospital in which the surgeon informed a spouse of the patient's fatal diagnosis in an elevator filled with people, including the researcher's student who related the event.

patients of similar age to share rooms and Hospital B inquired about the patient's smoking habits before assigning a roommate, the equation of similar age with communication homophily appears to be incorrect at least for females, since both of these young women stated their interests differed from those of their roommates, as did an elderly patient who said she had had no meaningful communication with her roommate. "She's eighty-six," explained the seventy-six year old patient.

## Initiation

Comparing the three categories in which more than half the patients named an individual contact, those of most extensive contact since hospitalization, most extensive and most important contact on the patient's health, the percentage of patient initiated communication differs by only 4.2 percent in the three areas, but other initiated communication steadily increases and equally initiated communication decreases as the communication becomes more focused on and important to the patient. Table 48 presents this initiation, subject data.

All of the patients naming a most extensive communication contact were satisfied with the initiation of subjects with that individual. Of those naming most extensive contacts on their own health, 96.6 percent were satisfied with the initiation process as were 93.9 percent of those naming most important communication contacts on their own health.

TABLE 48

INITIATION OF SUBJECTS IN THREE CATEGORIES

| | Most Extensive | Patient's Own Health | |
|---|---|---|---|
| | | Most Extensive | Most Important |
| Patient Initiated | 26.1% | 27.6% | 30.3% |
| Other Initiated | 17.4 | 24.1 | 48.5 |
| Equally Initiated | 56.5 | 48.3 | 21.2 |
| Total | 100.0% | 100.0% | 100.0% |
| Total patients | 23 | 29 | 33 |

Comparing initiation with professionals and with nonprofessionals on the subject of the patient's health, over 55 percent of the patients naming nonprofessionals as their most important contacts on their own health said the communication was patient initiated, whereas an equal percentage of the patients naming professional contacts under the same conditions said the communication was initiated by the professional. The percentages of patients reporting the initiation of subjects with the most extensive and most important contacts on their own health appear in Table 49. The fact that nonprofessional contacts predominate as most extensive contacts on the patient's health and professionals as the most important ones is readily apparent.

TABLE 49

INITIATION OF SUBJECTS ON PATIENTS' HEALTH BY CATEGORY OF CONTACT

| | Most Extensive | | Most Important | |
|---|---|---|---|---|
| | Prof. | Nonprof. | Prof. | Nonprof. |
| Patient Initiated | 22.2% | 30.0% | 23.1% | 57.1% |
| Other Initiated | 44.5 | 15.0 | 57.7 | 14.3 |
| Equally Initiated | 33.3 | 55.0 | 19.2 | 28.6 |
| Total | 100.0% | 100.0% | 100.0% | 100.0% |
| Total patients | 9 | 20 | 26 | 7 |

Health Decisions

Of the thirty-three patients naming a most important contact on his own health, 39.4 percent said a professional had asked his opinion at least once compared with 3 percent who replied a nonprofessional had asked his opinion that often. Of the thirty-three patients, 36.4 percent said the professional had not asked his opinion and 21.2 percent said the nonprofessional had not asked his opinion, indicating in the patients' perceptions at least, that 57.6 percent of the thirty-three patients believed that they were never asked for their opinions, suggestions, or decisions on their health care by the person they judged to be the most important contact on their health.

Satisfaction-Dissatisfaction

Hospitalization seemed to favorably influence the study patients' opinions of hospitals and health workers. Negative prehospitalization opinions of the former were reported by 28.6 percent of the patients and of the latter by 8.6 percent of the patients, but present negative opinions on the days of the interviews dropped to 8.6 percent for hospitals and 2.9 percent for health workers.

Nineteen, or 54.3 percent, of the sample expressed dissatisfaction with at least one aspect of their communications in the hospital. Nine of these were at Hospital A, or 50 percent of its sample, and 10 at Hospital B, or 58.8 percent of its sample. It is possible that the patients interviewed at Hospital B were more articulate than those interviewed at Hospital A. The higher concentration of white collar workers at Hospital B[1] offers one possible interpretation of the differences in expressed dissatisfaction between hospitals, however, Conant's argument that the articulate patient is able to obtain needed nursing services from almost any nurse[2] could be extrapolated to predict that the more articulate patients should be more satisfied with nursing services, provided they feel free to ask for them, than those with fewer verbal skills. The

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[1] See Table 47, page 86.

[2] Lucy H. Conant, "Use of Bales' Interaction Process Analysis to Study Nurse-Patient Interaction," Nursing Research 14 (Fall 1965) :304.

Duff and Hollingshead study collaborates this view, finding private patients more satisfied with the hospital than semiprivate or ward patients, but indicating also that private patients were more sophisticated than the others regarding directing their complaints to persons with the power to remedy the situation.[1] The present study's focus was determined by the patients' perceptions of their most extensive and most important communications. No attempt was made to evaluate the patients' satisfaction with nursing services, nor was much indirect evidence gained since only five patients named an individual nurse as a communication contact in the study, a finding not divergent from those documented by Skipper[2] and Coser[3] in field studies and Couture[4] in an experimental study regarding the usefulness of information patients can obtain from nurses.

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[1]Duff and Hollingshead, Sickness and Society, p. 281.

[2]Skipper, "Communication and the Hospitalized Patient," p. 71.

[3]Coser, Life in the Ward, p. 77.

[4]Nancy A. Couture, Communicating with Patients: Approach and Content Used by Nurses (Ann Arbor: University Microfilms, no. 68-1261, 1967) p. 124.

# CHAPTER V

## CONCLUSIONS AND RECOMMENDATIONS

Although the thirty-five patients in two western Michigan general hospitals were obtained by neither random nor quota sampling, they were fairly evenly distributed by sex, stage of illness, and mean hospital day the interview occurred. The sample approximates larger random samples in the proportion of married and separated or divorced individuals, of service and farm workers, and of years of schooling of the labor force. The patients in the sample were unevenly distributed between the two hospitals in age, sex, major medical classification, and ambulation. Large differences between the present sample and larger, random samples are evident in the proportion of widowed and single individuals, white and blue collar workers, and age of patients discharged from short-stay hospitals. A larger percentage of patients interviewed at the smaller hospital lived outside its county than did those at the larger hospital.

Nearly two-thirds of the patients had been hospitalized before, but not in the institution presently housing them. The attempt to estimate entry behavior on talkativeness verified by telephone visiting lacked face validity.

The concept that patients are overwhelmed with communications while in the hospital was not supported by

this study. Although 65.7 percent of the patients named an individual with whom he had most extensive communication since admission, 42.9 percent of the sample either named no single individual or one whom he saw less than once a day as his most extensive contact, and 20 percent named an individual with whom he usually communicated for ten minutes or less as his most extensive contact since admission in spite of the fact that none of the patients occupied a private room. Even among patients naming roommates as their most extensive contacts since admission, great variation occurred in the amount of time spent with the roommate: 13 percent of the patients naming an individual most extensive contact said they talked with the roommate "all day" but 30 percent said they talked with the roommate for less than ten minutes at a time. Lack of communication homophily with roommates was reported by 8.6 percent of the patients.

Of the thirty-five patients, 17.1 percent reported communicating on general health matters with someone, one-third with health professionals. Only 34.3 percent of the sample reported nontask-related communication with the hospital staff, 58.3 percent of which was with employees from units other than the patient's, usually casual, social contacts rather than devoted to health instruction. These data offer little evidence to refute criticisms of American health care being episodic and fragmented; the patients in this study perceived little general health information to be offered by the institutions or their staffs.

The patients studied seemed to look for affective support among their significant others and for information from their physicians, however, one patient related details of her quest for medical information from her sister-in-law by telephone.

Although 82 percent of the thirty-five patients reported an individual contact as most extensive on their own health, 69 percent of these named a nonprofessional person, usually a spouse or other relative. The latter contacts also predominated as those communicating through touch. More than three-fourths of the patients had communicated with someone through touch but over 90 percent of the patients reporting tactile communication indicated it occurred with nonprofessional contacts. Of the total sample, 57.1 percent named a most extensive contact on health feelings, of whom 85 percent were relatives; 51.4 percent named a most important contact on his health feelings, of whom 83.3 percent were relatives. The bedside telephone was an important communication link with family and friends altough seldom used for most extensive or most important communications. Only 2.9 percent of the patients denied using the telephone at all since admission.

The category of most important communication on the patient's health is the only one which prompted more than one-third of the patients responding to name a professional contact. Of the thirty-five patients, 94.3 percent reported a most important contact on their health, 75.8 percent of

whom were professional persons, 96 percent physicians. Although Coser's study states nurses believe they help patients to understand the physician's terminology, only one patient in the present study said she received such information from the nurse. Most of the patients obtained their information from physicians, but they were not readily available for communication. More than one-fifth of the thirty-five patients named individuals whom they saw less than once a day as most extensive or most important contact on their own health: 11.4 percent named professionals seen less than once a day as most extensive contact on their own health, 17.1 percent named such professionals as most important contact on their own health.

Although health care is supposedly being changed to allow more patient participation, these patients more often than not deferred to the professionals' judgment without disagreement. Over 55 percent of patients naming nonprofessionals as most important on their own health said the subjects were patient initiated rather than other or equally initiated, but the same percentage of patients naming professional contacts under identical conditions said the subjects were professional initiated. Regardless of the contact's status, 57.6 percent of the patients naming a most important contact on their own health said that person had never asked for the patient's opinions, suggestions, or decisions on his health care. Regarding initiation of subjects in patient-physician exchanges, 9.8 percent more

females than males naming physicians as most important contact on the patient's health reported physician initiation, and 12.9 percent more males than females reported equal initiation of subjects.

The thirty-five patients named between zero and six individual communication contacts each, with a mean of 2.3 and a median of 2. They named between zero and two professional contacts with a mean of 0.9 and a median of 1. No professional contacts were named by 22.9 percent of the sample, the oldest subgroup for whom a mean age was calculated, 64.1 years. In spite of the fact that the physician gatekeeper believed these patients required hospitalization, the patients perceived no communication with professionals in the areas covered by the interview guide. Although the patients did not categorize themselves as underloaded, an observer would be inclined to do so. Additional support for a concept of communication patterns varying with the age of the patient is found in the 31.4 percent of the sample who categorized themselves as underloaded during this hospitalization. This was the youngest subgroup for whom a mean age was calculated, 39.5 years. Only 9.1 percent of the subjects on which the patients indicated they desired more information ordinarily would be found in orientation booklets prepared for new patients.

Most extensive and most important communications were overwhelmingly face-to-face and occurred in the patient's room. Only 5.7 percent of the patients mentioned another

mode of communication and 2.9 percent another setting for most extensive or most important communications.

Outside of the physician, the providers of health care were seldom mentioned as individual contacts. Only 14.3 percent of the patients named individual nurses, of whom all at the larger hospital were students. Regarding indirect communication, 42.9 percent of the patients sent or received messages through human beings, of which 80 percent were sent to or received from professional persons. Such a situation is potentially frustrating and error-ridden, however, these communications were not considered by the patients to be their most extensive or most important. Only 22.9 percent of the sample had discussed the hospital organization with anyone, none with the providers of health care. Of the thirty-five patients, just 5.7 percent thought they had had a communication overload in connection with their present illnesses, none delivered by providers of health care.

The call signal was used a total of three times or less by 42.9 percent of the sample, and two-thirds of the most frequent users of the call signal were not ambulatory on the day of the interview. Whoever their teachers, these patients learned to be undemanding, as 76.6 percent of the thirty who described a good patient defined him.

Although no objective measurement ascertained correctness of perceptions, 88.6 percent of the sample said they could differentiate nurses from housekeepers, the

majority by the uniforms. Of the total sample, 88.6 percent said they did not know the head nurse on the unit, 94.4 percent of Hospital A's sample and 82.4 percent of Hospital B's sample being unaware of her.

These data indicate little discernable difference between the contacts named by patients in the two hospitals, one of which is three times the size of the other with more than two and one-half times the visiting hours of the smaller hospital.

Although attempts were made to minimize obvious biases, and the sample compares favorably with larger random samples in several demographic areas, a repetition of the present study with other patients would be valuable in validating the tentative conclusions. In spite of the weaknesses of interviewing as a data gathering device, certain dimensions of patient communication, notably its importance to the patient, can be ascertained only by asking him.

Similar information gathered from patients who are hospitalized for longer periods of time might show differences in communication patterns from those of newly hospitalized patients. A third group of patients who might show still different patterns are those repeatedly hospitalized in a given institution, however, neither group would provide the perspective of a newcomer to a social situation.

Perhaps because of the bureaucratic structure of the hospital, the patient has little opportunity for meaningful

communication with many of the people with whom he comes in contact. The present study did not investigate the total number of contacts a patient has but only his perceptions of his most extensive and most important ones. A study of his total contacts might illuminate the reasons he has so few meaningful communications with the hospital staff.

Of some interest, but based on so few observations as to require a separate study for any conclusions to be drawn, are the four patients naming as plural contacts members of their families, whom they were unable to narrow to individuals after probing. One can more easily understand lumping hospital roommates and nurses into categories then family members. Additional subjects for study would be patients similar to the two who named no individual contacts.

An objective test of the correctness of patient's perceptions of hospital personnel might be helpful if it becomes apparent that patients have major communications with them or might indicate why patients do not have major communications with them. The present study did not find persons in the hospital hierarchy to be of great concern to the patients.

Communication is a significant dimension of professional health care, however, as Korsch and Negrete indicate, more than one-half of the physician's time in general practice, pediatrics, and internal medicine is spent communicating, not healing per se. Skipper, Tagliacozzo and Mauksch's study also found patients highly valued a good explanation from

their physicians. Of even greater importance in mental than in physical health, communication is, as King maintains, the treatment tool of psychiatry.

Considering the fact that these patients were given opportunities to express dissatisfaction in fifty areas of communication, the fact that 54.3 percent of the thirty-five patients expressed dissatisfaction in at least one area may not be extrapolated to a negative vote of confidence for health institutions and workers, however, it does indicate a probably fruitful field for future study.

# APPENDICES

APPENDIX A

Interview Guide

1. Before you came to the hospital as a patient, how much contact had you had with hospitals? When did that contact occur?

2. Before you came to the hospital as a patient, how much contact had you had with health workers? How much contact with each? When did those contacts occur?

3. Did you have an opinion of hospitals before you were admitted here? Would you tell me what it was? What is your present opinion of hospitals?

4. Did you have an opinion of health workers before you came here as a patient? Would you tell me what it was? What is your present opinion of health workers in general? Are there any exceptions you would like to mention?

5. Are you naturally a very talkative person?

6. Do you ever call someone on the telephone just to talk? How often do you call to visit? How long do you usually talk?

7. Who does most of the talking at the dinner table at your house? What do you usually talk about?

8. With whom have you spent the most time communicating since you have been hospitalized? How long have you known this person?

9. What method of communication did you use usually (face-to-face, telephone, touch, intercom, letter writing)? Were you satisfied with this method? If not, why not?

10. Where did these communication exchanges take place? Were you satisfied with the setting? If not, why not?

11. Which of you usually brought up the subjects you have discussed? Have you been satisfied with this arrangement? If not, why not?

12. Would you tell me the kinds of subjects you have discussed most often with this person? Have you been satisfied with the subjects? If not, why not?

13. How often have you communicated with this person? Have you been satisfied with this number of exchanges? If not, why not?

14. For how long at a time have you usually communicated with this person? Have you been satisfied with this amount of time? If not, why not?

15. How often have you disagreed with this person? Did you tell him? Why or why not?

16. With whom have you spent the most time communicating about general health matters since you have been hospitalized?

17. What method of communication did you use usually? Have you been satisfied with this method? If not, why not?

18. Where did these communication exchanges take place? Were you satisfied with the setting? If not, why not?

19. To what extent were the subjects you have discussed with this person related to your present hospitalization? Have you been satisfied with these subjects? If not, why not?

20. Which of you usually brought up the subjects that you have discussed? Have you been satisfied with this arrangement? If not, why not?

21. How often have you communicated with this person? Have you been satisfied with this number of exchanges? If not, why not?

22. For how long at a time have you usually communicated with this person? Have you been satisfied with this amount of time? If not, why not?

23. Did you have difficulty understanding the terminology this person used? Did you ask him or her to explain or rephrase? When did you ask?

24. How often have you disagreed with this person? Did you tell him? Why or why not?

25. With whom have you had the most important communication about general health matters since you have been hospitalized? How long have you known this person?

26. What method of communication did you use usually? Have you been satisfied with this method? If not, why not?

27. Where did these communication exchanges take place? Were you satisfied with the setting? If not, why not?

28. To what extent were the subjects you have discussed with this person related to your present hospitalization? Have you been satisfied with these subjects? If not, why not?

29. Which of you usually brought up the subjects that you have discussed? Have you been satisfied with this arrangement? If not, why not?

30. How often have you communicated with this person? Have you been satisfied with this number of exchanges? If not, why not?

31. For how long at a time have you usually communicated with this person? Have you been satisfied with this amount of time? If not, why not?

32. Did you have difficulty understanding the terminology this person used? Did you ask him or her to explain or rephrase? When did you ask?

33. How often have you disagreed with this person? Did you tell him? Why or why not?

34. With whom have you spent the most time communicating about your own health since you have been hospitalized? How long have you known this person?

35. What method of communication did you use usually? Have you been satisfied with this method? If not, why not?

36. Where did these communication exchanges take place? Were you satisfied with the setting? If not, why not?

37. To what extent were the subjects you have discussed with this person related to your present hospitalization? Have you been satisfied with these subjects? If not, why not?

38. Which of you usually brought up the subjects that you have discussed? Have you been satisfied with this arrangement? If not, why not?

39. Has this person ever asked for your opinion, suggestions, or decisions regarding your health care? How often?

40. How often have you communicated with this person? Have you been satisfied with this number of exchanges? If not, why not?

41. For how long at a time have you usually communicated with this person? Have you been satisfied with this amount of time? If not, why not?

42. Did you have difficulty understanding the terminology this person used? Did you ask him or her to explain or rephrase? When did you ask?

43. How often have you disagreed with this person? Did you tell him? Why or why not?

44. With whom have you had the most important communication about your own health since you have been hospitalized? How long have you known this person?

45. What method of communication did you use usually? Have you been satisfied with this method? If not, why not?

46. Where did these communication exchanges take place? Were you satisfied with the setting? If not, why not?

47. To what extent were the subjects you have discussed with this person related to your present hospitalization? Have you been satisfied with these subjects? If not, why not?

48. Which of you usually brought up the subjects that you have discussed? Have you been satisfied with this arrangement? If not, why not?

49. Has this person ever asked for your opinion, suggestions, or decisions regarding your health care? How often?

50. How often have you communicated with this person? Have you been satisfied with this number of exchanges? If not, why not?

51. For how long at a time have you usually communicated with this person? Have you been satisfied with this amount of time? If not, why not?

52. Did you have difficulty understanding the terminology this person used? Did you ask him or her to explain or rephrase? When did you ask?

53. How often have you disagreed with this person? Did you tell him? Why or why not?

54. With whom have you spent the most time communicating about your feelings about health since you have been hospitalized?

55. What method of communication did you use usually? Have you been satisfied with this method? If not, why not?

56. Where did these communication exchanges take place? Were you satisfied with the setting? If not, why not?

57. How often have you communicated with this person? Have you been satisfied with this number of exchanges? If not, why not?

58. Which of you usually brought up the subject of your feelings about your health? Have you been satisfied with this arrangement? If not, why not?

59. For how long at a time have you usually communicated with this person? Have you been satisfied with this amount of time? If not, why not?

60. With whom have you had the most important communication about your feelings about your health since you have been hospitalized? How longhave you known this person?

61. What method of communication did you use usually? Have you been satisfied with this method? If not, why not?

62. Where did these communication exchanges take place? Were you satisfied with the setting? If not, why not?

63. How often have you communicated with this person? Have you been satisfied with this number of exchanges? If not, why not?

64. For how long at a time have you usually communicated with this person? Have you been satisfied with this amount of time? If not, why not?

65. Which of you usually brought up the subject of your feelings about your health? Have you been satisfied with this arrangement? If not, why not?

66. With whom have you communicated most about the way the hospital operates and how you fit into the system since you have been hospitalized? How long have you known this person?

67. What method of communication did you use usually? Have you been satisfied with the method? If not, why not?

68. Would you tell me the kinds of subjects you have discussed most often with this person? Have you been satisfied with the subjects? If not, why not?

69. Which of you usually brought up the subjects which you have discussed? Have you been satisfied with this arrangement? If not, why not?

70. How often have you communicated with this person? Have you been satisfied with this number of exchanges? If not, why not?

71. For how long at a time have you usually communicated with this person? Have you been satisfied with this amount of time? If not, why not?

72. Did you have difficulty understanding the terminology this person used? Did you ask him or her to explain or rephrase? When did you ask?

73. How often have you disagreed with this person? Did you tell him? Why or why not?

74. Have you ever felt you have received so much information that you could not handle all of it since you have been hospitalized? What kind of information was excessive? Who gave you the most excessive information? What did you do about the excessive information?

75. Since you have been hospitalized, have you ever felt you were receiving too little information? If yes, could you tell me the kinds of information you would have wanted?

76. Have your communications ever been interrupted or delayed in the hospital? How often? Were they delayed or interrupted by yourself or someone else? Who? Were you able to resume the communication satisfactorily later? Why or why not?

77. How much of your communication while in the hospital has been wordless, a handshake, pointing to an object, hushing someone?

78. How much of your communication in the hospital has been through touch, holding or squeezing your hand, for instance?

79. How much of your communication while in the hospital has been written? Did you send or receive the most messages? To whom or from whom?

80. How much of your communication while in the hospital has been spoken messages delivered by humans? Did you send or receive the messages most frequently? To whom or from whom?

81. How much of your communication in the hospital has been through the call signal? Who usually acknowledges your signal? Is this person able to provide the help for which you rang?

82. How much of your communication in the hospital has been by gestures and signals other than the call signal? Did you send or receive the messages most frequently? To whom or from whom?

83. How much of your communication in the hospital has been through the intercom system? Did you send or receive the messages the most? To whom or from whom?

84. How much of your communication in the hospital has been via the telephone? Did you call or were you called? Who did you call or called you?

85. Have you used other methods besides these I have mentioned?

86. How do you tell what a health worker's job is?

87. How often have health workers "just talked" with you as compared to talking with you while performing some task?

88. Who is most likely to "just talk" with you? How long have you known this person?

89. Would you tell me the kinds of subjects you have discussed most frequently with this person? Have you been satisfied with these subjects?

90. Which of you brings up the subjects? Are you satisfied with this arrangement?

91. How often have you communicated with this person? Have you been satisfied with this number of exchanges? If not, why not?

92. For how long at a time have you usually talked? Have you been satisfied with this amount of time? If not, why not?

93. Could you describe a good patient in regard to his communication with health workers? How would you rate yourself in this regard?

94. Demographic Data:

Age:
Sex:
Race:
Marital Status:
Place of Birth:
Present County of Residence:
Length of Time in County of Residence:
Occupation:
    Patient:
    Spouse:
    Father:
    Mother:
Highest Grade Completed:
    Patient:
    Spouse:
    Father:
    Mother:
Medical or Surgical Patient:
Previous Hospitalizations:
Hospital A or B:
Ambulatory or Not:
Number of Patient Beds in Room:
Date Interviewed:
Hospital Day:

APPENDIX B

Participation Request Letter

October 4, 1973

Mr. John Doe
Administrator
Hospital A
City, Michigan

Dear Mr. Doe:

As part of my master's program at Michigan State University I am studying patients' communication patterns. As you undoubtedly know, little empirical data has been systematically collected to support or refute intuitive assertions such as "the patient talks to the maids more than to the nurses" or "the patient thinks everyone in white is a nurse." My study proposes to ask patients with whom they communicate, on what topics, and with what satisfaction. Enclosed is an abstract of the proposed study.

Would you be willing to participate in the study by permitting me to talk to your patients who are willing to be interviewed? Other criteria for inclusion are that the patients:

1. are not acutely ill
2. are between the third and tenth hospital day
3. have never been hospitalized or employed in your institution.

From my experience pretesting my interview guide, I expect each interview will require approximately one hour or less. My tentative schedule specifies collecting the data this winter, sometime after January 1, 1974.

Dr. R. V. Farace, Director of the Knowledge Utilization Program of the Department of Communication at Michigan State University, will supervise my project.

Thank you for considering this request. If you have any questions or desire additional information, I will be happy to respond.

Yours sincerely,

(Mrs.) Carroll Lutz, R.N.
Graduate Student
Department of Communication
Michigan State University

APPENDIX C

## Proposal Abstract

EXPLORATORY STUDY OF PATIENTS' COMMUNICATION PATTERNS
DURING INITIAL HOSPITALIZATION
IN A SPECIFIC INSTITUTION


### Abstract

The aim of this exploratory study is to gather data to begin constructing a framework for a theory of communicating with patients. Data will be collected through open-ended individual interviews with patients early in an initial hospitalization within a particular institution. The study is expected to generate the following information: the amount, frequency, and duration of patient communication with professionals, nonprofessionals, and lay persons regarding his health; the most frequently used communication channels; the patient's communication load; his position as initiator or dominator of communication transactions and his satisfaction with his position; the sources of delay and interruptions in communication; the sources of health decisions affecting the patient and his satisfaction with the process; and the patient's perception of a "good" patient regarding communication and his self rating on this dimension. Findings from the study would allow practitioners to see themselves as patients see them, permit educators to document differences in communication behavior of practitioners with various preparations, and offer researchers possible hypotheses for future testing.



Carroll Lutz, R. N.
Graduate Student
Department of Communication
Michigan State University

APPENDIX D

## Occupational Classification Used[1]

White Collar:

Accountant
Antique Store Owner
Assistant Motel Manager
Automobile Parts Store Owner
Bar Owner (2)
Beauty Shop Owner
Building Superintendent
Bookkeeper
Builder (2)
Caterer, Self-employed
Dietary Aide
Laboratory Technician
Plant Supervisor
Receptionist
Salesperson (4)
Sales Manager
Secretary
Storekeeper
Teacher (3)
Wholesale Distributor

Blue Collar:

Burrbench Operator
Car Ferry Worker
Carpenter (2)
Chocolate Dipper
Construction Worker
Coremaker
Crater, Porcelain Factory
Diecast Machine Operator
Dipcore Man
Electrician
Gluing Machine Set-up Man
Factory Worker (7)
Foundry Worker
Furniture Trimmer
Labeller, Cannery
Machinist (6)
Metal Finisher
Packer (2)
Patternmaker (2)
Railroad Worker (2)
Sheetmetal Worker (2)
Tool and Die Maker
Truck Driver
Utility Man, Leather Company
Woodsman

Service:

Cook
Detective
Domestic Worker
Laundry Worker
Police Officer

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[1]The figures in parentheses indicate the number of persons named for that occupation.

APPENDIX E

## Stage of Illness Classification of Patients Listed by Admitting Diagnosis[1]

Diagnostic:

Abnormal sella turcica
Cancer of lung (2)
Inflammation of gall bladder
Loss of vision (2)
Pelvic mass
Pyloric obstruction
Seizures
Ureteral calculus, possible (2)

Treatment:

Bleeding peptic ulcer
Cerebral vascular accident (2)
Diabetes, newly diagnosed
Fractured thoracic vertebrae
Myocardial infarction (3)
Neck pain
Prostatic hypertrophy, benign
Total hip replacement (2)

Prognostic:

Appendectomy
Bilateral metatarsalgia
Dislocated shoulder
Fractured ankle (2)
Herniorrhophy
Hysterectomy, abdominal
Mastectomy, radical
Non-functioning gall bladder
Transurethral resection (2)
Urinary incontinence

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[1]The figures in parentheses indicate the number of patients with that diagnosis.

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