Communication between Vietnamese training nurses and patients

- an ethnographic pilot study

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FOREWORD

The making of this study and my stay in Việt Nam has been a long process in which I owe many people much gratitude. I would like to thank Anna-Lena Hellström and Solveig Lundgren for believing in me in the beginning and helping me start up this project. Without your support and knowledge, it surely had not been done. I also thank Maj-Lis Voss for helping me establish contact with Hanoi Medical University. My warmest thanks go to Hoàng Công Chánh for all the time, effort and friendship you invested in me before and during my stay in Hà Nội. Ối Giời Ơi, I will always keep you close to my heart. I thank Trương Quang Trung for help with gaining access to the hospital and many other things, not to say the least being such a good friend. The staff and patients of the studied ward, I am forever thankful to you. Cám ơn nhiêu. I thank my supervisor Linda Berg for the dedication and intelligent input throughout this process. Last but certainly not least, I thank Hoàng Lan Vân for all the work you put in to this project, not only being an interpreter but a great companion and friend. I truly appreciate all the time you dedicated and cannot thank you enough.

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ABSTRACT

Introduction
Communication is one of the most important tools that the nurse has in caring for patients and especially in establishing relationships with them. No previous studies have been published on communication in Vietnamese nursing, which is beneficial to have knowledge about to nurses worldwide as the world is becoming ever more globalised.

Aim
The aim of this study is to describe the communication between Vietnamese training nurses and patients during nursing procedures.

Methodology
The pilot study was performed with an ethnographic methodology containing participant observations and semi-structured interviews. Data was analysed using content analysis.

Result
The training nurses were found to use conscious strategies in their communication with the patients. Much of the studied communication was found to be instrumental and relating to the task the training nurse was performing. The characteristics of the patients seemed to be an influential factor on the communication.

Discussion
Being too busy is one excuse as to why the training nurses converse too little with patients, but the results of this study suggest that it is rather a matter of how the training nurses arrange their time as there are opportunities to communicate with the patients that are not taken advantage of.

Key words: communication, nonverbal communication, ethnography, training nurses, Vietnam.

SAMMANFATTNING

Introduktion
Kommunikation är ett av de viktigaste omvårdnadsverktyg sjuksköterskan har, särskilt för att skapa relationer med patienter. Inga studier har tidigare publicerats om kommunikation i vietnamesisk omvårdnad, något som är bra att ha kunskap om för sjuksköterskor världen över då världen blir mer och mer globaliserad.

Syfte
Syftet med denna studie är att beskriva kommunikationen mellan vietnamesiska sjuksköterskor i upplärning och patienter i omvårdnadssituationer.

Metod
Pilotstudien genomfördes med etnografisk metodologi och innehöll deltagande observationer och halvstrukturerade intervjuer. Data analyserades genom innehållsanalys.

Resultat
Sjuksköterskorna använde medvetna strategier i kommunikationen med patienter. Mycket av den observerade kommunikationen fanns vara instrumental och härrörde till uppgiften som sjuksköterskan utförde. Patienternas personlighet tycktes vara en betydande faktor i kommunikationen.

Diskussion
Att ha för mycket att göra är en ursäkt som används till varför sjuksköterskor pratar för lite med sina patienter, men resultatet från denna studie föreslår att det snarare handlar om hur sjuksköterskorna disponerar sin tid, då många tillfällen att kommunicera med patienterna inte togs till vara.

Nyckelord: kommunikation, icke-verbal kommunikation, etnografi, Vietnam.

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INTRODUCTION

In every meeting with a patient, the nurse communicates with her. Even if the nurse does not say anything, this is also communicating something to the patient. It might therefore be stated that the most common, and possibly also most important, task for the nurse is communication. Nursing theorist Joyce Travelbee (1971, p. 93) alines with this in stating that communication is the nurse's tool to fulfilling the purpose of nursing:

> *”Communication is a process which can enable the nurse to establish a human-to-human relationship and thereby fulfill the purpose of nursing, namely, to assist individuals and families to prevent and to cope with the experience of illness and suffering and, if necessary, to assist them to find meaning in these experiences”*

The researcher first became interested in the communication between Vietnamese nurses and patients when practising as a nursing student at a pediatric hospital in Hanoi. Curiosity arose as to what characterised communication between Vietnamese nurses and patients. This paper aims to give a rich description of communication between Vietnamese training nurses and patients, taking in as many aspects as possible.

In this paper, for comfortable reading, when any subjects do not clearly have a gender, they will be referred to as 'she'.

BACKGROUND

Ontology

Caring science has its core in a holistic and humanistic outlook on the human being. This means that a person has a free will and is made up from parts such as body, mind and spirit to make up an entity. Every person is her own individual and a unique subject that can never be replaced (Birkler, 2007). King (1981) views the human being as a complex, open and living system. The person has numerous relationships that completes the entity. These relationships can stretch over time so that the person has a relationship to her past, present and future (Birkler, 2007). The human being can never be seen as an isolated object, her interaction with her surroundings must always be taken into consideration (Wiklund, 2003).

Epistemology

Caring science produces research concerning the concept of caring. It is a wide concept that applies to all professionals who care for people, which means that it may include professions such as nursing, physiotherapy and occupational therapy. The core of caring is described through caring science, by asking ”what-questions”, such as for example what statues good caring? (Wiklund, 2003). Nursing science is more narrow in that it concerns the profession of nursing. It answers questions starting with ”how?”, such as for example how patients experience certain situations?

Speziale and Carpenter (2007) points out that as nursing research strives to describe and understand human experiences, it is important to choose a research tradition that provides a meaningful way to conduct this. One of the foundations for establishing a humanistic perspective on research is to recognize that reality is dynamic and subjective. Empirical scientists believe that if objective measurement of a phenomenon cannot take place then the existence of that phenomenon may be questioned. Scientists in the humanistic fields however, acknowledge that few meaningful objective measurements can be used when studying humans in a social context.

Qualitative research methods have a wide range. A common denominator is that all qualitative research methods have a holistic outlook and recognize that the human world is complex. The focus of qualitative research methods is the human experience, which is unique regarding both the person and the situation (Munhall & Oiler-Boyd, 1993).

Traditional positivist scientists argue that research have to be objective, while humanistic scientists recognize that when studying the human experience, the researcher involves herself in the process of finding knowledge (Speziale & Carpenter, 2007). The current study is one example of a study that would have been difficult to carry out in a traditional positivist, and objective, way as the researcher involves herself in the observations and interviews.

Nursing theory

Travelbee (1971) states that the most important tool that the professional nurse has in order to establish a human to human relationship is communication. By communicating the nurse can find out what differs one particular patient from others. In order to do this, the nurse must be careful not to mix her personal feelings and needs into the communication with the patient. She needs to find use for her own personality but keep focus on the patient's needs and wants. This is how the nurse becomes professional in her work.

Nursing theorists believe that health is a unique experience. What one person regards as being healthy may differ from what another defines as healthy. The feeling of being healthy may also vary in the same person over time, depending on what experiences this person makes. Health is not a static matter, but rather something that fluctuates. The key to understanding health is focusing on the subjective experience, which is possible through communication (Travelbee, 1971).

The aim for the nurse, according to Travelbee (1971), is to help the patient find meaning in the situation. In order to accomplish this, a human to human relationship needs to be established. This relationship cannot be established between roles, but only between persons. It is therefore important that the nurse and patient put their roles aside and act as persons in the meeting. In order to accomplish this, the nurse needs to show sympathy and empathy. Empathy is defined by Travelbee as the ability to penetrate, take part in or understand the psychological condition that another person is in right there and then. It is difficult for the nurse to feel empathy for every patient that she meets. Empathy is something that the professional nurse acquire over time while she gains personal experiences and meets different patients. A human to human relationship is set when the two persons find a mutual understanding for each other.

Communication

Linear communication theory

The linear communication theory defines communication as an activity between people involving conveying messages from a source to a receiver with the purpose of influencing the behavior of the receiver. This typically involves three parts: sender, message and receiver. The sender is the source of the message and the one who initiates the communication. In encoding the message, the sender gives information or feelings labels by putting them into words or expressing non-verbal cues such as facial expressions or gestures. The sender organizes the message in such a way that it is focused on key ideas that the sender may want to emphasize. The message consists of verbal and non-verbal expressions. It may describe thoughts, experiences or feelings etc. In order for messages to be effective it is crucial that they are authentic and expressed in an appropriate language for the receiver to understand. The receiver is the recipient of the message and the one who decodes it. This means that the receiver processes the message internally in order to make sense of it. The channels used are the sensitory systems through which the message is sent, such as visual, hearing, touching, smelling or tasting (Arnold & Boggs, 2003).

Circular communication theory

The circular communication theory is based around how humans influence and are influenced by communication. Communication is viewed as a continuous mutually interconnected activity. The sender and receiver influence each other in both sending and receiving messages. Apart from the terms in the linear communication theory, the circular communication theory adds a few more: Input is when a person receives information from the environment, such as for example a message of communication or a sensation of touch. Throughput is an internal process of the information where the person reacts according to internal functions. Output is to produce new information or behavior, as a result of the preceding process.

The relationship between the sender and receiver can be described as either symmetrical or complementary. In the symmetrical relationship there is an equal relationship between the two parts whereas there in the complementary is one part holding a higher position than the other. Feedback is described as verbal or non-verbal response from the receiver about the message sent. It always occurs, even if the receiver does not say or do

anything, as this is also a kind of response. The feedback may be focused on the content of the message, on the relationship between the content and the person, feelings towards the message or unclearities in the message (Arnold & Boggs, 2003).

Communication in the nursing context

Sheldon (2004) states that the relationship between the nurse and the patient has special characteristics that differs the relationship from others. For one, the nurse has the role of a professional in this relationship and the patient seeks assistance from the nurse. The patient may have to reveal intimate parts of her life or body to the nurse and may also have to go through painful procedures conducted by the nurse.

King (1981) believed that the relationship between the nurse and the patient starts with the two parts making judgements about each other based on how they individually perceive the situation. She states that the interpersonal relationship in the nursing context involves three parts; relationship, process and transaction. Based on the preceding judgements, the nurse and the patient make verbal and nonverbal actions which result in reactions in both parts. Transaction is the result of the communication and relationship between the nurse and the patient.

Although taking on the role as the professional in the relationship with the patient, the nurse is also a person just like anyone else with her own personal background. She has her own feelings, hopes and fears. Self-awareness is a process which includes an active process of learning about the self. In doing this, the nurse can learn how to use herself therapeutically in her work with patients. Sheldon (2004) suggests that if the nurse is able to separate her own reactions from the patients' responses, then more effective interaction and a truly patient-centered communication can take place. Travelbee (1971) believed that the nurse should use herself in a therapeutical way in order to promote health and relieve suffering in the patient. She described the therapeutical use of the self as using the nurse's personality in a conscious and strategic way.

Rogers (1951) believed that the therapeutic relationship was central to providing changes in the thoughts and actions of the patient. As the patient is the focus of interactions, communication becomes client-centered. Rogers stated that the health care provider should communicate empathy, positive regardment and congruence to enhance

the patients chances of adjusting to the circumstances and moving towards health.

Training nurses

Training nurses are registered nurses in a junior stage of their career. In the hospital where this study takes place, nurses are considered training nurses for their first six months of working in a new ward. They work independently and have own responsibility for their patients but can seek assistance from more experienced nurses working in the ward when needed. The training nurses might be new to the profession or have previous experience from other wards. Training nurses are interesting to study as they are the nurses of tomorrow. How they communicate with patients early in their career may be considered of importance to how they communicate later on.

PREVIOUS RESEARCH

A considerable amount of research has been carried out worldwide on the communication between nurses and patients. For this review of previous research, the aim was initially to find research on the communication of training nurses in Vietnam. The search was carried out in March 2010 in the Cinahl, Pubmed and Scopus databases. The search in the Cinahl database was carried out firstly and followed by searches in Pubmed and Scopus. The search in Pubmed and Scopus did not yield any additional articles and are therefore not included in the overview of the article search which appears as appendix 1. As no relevant articles were found of studies carried out in Vietnam, the search was widened to first include the rest of Asia, and as this did not yield enough results a worldwide search was carried out. When an insufficient number of articles were found on the communication regarding training nurses, the search was extended to include registered nurses as well. Advantage was given to studies on oncology wards as the present study took place in such a ward. Furthermore the researcher strived to include both qualitative and quantitative studies as well as studies being carried out in different cultural settings around the world. The articles included described studies carried out in Thailand, USA, UK, Ireland, South Korea, Iran and the Netherlands.

In reviewing the previous research, three themes appeared; facilitators in communication, barriers in communication, and types of communication. The result of this review will be presented under these headlines.

Facilitators in communication

McCabe (2004) found that patients were reassured when nurses used a personal approach and called them by their name. Patients value open and honest communication and want nurses to use simple words that they can easily understand (McCabe, 2004). In accordance with the Thai tradition of Kreng Jai though, it is preferred not to always speak honestly, as you want to keep the other person comfortable (Burnard & Naiyapatana, 2004).

The patients in McCabe's study (2004) found that nurses showed genuineness mostly through nonverbal communication, such as tone of voice. To them, genuineness demonstrated respect, understanding and support. When nurses showed sympathy for the patients the patients felt understood, cared for and that their feelings were justified (McCabe, 2004).

Wilkinson found that a predictor for facilitating communicative behavior was that the nurses felt stressed when the patient received poor care (Wilkinson, 1991). In another study (Caris-Verhallen, de Gruijter, Kerkstra & Bensing, 1999) a correspondance was found between nurses having a positive attitude towards elderly people and using more social talk and less instruction and guidance. This study also showed that the nurses who were employed for more hours a week engaged more in communication about lifestyle and emotions and also smiled more compared to colleagues who had a lower percentage of weekly employment (Caris-Verhallen et al., 1999). This is in concordance with student nurses' views that a facilitator in communication is to have time to establish a relationship with the patient (Tuohy, 2003).

Humour showed to be a facilitator in McCabe's study (2004). The nurses were described as friendly and happy. It also seemed to improve the patients self-esteem when they had someone to laugh and joke with, and especially when they could make someone else laugh (McCabe, 2004). Student nurses also found that having a laugh and to encourage the patients may facilitate communication (Tuohy, 2003). Burnard and Naiyapatana (2004) describe that smiling is a natural part in Thai communication and something that may enhance communication between nurses and patients.

Barriers in communication

Heavy workload

The barrier mentioned most in the studies was nurses having a heavy workload or being busy. McCabe (2004) found that patients experienced nurses as too busy to be able to communicate with them. However, the patients in this study were very careful not to blame the nurses for this lack of communication but instead emphasized that they could see that the nurses were very busy and that they understood that there was no time to talk to patients when the nurses had many other work tasks to perform (McCabe, 2004). In Thailand, the concept of Kreng Jai, to think of the other person before yourself, may have made the patients reluctant to bother the nurses, when they could see that the nurses were already busy (Burnard & Naiyapatana, 2004). South Korean patients ranked being hesitant to disturb the nurse high on a list of barriers (Park & Song, 2005).

A Dutch study (Caris-Verhallen et al., 1999) found that nurses who worked in residential care and had many patients to take care of in one shift communicated more about lifestyle and emotions than about nursing and health with their patients. The researchers suggest that this may be a way for the nurses of keeping the conversation simple and blocking the patients' opportunities to speak about their health problems. The same study found that nurses working in residential homes who had many patients to take care of in one shift talked significantly less about subjects that did not immediately arise from the nursing procedures but instead used communication that structured the encounter.

Studies from both South Korea (Park & Song, 2005) and Iran (Anoosheh, Zarkhah, Faghihzadeh, & Vaismoradi, 2009) has shown that nurses rank 'heavy workload' or 'being too busy' the highest of barriers in communication with patients. In accordance with these, Tuohy (2003) found that student nurses considered the business of the ward to be a hinder in communicating with patients. She also found that student nurses experienced the morning hours of their shifts as very busy with almost no opportunity to conduct anything else than brief, task-focused communication with the patients, but that there in the afternoon was more time to actually sit down and talk (Tuohy, 2003). However, Wilkinson (1991) studied communication in a few different wards and found most facilitating communication to be carried out by nurses working in the busiest ward. Wilkinson suggests that there might be other factors on a ward that may affect

communication than being busy.

Education and experience

Caris-Verhallen et al. (1999) found that nurses with a higher degree of education employed less in social conversation with elderly patients and more in communication structuring the encounter than nurses with a lower degree of education. The higher trained nurses also used less nonverbal communication such as eye-gaze and head nodding and showed more irritation and dominance in the encounters. The researchers assessed the higher educated nurses as less involved in the situations compared to lower educated colleagues.

In McCabe's study (2004) the patients experienced what they labeled as 'senior nurses' to be too busy to communicate with the patient, and connected this to the 'senior nurse' having more responsibility. The patients in this study also found the student nurses to be the easiest to talk to, as they were understanding and the patients felt that they could talk about things that worried them with the student nurses. McCabe suggests that this might be because the student nurses have more time to give the patients as they may not be fully responsible for the complete care of the patients or that they have not yet been socialized into the task-centered communication style of the ward.

Nurses in an American study (Sheldon, Barrett & Ellington, 2006), which investigated difficult comunication in nursing, found themselved unprepared for communicating with patients when they were recently graduated and suggested that it is clinical experience and not formal education that prepares the nurses for this difficult communication. Caris-Verhallen et al. (1999) similarily found that the years of experience in nursing corresponded more than the years of education with the nurses' tendency to engage in affective commuication. Wilkinson (1991) however, found nurses who had completed a course in oncology nursing to be the best facilitators of communication.

Culturally specific barriers

A study from Thailand (Burnard & Naiyapatana, 2004) shows that nurses may treat patients differently depending on their status outside of the hospital. Whether the patient has high or low social status may affect how the nurse communicates with the patient.

The nurse may for example be more reluctant to give instructions or demand something from a patient with high social status compared to a patient with lower social status. However, some participants in this study claim that the concept of social status is played out in the hospital setting and that nurses treat all patients alike (Burnard & Naiyapatana, 2004). Anoosheh et al. (2009) mention the custom of Iranian nurses not being allowed to touch or gaze at patients of the opposite sex unless in emergency situations. Sex difference is considered a barrier in communication by the participants in the study. More so by patients than by nurses. The barrier ranked highest by the Iranian patients though, was the difference in dialects between the nurse and patients which was found to make communication difficult.

Patients' illnesses

Caris-Verhallen et al. (1999) found that nurses in residential care and residential homes did not change their verbal communication with the patients depending on the health state of the patient. In the residential care, the nonverbal communication was also unaffected by the patients' characteristics (Caris-Verhallen et al., 1999). In the South Korean study (Park & Song, 2005) both patients and nurses ranked the patient not feeling well and being tired high as barriers in communication. In the Iranian study (Anoosheh et al., 2009) patients and nurses agreed on patients having a contagious disease to be a barrier. The older patients' forgetfulness was considered a hinder in communication by student nurses in one study (Tuohy, 2003). The nurses in the study by Sheldon, Barrett and Ellington (2006) clearly pointed out specific diagnoses, for example metastatic cancer, where communication with the patient was considered difficult. Sivesind et al. (2003) found that nurses considered the communication regarding the patients physical health; such as complaints about pain, fatigue, appetite and weight loss, to be the least difficult to communicate about and the subjects they felt most skilled at.

Nurses' characteristics

South Korean patients listed three items regarding the nurses' characteristics in the top five barriers; nurses working without a sincere attitude, using an authorative attitude and being unfriendly (Park & Song, 2005). In the Iranian study (Anoosheh et al., 2009), patients were found to focus on personal and social factors in the barriers where nurses were more inclined to focus on job-related factors. Nurses in an American study

(Sheldon, Barrett & Ellington, 2006) found their own emotions, such as helplessness and hopelessness about the patient's situation, to be hinders in the communication. Nurses who claimed themselves to be atheist or having a fear of death were found to use more blocking behavior in communication in one study (Wilkinson, 1991). Caris-Verhallen et al. (1999) found nurses' characteristics; such as age and gender, to have no affect on the communication. The Thai nurses were found to be shy and speak quietly, but how this affected the communication is not discussed by the researchers (Burnard & Naiyapatana, 2004).

Types of communication

Verbal communication

The patients in McCabe's study (2004) described empathetic communication as reassurance, to make the patient feel at ease, not be stressed for time, be relaxed, be concerned about the patient's condition but still professional. One patient describes it as ”adding the human touch” (McCabe, 2004, pp 45). Student nurses believe effective verbal communication to include questioning, listening, encouraging, praising and instructing but also feel that sometimes some degree of leading or blocking behavior may be needed (Tuohy, 2003).

Kruijver, Kerkstra, Bensing & van de Wiel (2001) differs between instrumental and affective communication in interviews with simulated cancer patients. The results show that the nurses use 62 % instrumental communication, where providing medical information constitute the biggest part with 24 %. Other big parts were information about psychosocial issues (11 %) and organisation of the ward (6 %). Of the 38 % of the communication that was labeled as affective communication, global affective behavior such as giving agreements (19 %) and paraphrasing (11 %) dominated. As for specific affective behavior; empathy, reassurance and concern each constituted 2 % of the communication. As 88 % of the questions were closed ones, the patient was not given room to express their feelings, and the result was that the patient did not express much of her feelings (Kruijver et al., 2001).

Wilkinson (1991) describe four strategies in nursing communication; facilitation, blocking, ignorance and information. The facilitators invite the patients to disclose their problems, giving the nurse the opportunity to make an in-depth assessment. Blocking

behavior includes preventing the patient to speak about their problems and results in the nurse getting superficial information about the patient. The ignoring nurse ignores cues from patients, switching topics and keeping out of loaded conversation areas. The informing nurse gives the patient inappropriate information and engage in opinion-giving in order to maintain control over the situation (Wilkinson, 1991).

Nonverbal communication

Student nurses consider effective nonverbal communication to include being on the same eye-level, having eye-contact, facial expressions and appreciative touch. Touch was believed to transmit a sense of support and comfort (Tuohy, 2003). Kruijver et al. (2001) found that eye-gazing was used 88 % of the time during the interviews and head nodding was frequently used. However smiling, touching and forward leaning was rarely used, even though the patient was distressed at times during the interview (Kruijver et al., 2001).

DEFINITION OF RESEARCH PROBLEM

Communication is the bridge between the nurse and the patient, where they can meet, connect and understand each other. Communication is an important part of the nurse's tool box and one of the corner stones in the art of nursing. Previous research has shown that a well functioning communication can help to establish a relationship between the nurse and the patient and have many positive effects on the patients' experiences of nursing care.

As we are living in an ever more globalized world, it is important for the nurse to have an understanding for patients from different cultural backgrounds. A description of how Vietnamese nurses and patients communicate may help nurses in different parts of the world to understand how patients may have varying expectations and manors in the meeting with the nurse.

When reviewing previous research, little was found on nursing communication from Asian countries, and none from Vietnam specifically. Little research was also found on training nurses, which are interesting to study as they are the nurses of tomorrow. How they communicate with patients early in their career may be considered of importance as to how they communicate later on in their career.

The review of previous research shows that much of the research that has already been carried out on communication between nurses and patients tend to focus either on barriers or facilitators in this communication. When focusing on these, there may be nuances of the communication that are not captured or left out. For this reason, this study will look at the communication between training nurses and patients from a wide perspective, taking in as many aspects and nuances as possible.

AIM

The aim of this study is to describe the communication between Vietnamese training nurses and patients during nursing procedures.

METHODOLOGY

ETHNOGRAPHY

This study will be performed in an ethnographic fashion. Ethnographers intend to learn about people by learning from them (Morse & Field, 1996; Roper & Shapira, 2000). The word ethnography means ”portrait of people” (Burns & Grove, 1995). It can be described as a method for investigating patterns of behavior within specific cultures. Ethnography was originally derived from the field of anthropology. Bronislaw Malinowski, a British anthropologist, is generally considered the father of the kind of extensive field work which signifies ethnography (Roper & Shapira, 2000).

The method of ethnography was chosen for this study based on conditions such as the researcher conducting research in a culture different from her own, having little previous knowledge on the subject, having a wish to give a rich description of the communication and understanding nursing communication from the communicators' points of views.

The concept of culture is central in ethnographic research and can be viewed as having two dimensions: behavioral and cognitive. In the behavioral dimension culture is observed by patterns of behavior and customs; such as what groups within a culture produce and the way they live their lives. The cognitive side include the views, beliefs and knowledge of the people in a specific culture. When combining these two dimensions, ethnographers study what people do and what they know (Roper & Shapira,

2000).

When observing a culture, the ethnographic researcher strives for a holistic perspective in order to capture the full range of knowledge, activities and beliefs of the studied group. This means that the observations will be analyzed with a focus on what meaning they have to the members of the group (Roper & Shapira, 2000).

The ethnographer strives to find the emic perspective, being the insider's view of the world. This is done partly by participant observations in order to receive a deep understanding of the practices and beliefs of the studied group (Beanland & Scheider, 2000; Burns & Grove, 1995; Morse & Field, 1996; Roper & Shapira, 2000). The aim is to find the peoples' meaning of different matters. The researcher brings the outsider's perpective, the etic perspective, in trying to make sense of and understand what is being observed (Beanland & Scheider, 2000; Burns & Grove, 1995; Roper & Shapira, 2000). Ethnographers recognize that ethnography is neither subjective nor objective. The researcher understands the observations through the filter that is her own cultural background but also attempts to take a step back and study the situation as it appears and happens to the studied people. The reflexive aspect of ethnography assumes that the researcher makes interpretations of observations and is a part of the world that is being studied. This third perspective, that could not be seen by the people of the culture being studied or the researcher alone, is one strength of ethnography (Roper & Shapira, 2000).

Most ethnographies conducted in the field of nursing today has their focus on a specific problem within a set context among a small number of people. These are called focused ethnographies, also known as mini ethnography or micro ethnography. Focused ethnographies answer questions made before going into the field and may provide useful information for health care professionals. They can be completed in a shorter amount of time than classical ethnographies as they are so focused, but they share with the classical ethnographies the description of individuals as well as groups with a holistic perspective and aim to explore cultural beliefs and practices that generate the observed behavior (Roper & Shapira, 2000). This study will be conducted as a focused ethnography.

DATA COLLECTION

Data collection will be carried out through participant observations and semistructured interviews. The participant observations will be performed in three patient rooms of different wards of the hospital. The researcher and interpreter will observe for 1-2 hours in the morning or afternoon, which is estimated to cover about 4-6 observed episodes.

During an observed episode, the researcher and interpreter will stand close to the nurse and patient and observe the communication between the two. The researcher and interpreter will not engage in any conversation unless specifically invited by the nurse or patient. Following each episode, the researcher will, with help from the interpreter, make short field notes in a note pad of what has happened in the observed episode.

Following each block of observations, the researcher will on the same day extend the short field notes into full ones. After finishing the extended field notes they will be read by the interpreter who will, in a written answer, give her overall views on the situations.

Roper and Shapira (2000) describes four levels of participant observation; observer only, observer as participant, participant as observer and participant only. As observer only, the researcher does just that – observes without participating in any of the activities. The observer as participant-researcher has a brief and formal contact with the informants and only participate in the activities to a limited extent. In order to be a participant as observer, one most devote much time into gaining access, but with access gained, the researcher has a big opportunity to receive insider information about what it is like to be a member of the studied group. To be a participant only is difficult research to conduct due to ethical reasons. The researcher would have to study a group that the researcher is already a part of, without the members of the group knowing about the research being conducted.

The researcher and interpreter will not be allowed by hospital policy to engage in any technical nursing procedures. They will be allowed to engage in basic nursing such as for example assisting the patients in their morning routine. The observer only-role is described by Roper and Shapira (2000) to render in superficial, etic knowledge. The researcher will take some conscious measurements to become involved with the patients and training nurses, including engaging in conversation, laughing and joking, assisting

when assistance is needed and showing interest in patients' health conditions. The observations will hence vary between being observer only and observer as participant.

The interviews will be conducted in locations of the training nurses' choices, tape-recorded and last about 60-90 minutes. They will be semi-structured, the main themes are for the nurses to describe one episode where the communication with a patient has been experienced as good and one episode where it was experienced as less good, as shown in appendix 2. The nurses will take part of the interview questions beforehand, in order for them to prepare themselves. The interviews will be transcribed verbatim and translated into English by the interpreter.

SAMPLE

The observation part of the study will take place in three patient rooms in different wards of a university hospital in Hanoi. This hospital was chosen based on that many training nurses work here as it is a university hospital as well as the researcher having access to the hospital through acquaintances. Wards of different specialities will be chosen, in order to provide variation in patients, nurses and situations. All the training nurses of each ward and all the patients in the rooms chosen for the study will be asked to participate. This is estimated to be approximately 60 patients and 20 training nurses. Nurses and patients will be observed to different degrees, depending on how many interactions they engage in during the times of observations.

Roper and Shapira (2000) describe a purposeful sample as including people selected because of specific characteristics or knowledge that they may have which will gain the study. In this study a purposeful sampling will be used as the hospital will be chosen based on it having many training nurses and the different wards being able to provide a variety of patients and situations.

Twenty nurses will be interviewed using a semi-structured technique. They will be selected from the training nurses working in the observed wards, and will be told the main questions of the interview. The sample will be based on voluntariness and their own interest in participating, in order to receive as rich answers in the interviews as possible. This is again using purposeful sampling (Roper & Shapira, 2000).

DATA ANALYSIS

The transcribed and translated interviews and the extended field notes will be analyzed using content analysis. The interviews and extended field notes, by Graneheim and Lundman (2004) referred to as the units of analysis, will be read through first briefly to get an overview and then repeated several times to get a deeper understanding of the content of the material. In content analysis, a distinction between manifest and latent content is made. The manifest content is what can easily be read in the text, with little degree of interpretation, while the latent content can be described as the underlying meaning of the text (Graneheim & Lundman, 2004). While reading through the texts, smaller interesting parts of the text will be underlined. Graneheim and Lundman (2004) labels these shorter parts of the text, which corresponds to one specific topic, a content area. A smaller part of the content area is the meaning unit, which consists of words or a statement.

The process of making the text shorter but keeping the core is labeled as condensation. The condensed text will then be abstracted to a higher interpretative level by the process of abstraction (Graneheim & Lundman, 2004). In order to work with the texts more easily, the meaning units will after several read throughs be given codes, corresponding to their content. Graneheim and Lundman (2004) states that coding the meaning units allows the researcher to approach and think about the data in new ways. As the codes will be pulled out of the texts and looked at it may became clear that some of them share common traits, which initiates the process of making categories. Krippendorf (2004) argues that categories should be exhaustive and mutually exclusive, meaning that they should cover all data and that no data should be fitted into many categories. Graneheim and Lundman (2004) however argue that when describing experiences, it is very difficult to have mutually exclusive categories. They further argue that categories strive to answer the question of ”What?” and will therefore express the manifest content of the material. Themes however, answer the question of ”How?” and describes the latent content. It can be described as the underlying thread leaping through meaning units, codes and categories.

PRE-CONCEIVED IDEAS

In order to handle and process her pre-conceived ideas during the process of data collection, the researcher, in addition to writing down field notes, will keep a more

personal journal on her own feelings and ideas after every day of observation. The researcher's pre-conceived ideas and especially their effect on the result will be further discussed in the method discussion.

PILOT STUDY

In order to test the chosen methodology, a pilot study has been carried out. This included six observation blocks at 2-3 hours each as well as three semi-structured interviews with training nurses of the studied ward.

The observations were carried out in one patient room of the ward. All the patients who were treated in this room during the observations were asked to participate, except for one who was judged by the researcher and interpreter to be in a too serious medical condition to participate. Of the patients who were asked to participate, 26 agreed and two initially declined. The patients who did not want to participate in the study continued to get treatment in the same room but their interactions with the training nurses would not be observed for the study. After some days one of these patients asked the interpreter to be included in the study, which he then was. All the training nurses of the ward, in total 11 training nurses, were asked to participate in the study. They all agreed.

The researcher and interpreter usually started their work in the room at about 7.30 a.m. with localizing any new patients and giving them information about the study. As the nurses started their morning work of taking blood pressures, handing out medicines, getting blood samples, establishing IV-lines and connecting IV-fluids etc., the researcher and interpreter would observe some situations where they had the opportunity to follow the interaction from beginning to end. If they had missed the start of a communication episode, it would not be observed.

When observing, the researcher and interpreter would typically stand at the end of the patient's bed and observe both verbal and nonverbal communication of the nurse, patient and other people such as patients, visitors or staff who engaged in conversation. The researcher would sometimes have an observer only-role and sometimes have an participant as observer-role. The interpreter would give the researcher short summaries of what was being said while the episode was on-going. Following each observation, the

researcher would write down a short field note of the episode and the interpreter would assist the researcher in remembering what had been said and done. A new interaction would not be observed until the previous one had been properly recorded in the field note.

The researcher and interpreter would observe 4-6 episodes per day, and after completing this the researcher would later the same day write down extended field notes of each episode. After finishing the extended field notes they would be read by the interpreter who would enrich the notes by giving her views on the situations. This made it possible for the field notes to come closer to the emic perspective.

The semi-structured interviews were conducted in the nurses' workplaces, tape-recorded and lasted about 60-90 minutes. The main questions in the interviews regarded episodes where the nurses had experienced communication as good and episodes where it had been experienced as less good. The interview guide appears as appendix 4. The nurses took part of the interview questions beforehand, in order for them to prepare themselves. The researcher would ask the questions in English, the interpreter translate them to Vietnamese and the informant would answer in Vietnamese. A summary of the informant's answer would be given back in English to the researcher for her to ask follow-up questions. The interviews were transcribed verbatim and translated into English by the interpreter.

ETHICAL CONSIDERATIONS

The declaration of Helsinki is a statement of ethical considerations regarding medical research on human subjects. It may however come to use in fields other than the strictly medical. The declaration has some main features, including the principle of putting the individual person's health first, to be especially careful with research subjcets who for some reason are particularly vulnerable, to assess possible risks with the research, to ensure confidentiality, to seek consent from research subjects and to make the result of the research public (World Medical Association Declaration of Helsinki, n.d.). The participant informations and consent forms for this study will appear as appendix 3 and 4.

Forskningsetiska principer i humanistisk-samhällsvetenskaplig forskning is a Swedish

document applicable for the field in which the present research has been carried out. It deals with four main demands in research. The information demand states that the researcher is to inform the participants of the aim of the study. The demand of consent forces the researcher to obtain consent from participants or, if applicable, their legal guardians. The confidentiality demand states that information on the participants should be handled with confidentiality and stored in such a way that unauthorized people are unable to get to them. The demand of usage brings forth that information from the participants can only be used for research and no other purposes (Forskningsetiska principer inom humanistisk-samhällsvetenskaplig forskning, n.d.).

Ethical guidelines for nursing research in the Nordic Countries states four basic principles in nursing research. The principle of autonomy also includes dignity, vulnerability and integrity (Ethical guidelines for nursing research in the Nordic Countries, n.d.). In order to respect the particpants' autonomy the researcher will be careful to explain the voluntariness in participating in the study, so that no one should feel that they are forced to participate, and also that they can withdraw their participation at any time without any negative consequences on their health care or their work situation. The principle of beneficence states that the research performed should be of benefit to the group it addresses (Ethical guidelines for nursing research in the Nordic Countries, n.d.). For the present study this matter is especially important as the research is carried out in one country but published in another. The researcher will therefore take precautions to make sure that the result of the study will also be presented in Vietnam. The principle of non-maleficence deals with the research doing no harm (Ethical guidelines for nursing research in the Nordic Countries, n.d.). Possible risks will be considered before carrying out this study and assurance will be made that the participants are aware of that they can leave the study at any time. The principle of justice involves the responsibility of the researcher to protect weak groups and make sure that they are not exploited in research (Ethical guidelines for nursing research in the Nordic Countries, n.d.). The matter of justice will be assured as the participants in this study will be cognitively able to decide for themselves if they want to participate or not. If there is any risk that the patient is too sick or too occupied with her health condition to make a decision for herself whether to participate or not, the patient will not be asked to participate in the study.

The Swedish law on ethical approval states that permission from ethical committees shall be sought if the research may harm the participants either physically or mentally (Lag (2003:460) om etikprövning av forskning som avser människor, n.d.). Ethical considerations were made by responsibles for ethic issues of Gothenburg University but as this study was considered not to have the risk of doing such harm, ethical approval from a committee was not sought.

When considering the advantages and disadvantages of this study, a possible advantage is considered to be unconscious improvement in the communication between the nurses and patients. As it is being studied, more attention may be laid on the communication from all parts, and this may enhance the communication. It is an expectation that the result of this study will help to improve nursing communication also in the long run. The possible risks of this study are mostly found in the voluntariness. There may be concerns that the participants may feel pressure from other people to participate in the study. To avoid this, much effort will be put into explaining the voluntariness of the participation to the participants. Another risk may be the participants feeling exposed or exploited. Precautions against this includes explaining the right to withdraw from the study at any time. All in all, the advantages are considered to outweigh the disadvantages.

RESULT

The result of this study will be presented in two parts; interviews and observations.

INTERVIEWS

In analyzing the interviews, four themes emerged: using conscious strategies in communication, personality influenced communication, forming deeper relationships through communication and time together influenced communication. The quotations in the following text are taken from the translated and transcribed interviews with the training nurses.

Using conscious strategies in communication

It was evident that the training nurses used conscious strategies when communicating with the patients. One training nurse described that she would try to find out information about the patients beforehand, from doctors or other nurses.

”Before I took care of the patient, I met the doctor to ask about her, because the doctor had a look at her first, so he knew her.”

But this was not always possible, due to a heavy workload:

”When the number of patients was small, I always asked the doctor about the patient's condition. Uhm, now there are so many patients so I cannot do this.”

One training nurse described that because she had received information about one patient beforehand, she was able to establish a good relationship with the patient. She had found out that the patient was very interested in Buddhism and what her favourite pagoda was, so by starting to talk about this she would build a deeper relationship with the patient.

”She talked to me about Buddhism. We talked to each other more and more, so I could understand her more and more. She told me about her family, everything, everything. Just because I knew about her favourite pagoda.”

But having beforehand information about the patients was not always an advantage. One training nurse described that because she had heard beforehand that a patient was difficult and that she should be careful with him or he might get angry, she hesitated when treating him which lead to the patient not feeling confidence in her.

All of the interviewed training nurses stated that they had a strategy of speaking gently to the patient, in order to comfort the patient. They also stated that they tried to speak openly to the patient and answer all of their questions truthfully. One training nurse stated that informing the patient about her treatment was a mean to give her comfort, that the patient was comforted and given hope by the training nurse informing about the treatment she was about to get.

”Most important with a cancer patient is a real psychological comfort.”

Personality influenced communication

The training nurses found that it was easier to establish good communication with patients who had a pleasant personality:

> *"This patient was so warm and friendly, so when I communicated with her I felt so comfortable."*

On the other hand, when the patient had a less charming personality, communication suffered:

> *"When I said hello he only said "uhm" and then I asked him to point on the scale to know how much pain he had but he could not point. He just told me to give him some painkillers or whatever and not to ask him... He was so angry, he just wanted his pain to decrease quickly."*

Forming deeper relationships through communication

With the patients who returned several times for chemotherapy, the training nurses seemed to form deeper relationships. They talked about their families as well as their condition and could share thoughts high and low.

> *"The patient in my ward has to return to hospital many times for chemotherapy... She always goes to find me first and then she talks very openly with me. She shares with me that she has taken her medicine or she has gained weight, or that she is so happy because her sisters in Saigon care so much about her."*

The same training nurse expresses that the patients almost become family to her:

> *"I always stand close when I talk to her and I probably do some familiar manners such as hold her hand... I always regard them [the patients] as my family."*

Time together influenced communication

When describing the communication that they judged as good, the training nurses

described that they had much time for the patient. That the patients either needed a lot of attention from the training nurse because of their condition, or that they stayed at the ward for a long time. It seemed as if when the training nurses took care of a patient for a longer period of time, it was easier to establish a good communication with this patient.

> ”*I did with this patient so much, so much work for her. With other patients I just injected two times a day only, two times a day I delivered medicines. But this patient should also be on blood transfusions... And not just for one or two days, it lasted about ten days.”*

The training nurses also described that the moments of good communication had taken place when it was quite calm in the ward and not so many patients to take care of.

OBSERVATIONS

As the environment in the room is important for communication and therefore will affect the result of this study, a description of the patient room will be provided.

The first impression of the room is that it is very big and light, with a lot of space. The room is approximately 10x6 meters. The walls are covered with light grey tile which gives the impression of freshness and cleanliness. The floor and the ceiling are also in light colours. There are 5 windows in the room, with dark green curtains that may be used to cover them. The views from the windows are of a busy Hanoian street and the surrounding neighbourhood and to the other side of a small lake, which is currently under construction. At one of the shorter walls a TV is hanging from the wall, positioned so that all the patients can look at it. The TV is usually always on, on a low volume. The other shorter wall is made up of blurred glass and boarders the staff's meeting room. By the ceiling is an opening to provide air condition to both the rooms, which may also make it possible to the patients in the room to listen to staff meetings.

Along the walls are 12 beds, with about 0,5 meter of space between them. There are no curtains or screens between the beds. To every bed there is a small locker in light pastel colours, for the patients to keep their medications on and some personal belongings, food and hygiene articles in. The beds look modern, fresh and comfortable and can be

elevated in the head end. The beds are numbered from 17-28 with a yellow sign on the wall above every bed. The beds are positioned with the head ends towards the walls, so when the patients sit in the beds they have a view over the patients on the other side of the room. Between the two rows of beds along the walls, there is a big space of open floor, which gives the room a spacious feel, even though the beds are squeezed in quite tightly. There are many extra chairs that are soft to sit on and comfortable, for relatives to use when visting.

The door of the room is usually always open and lets in sounds from the corridor, where many relatives wait outside of visting hours so it gets quite noisy sometimes. Also there are the sounds of the staff making conversation and people going to and from all the time. Next to the door is a 10 liter water tank with fresh water for the patients to use.

There is a desk at the one end of the room, where all the patient charts are kept on the desk or standing in folders and also other administrative materials such as pens and papers. Next to the desk is usually where the nurses' cart is. On this cart a lot of the material needed for setting up infusions or taking blood samples are kept, such as syringes, needles, gloves etc. The cart has wheels so it can be rolled around the room, but it usually stands by the desk. As the nurses have almost all the material they need in the room, either on the desk, the cart or on the patients' lockers, the nurses spend a lot of time in the room with the patients and are therefore available for questions and conversations.

When analyzing the field notes of the observations, three themes emerged: task-solving communication during nursing procedures, engaged communication during nursing procedures and hindrances in communication during nursing procedures. In the following presentation, quotes from the extended field notes will be used in order to illustrate the results.

Task-solving communication during nursing procedures

The conversations rarely had structured beginnings, such as greetings or how-do-you-dos, but rather started with the training nurse telling the patient what she was about to do. Similary, when the training nurse had finished with her task she left the patient without any ending phrases.

The most frequent conversation observed between training nurses and patients was the negotiation of vein, where the patient usually had one suggestion for which vein the nurse should use but the nurse wanted to use another vein. So the nurse would argue her stand point on which vein to choose and the patient would have other suggestions.

> *”As the nurse approaches the bed the patient tells the nurse which vein she would like to have the needle in... The nurse wants to put the needle in another vein. She asks the patient if it was difficult to move when she got chemotherapy in the previous vein yesterday. The patient says no. The nurse changes her mind and asks permission to put the needle in an upper vein. Patient okays this.”*

As shown in the quote above, the training nurses usually would ask the patients for permission to use the vein that thay had chosen. As the patients got infusions a few times a day they were quite conscious about where it was comfortable to have the needles placed.

The training nurses would most frequently ask the patients questions about the technical procedures, such as where they would like a needle or if they had any pain from the infusion. The patients would answer them adequately. An interesting observation was however that the training nurses did not always answer the patients questions or remarks, but rather left the questions hanging in the air.

> *”The patient suggests that the nurse should put the needle in the arm instead. The nurse does not answer to this, she is very concentrated on the task.”*

It seemed as if sometimes when the training nurses did not answer the patients questions it was because they did not know the answer, other times they seemed so focused on their task that they ignored the question.

Engaged communication during nursing procedures

The training nurses used the sensation of touch in different ways in their work. Most of the time the touch between the training nurse and the patient was instrumental, meaning

that it was related to the procedure that the training nurse was performing. The touch would at some times be seen as uncaring, when the training nurses bended and pulled in the patients arms or legs without much consideration of the patients' comfort.

> *”The nurse seems a bit rough when she examines the arms, she twists and bends them fast and rough.”*

But the training nurses would also use caring touch, for example by massaging the patients arm gently after taking a blood pressure, or stroking a patient's hand while the patient was talking about something difficult.

It was noted that patients looked at nurses to a greater extent than nurses looked at patients, which could perhaps be explained by the nurses being busy performing technical tasks and had their eyes on what they were doing. Eye contact was sometime difficult to establish when the nurses had their backs towards the patients they were talking to, for example while they were preparing medications at the cart in the middle of the room.

A considerable facilitating factor in the communication between the training nurses and the patients was the use of the cart that the nurses worked at when preparing infusions or blood samples. This made them very available to the patients, as they never had to leave the room to prepare any medications or procedures. All equipment they needed was on the cart. The patient could watch the training nurses work and talk to them whenever they needed.

The personal chemistry between the training nurse and the patient seemed to be a positive factor in the communication. Especially the characteristics of the patient was seen as important to the development of a conversation between the training nurse and the patient. In a few of the observed episodes the patients initiated the conversation with a joke, which made the following conversation flow with ease. Some of the observed male patients came across as especially easy-going, they often made jokes with each other, other patients and the nurses. When caring for this group of patients, the training nurses communicated with the patient to a greater extent, and in a more cheerful way.

”As the nurse approaches the patient he starts smiling and joking with the nurse and the observers... The mood of the setting is all through good. The patient is smiling and says everything in a joking, almost flirty tone. The nurse seems happy to work with this patient.”

When the training nurses initiated the procedure by presenting themselves or what they were about to do, or asking for the patients name, the patient seemed to be invited to strike up a conversation. When the training nurses in one way or another had an introduction to the procedure, the patients would talk more to the nurse, as opposed to the time when the training nurse started working on the patient without any introduction of herself, the medications or the procedure. Without the introduction, the patients would also remain silent as the nurses performed their work.

When the training nurses communicated with the patient, they usually explained what they were about to do and rarely asked about the patients condition. However, when they did ask the patients for pain or about their general condition, it was noticed that the patients seemed more likely not only to answer to the question but also develop the conversation to other topics. It seemed as if the patients felt like they were invited to the conversation by the training nurse asking them a question, and once they got talking, they also talked about other subjects than the question had aimed at.

”The nurse turns around from the other patient and greets the patient like an older lady and asks for her name. The patient answers and the nurse asks how many times she has been to the hospital. The patient answers that she does not remember and starts talking about her medical history, about where she has had surgeries and her feelings when she found out about her disease.”

Hindrances in communication during nursing procedures

One of the most evident barriers in communication between the training nurses and patients was the use of breathing masks among the nurses. The training nurses were wearing breathing masks in a majority of the observed episodes, although they were sometimes pulled down on the nurses' chins. When worn correctly, the breathing masks covered the training nurses' faces from just under the eyes and over the chin. This means

that many of the facial expressions that the training nurses may have used were lost on the patients as the noses, cheeks and mouths were covered by the masks. Also, when the training nurses spoke in a low voice, it was difficult for the patients to hear what the nurses said because of the cover of the breathing mask.

Another barrier noticed was the furnishing of the room. The patients' beds stood very close to each other, making the gap between the beds too narrow for the training nurses to put a chair in to sit on. It was certainly possible, as the relatives of the patients who came to visit sat down on chairs between the beds, but it would have taken the training nurses extra time to fit in a chair. A chair would also have limited their working space and made it difficult for them to move around the patient. This resulted in the training nurses standing up or bent over the patient when talking to them. This difference in height would have affected the communication as it is less comfortable to talk to someone who is positioned above oneself.

> *"The nurse is standing bent over the patient's arm, she has double face masks on"*

The closeness of the patients beds would also make it extremely difficult to have private conversations between the patients and the nurses, as the next patient was in a bed less than a metre away. There were no drapes between the beds, so the neighbouring patients were usually curiously watching what was happening or being said in the next bed.

An occurence that two patients showed discontent with at two different occasions was the use of cell phones among training nurses. When the training nurses' cell phones rang in the middle of a procedure or conversation and they answered the calls, it was clearly a hinder. The cell phone conversations were brief and only lasted 15-20 seconds but they were nevertheless an interruption in a process.

> *"The nurse's cell phone rings and the nurse leaves the bed to answer the phone. Patient says something out in the open to express her discontent with this action. She looks the observer in the eyes and shakes her head. The nurse quickly finishes the phone call and walks back to the bed."*

The age difference between the training nurses and the patients could be seen as a barrier on a few occasions when the training nurse used a youthful language or slang that the patient could not understand or was confused by.

Performing technically advanced procedures or procedures that were painful to the patient were also seen as a hindrance in the communication. The training nurses were usually very quiet when performing tasks such as taking blood tests or establishing an IV-line. If the patients would talk to them or ask them something they would usually not answer if they were in the middle of the procedure. After the task was performed however, there was usually a change in mood were both the nurse and patient was seen as more cheerful and more likely to engage in conversation.

Nurses being busy and working on more than one patient at a time was noticed as a hinder in establishing a deeper conversation with the patient. When the training nurse told one patient something on her way to the next patient there was little chance for the first patient to respond to what the nurse had said. Sometimes the training nurses would speak to patients while preparing medications at the cart that they used in the middle of the room. Not seldom would this conversation take place when the training nurse had their back to the patient, which made it impossible for both nurses and patients to see and interpret any facial expressions on the one that they were talking to.

DISCUSSION

METHOD DISCUSSION

In quantitative research, the concepts of reliability, validity and generalisability are used to measure the trustworthiness of a study. Graneheim and Lundman (2004) however, claim that in order to separate the two traditions of quantitative and qualitative research, one can use the concepts of credibility, dependability and transferability when measuring the trustworthiness of a qualitative study.

Credibility

Credibility has to do with the focus of the research and how well data collection and analysis address the focus of the research question (Graneheim & Lundman, 2004). It could be said that credibility asks the question of whether the researcher has studied and analysed what was intended to. Firstly, let's look at the data collection. This study

intended to explore the communication between Vietnamese traning nurses and patients. This was done through participant observations and interviews with training nurses in one ward at a university hospital in Hanoi. The observations were conducted first and the interviews second, so that there would be an opportunity to get some knowledge of the nurses' work situation at the ward before conducting the interviews. The participant observations were only conducted in one room, in order for the patients to become familiar with the observers so that they would act as natural as possible in the observed situations. Had patients in a few different rooms been observed other findings might have been discovered and there might have been a broader spectrum of observations as more patients and nurses would have been observed. The quality and depth of the participant observations were however judged to be more important than the quantity of observations and phenonema found, which is why only patients and nurses in one room were studied. The patients in this room were in quite good condition, patients in other rooms had more critical conditions or had maybe just came out of surgery. If these patients had also been studied, the study had probably had more aspects to it, but because of the limitation of time and resources, this was not done. Using participant observations and interviews was found to be a credible method for the research focus.

Credibility also has to do with the analysis of the gathered data. In content analysis, it is critical to find the appropriate meaning unit. If the meaning unit is too large it may be too broad and describe many different meanings. If the meaning unit is too small the risk is that the content will be fragmentated (Graneheim & Lundman, 2004). For this reason, precautions were taken in analysing the texts such as; reading them through carefully many times before commending analysis and working back and forth with the analysis to see that the condensed meaning and codes related to the original text. The use of quotations from the observations and interviews was chosen in order to assure credibility.

Dependability

Dependability deals with the changes over time in data and also the researcher's approach to data collection and analysis (Graneheim & Lundman, 2004). As a researcher collects data some kind of analysing process takes place already at this stage, and may direct the researcher to focus the data collection in one way or another. This may mean that the participant observations or interviews may find another depth after

some time, when the researcher has found something particularly interesting, but it may also mean that important data is lost if the researcher is too narrow in the data collection. For the present study this may be especially important as the data collection was done during an extended period of time, for which reason the focus may be shifted after some time.

To avoid overseeing data in the collection, a habit of making a quick analysis of the data after transcribing the observations was established. These small notes both worked as a reminder when time came for analysis, but also as a quick check of what was found out in the participant observations that day, in order to be more observant the next observation day on finding deeper understanding of those phenomena, but also not to bypass other important issues.

When reading through the interviews, it is clear that for each interview there is a deepening in the content handled. The researcher acknowledges that as she became more familiar with the interview situation and technique, she was able to ask more in-depth questions in order to find the core of the stories told. The experience from the previous interviews and observations could be used and more penetrating questions could be asked.

Transferability

Transferability refers to the extent of which the findings can be transferred to other settings or groups. To insure transferability a rich description of the culture and context, the selection and characteristics of participants as well as data collection and the analysis of data should be provided (Graneheim & Lundman, 2004).

When making participant observations, the focus of the observations will largely depend on the observer. What the researcher in this study has found remarkable and interesting while observing may not be the same as another researcher would have found although making the same observations. The focus would largely depend on the researchers pre-conceived ideas and previous experience. As the researcher of this study had previous experience at another hospital in Hanoi, this may affect the findings of the study. In order to handle the pre-conceived ideas they were written down before commencing observations. This way, they could stay in the background through the process of data

collection and make sure that what was observed was not only fulfilling pre-conceived ideas.

The study might have gained transferability if it had included patients with more varied diagnoses and in different health states. The studied patients were homogenous regarding diagnoses and had the diagnoses been more varied a more transferable result might have been found.

Interpreter

The use of an interpreter for this study was inevitable as the researcher's knowledge of the Vietnamese language was far too limited to get an understanding of everything said in the observations and interviews. The interpreter was recruited from the staff of junior teachers at Hanoi Medical University, as a relation to them had already been established and they were assessed to have enough time to help out through this project. When finding the appropriate interpreter, much attention was laid on finding a person with a humble personality, that would not intimidate the nurses and patients in the observation situations. It was considered important that the researcher and interpreter could blend in to the athmosphere of the ward as much as possible, which is why the personality of the interpreter was considered especially important. For this reason, the interpreter may not necessarily have been the best English speaker of the group, which did sometimes affect the findings of the observations and interviews. In the interviews the interpreter made a short summary of what the interviewee said in order for the researcher to ask follow-up questions. When reading the translated transcripts however, the researcher found that some of the information was lost in the summary of the answers, and therefore appropriate follow-up questions were not asked.

The use of an interpreter automatically meant one more person to relate to in the observations and interviews, which may have made the situations less intimate and therefore hindered more in-depth findings. In the interviews however, the use of an interpreter was sometimes seen as a big advantage to the researcher as the interviewee was given more time to think about her answers while the interpreter translated for the researcher and would often develop their answers more fully after the interpreter had translated for the researcher. The interviewees who understood English would get a recap of their answer and could fill in any blanks that they discovered that their answers

had. The researcher believes that in an interview between only a researcher and an interviewee this time for reflection is seldom given to the interviewee.

RESULT DISCUSSION

The aim for the pilot study was to describe the communication between Vietnamese training nurses and patients during nursing procedures. The training nurses described that they used conscious strategies when communicating with patients in order to establish good relationships with the patients. The training nurse and the patient having matching personalities seemed to be an influencial factor on the communication, as well as having a lot of time for the patient. Much of the observed communication was focused on solving tasks that the training nurses were performing. However, when the training nurses invited the patients to speak about their health conditions, the patients would happily do so. The training nurses were observed to use both instrumental and caring touch in their work. The use of breathing masks and the furnishing of the room were seen as hindrances in the communication.

Arnold and Boggs (2003) as well as Sheldon (2004) regognize the special circumstances that surrounds the relationship between a nurse and patient. Arnold and Boggs (2003) labels the relationship as complementary as one part has a higher rank or position than the other, while Sheldon (2004) points out that the nurse is a professional in this relationship, from which the patient seeks help. Either way you look at it, one can come to the conclusion that the relationship between the nurse and the patient is not an equal one. The nurse has the knowledge and much of the power and the patient is dependent on the nurse. This makes the formation of a relationship with the patient into a challenge for the nurse, as she must take certain precautions. She should recognize that she is the superior in the relationship and that this comes with certain responsibilities, such as for example taking responsibility for the communication with the patient. Patients look to the nurses to be the leaders in the communication and the nurses need to take on this responsibility in order to form a relationship with the patient.

In the interviews the training nurses mentioned that the workload of the ward may negatively affect the communication. Through observations it was however found that training nurses spent a lot of time close to the patients where they had the possibility to converse with them, but for some reason did not. Perhaps were they focused on their

technically advanced tasks. If the training nurses had used their time with the patient more effectively, they would have had more time to communicate with the patients. In previous research, nurses being busy has been claimed to be a hinder in communication with patients (Anoosheh et al., 2009; Caris-Verhallen et al., 1999; McCabe, 2004; Park & Song, 2005; Tuohy, 2003).

The training nurses interviewed stated that they would like to have familiar relationships with their patients and that they try to treat their patients like family members. Travelbee (1971) states that human-to-human relationships can be established through communication. The relationships between the training nurses and patients might had benefitted from the nurses communicating more with their patients, for instance while performing other tasks related to the patients.

The student nurses in Tuohy's study (2003) found that the morning hours of the shifts were too busy for them to talk to patients, but the afternoons were slower and offered more time for conversation. If this is also the case on the studied ward, the reseracher might have missed out on this as the observations were only performed during the morning hours. In further reserach it should be suggested that observations be carried out at different times of the day.

As the nurses in this study were training nurses with limited clinical experience, this might perhaps affect their communication. If studied again in a few years, these nurses might communicate in different manners with their patients. Nurses in Sheldon's study (2006) stated that they were unprepared for communicating with patients when they were newly graduated and that this was a skill acquired through clinical experience rather than theoretical knowledge.

Although inexperienced, it was made evident in the interviews that the nurses had highly conscious strategies when communicating with patients. McCabe (2004) found that patients valued that nurses communicated with them in an honest and open way, which concurs with the strategies that the training nurses claimed to have. McCabe (2004) also found that patients felt reassured when the nurses called them by their name, which the training nurses were sometimes found to be doing.

A study carried out in Thailand found specific cultural differences in the communication, which mostly had to do with social status (Burnard & Naiyapatana, 2004). Even though no differences based on social status were noticed in this study, there might be a few characteristics in the communication that could be explained by culture. The absence of proper beginnings and endings to the conversations such as greetings and good-byes as well as how do you do's got the reseracher's attention. When contemplating over this, the researcher found that everyday conversations that she observed out in the streets were carried out in a similar fashion, without proper beginnings and endings. When speaking to Vietnamese people on the phone, they would rarely say good bye before ending the call but rather just hang up the phone.

Vietnam has a very marked social and family-centered culture as opposed to most individualistic cultures in Europe. This may have made the Vietnamese patients less conscious about the beds standing so close to each other that secluded conversation between the nurse and patient was impossible to accomplish. The Vietnamese patients may be more used to sharing, what a European would consider, intimate information with a group of people as they live in a more social culture.

All the patients that the nurses cared for had the same general disease; cancer, although it was located in different parts of the body in different patients and the patients' conditions also varied. It would still probably be an advantage for the communication that the nurses are familiar with the patients' diseases as opposed to other wards where nurses take care of patients with varying diagnoses. All the observed patients received chemotherapy, to which nausea is a very common side effect. As the observations took place in the morning hours, the patients had generally not received the chemotherapy yet and were therefore not nauseous. Had the observations been carried out at different times of the day would nausea probably have been a factor in the communication. A few previous studies (Anoosheh et al., 2009; Caris-Verhallen et al., 1999; Tuohy, 2003; Sheldon, Barrett & Ellington, 2006) also pointed out how the patients' illnesses affected the communication negatively.

As the patients received chemotherapy during long periods of time, they returned to the hospital many times, which would make it easier for the nurses to establish a relationship. The student nurses in Tuohy's study (2003) pointed out that in order to

accomplish a caring relationship with the patients some continuity over time was needed. In the interviews, the nurses concurred with this statement.

One of the interviewed nurses expressed that because she felt scared of one patient, communication with this patient was struggling. One previous study (Sheldon, Barrett & Ellington, 2006) found that the nurses own emotions may sometimes be hinders in the communication with patients.

The training nurses engaged mostly in instrumental communication, i.e. it concerned instructions and information about the tasks that the nurses were performing. As mentioned earlier, this may have been different had the observations been carried out at different times of the day. Kruijver et. al. (2001) stated that 62 % of nurses' communication was instrumental.

As the training nurses had no chance to sit down next to the patients due to the furnishing of the room, the same level of eyes was difficult to achieve in the observed situations. The training nurses usually used breathing masks, which made nonverbal communication via facial expressions impossible. Student nurses in one study considered effective nonverbal communication to be facilitated by nurse and patient being on the same eye level, having eye contact and by using facial expressions (Tuohy, 2003).

The training nurses were seldom the ones to initiate a humourous situation, but they were good fun when their patients told jokes or came up with funny situations, something that would without a doubt strengthen the relationship between the nurses and the patients. Patients in a previous study stated that they would improve their self-esteem when humour was being used in the communication with the nurses (McCabe, 2004).

Implications for a full-scale study

When performing a full-scale study, much more time can be spent on observations and interviews. Although the researcher felt that with only six days of observation she could still get a somewhat good relationship to the patients in the studied room so that they could relax in her company, this is probably even more true with the nurses if the

researcher can spend more time on observations. In a full-scale study, observations could be made on different times of the day which would certainly give more aspects on the communication. It would probably be valuable to also make observations in different hospitals or in different wards, to gain even more insight to how different locations, illnesses etc can influence communication.

The use of interpreter was inevitable for the pilot study, but if the researcher deepens her skills at Vietnamese it may be able to be avoided in the full-scale study. The use of interpreter was not only seen as a disadvantage, as discussed earlier, but if an interpreter is used for the full-scale study the use of a professional interpreter should be considered.

The interview questions should be audited with input from a Vietnamese supervisor, as they were sometimes difficult to understand for the interviewees. The use of a professional interpreter in the interviews may also be beneficial to the result.

The method was assessed as appropriate for the aim and should be used in a full-scale study as it gives the result many aspects, from both observations and interviews. In further studies, it would be interesting to also interview patients in order to explore their views on nursing communication.

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Appendix 1: Overview of article search

Database	Search phrases	Limitations	Articles found	Articles used	Articles excluded
CINAHL	patient communication AND ethnography	Peer reviewed, research article, English language	4	1	3 not relevant
CINAHL	patient communication AND nursing	As above	169	7	162 not relevant
CINAHL	communication AND culture AND nursing	As above	261	1	260 not relevant
CINAHL	communication barriers AND older patients	As above	8	1	7 not relevant
CINAHL	Nurse-patient relations AND communication AND oncology	As above	30	2	28 not relevant

Appendix 2: Interview schedule

Interview schedule
Kế hoạch phỏng vấn

Main question:
Câu hỏi chính:

- Can you please tell me about one episode when you think that the communication between you and one of your patients worked well?

Anh (chị) hãy kể lại một tình huống giao tiếp với bệnh nhân mà anh (chị) nghĩ là tốt nhất?

- Can you please tell me about one episode when you think that the communication between you and one of your patients worked less than well?
  Anh (chị) hãy kể lại một tình huống giao tiếp với bệnh nhân mà anh (chị) nghĩ là không được tốt?

Follow-up questions:
Câu hỏi liên quan:

- Can you tell me something about how the outer environment affected this situation?
  Anh (chị) có thể nói cho tôi biết một số yếu tố môi trường bên ngoài ảnh hưởng tới tình huống đã xảy ra?
- What do you think made this situation special?
  Anh (chị) cho rằng điều gì khiến tình huống đặc biệt?
- Can you describe your feelings in this situation?
  Anh (chị) có thể mô tả lại cảm giác của mình trong tình huống đó?
- What mood were you in when you came into this situation?
  Tâm trạng của anh (chị) như thế nào khi gặp tình huống đó?
- What previous experiences did you bring into this situation?
  Anh (chị) có những kinh nghiệm gì trước đó khi xử lí tình huống này?
- How would you describe the patients mood when coming into this situation?
  Anh (chị) có thể mô tả lại tâm trạng của bệnh nhân trong tình huống đó?
- Do you know about any previous experiences that the patient brought into this situation?
  Anh (chị) có biết những kinh nghiệm trước đó mà bệnh nhân đã sử dụng vào trong tình huống này?
- Can you describe ”this” more for me? Can you elaborate ”this”? What do you mean when you say ”this”?

Anh (chị) có thể mô tả/ kể lại điều đó rõ hơn cho tôi được không? Có thể nói chi tiết hơn không? Ý của anh (chị) là gì khi nói đến điều đó?

Appendix 3: Participant information and Consent form for observations

UNIVERSITY OF GOTHENBURG

Information for research participants
Thông tin dành cho người tham gia nghiên cứu

Background of the Study
Cơ sở của nghiên cứu
Communication is one of the most important tools that the nurse uses in her daily work with patients. Studies of how nurses and patients communicate may provide important insights as to what characterize this interaction. To this date, no research on how Vietnamese training nurses communicate with patients has been published. It is therefore of interest to study this topic.

Giao tiếp là một trong những kĩ năng quan trọng nhất mà người điều dưỡng sử dụng trong công việc chăm sóc bệnh nhân hàng ngày. Những nghiên cứu về cách giao tiếp giữa điều dưỡng và bệnh nhân đã đưa ra những hiểu biết sâu sắc khi mô tả sự tương tác này. Cho đến nay chưa có nghiên cứu nào được công bố về lĩnh vực giao tiếp với bệnh nhân của điều dưỡng học việc tại Việt Nam. Vì vậy chúng tôi rất mong muốn được tiến hành nghiên cứu về lĩnh vực này.

The aim of this study is to describe how Vietnamese training nurses communicate with their patients. You are being asked to participate in this study as you are a training nurse or a patient at this ward.

Mục tiêu của nghiên cứu này là tiến hành mô tả cách giao tiếp với bệnh nhân của điều dưỡng Việt Nam đang trong quá trình học việc tại cơ sở y tế. Anh (chị) sẽ được yêu cầu tham gia vào nghiên cứu nếu anh (chị) là điều dưỡng học việc hoặc bệnh nhân tại bệnh phòng.

Conduction of the Study
Cách thức tiến hành nghiên cứu
During 3-4 weeks the researcher and the translator will be conducting participant observations at the ward during the morning hours. For you, as a participant of this study, this may mean that sometimes the researcher and the translator will be present when you interact with your training nurse/with your patients. Participants in this study may be more or less observed, depending on the amount of interaction between the training nurses and the patients. This should not be seen as a measure of interest for certain participants from the researcher.

Trong 3-4 tuần, nghiên cứu viên và phiên dịch sẽ tiến hành quan sát tại bệnh phòng trong cả buổi sáng. Điều đó có nghĩa là người nghiên cứu và phiên dịch sẽ quan sát anh (chị), những người tham gia trong nghiên cứu này, trong khi giao tiếp với bệnh nhân. Những người tham gia trong nghiên cứu có thể sẽ được quan sát nhiều hoặc ít hơn tùy thuộc vào số lượng cuộc giao tiếp giữa họ và người bệnh chứ không phụ thuộc vào nghiên cứu viên quan tâm tới họ nhiều hay ít.

The researcher and translator hope that their presence will make as little intrusion to the daily happenings at the ward as possible and that the traning nurses and patients are able to go about their daily routines without minding the observers to the fullest extent possible. The researcher and the translator will not observe the communication in order to judge its quality, but to understand the different components and aspects of communication in the nursing context. The translator's part in the observation will be to explain what is being said in the conversation when the researcher asks for a translation. Following some of the observations the researcher may want to ask you, as a participant in this study, some questions about the preceding conversation and the translator may then assist the researcher in this.

Nghiên cứu viên và phiên dịch hi vọng sự có mặt của họ sẽ không gây ảnh hưởng tới công việc hàng ngày tại bệnh phòng, điều dưỡng viên và bệnh nhân có thể làm những việc hàng ngày mà hầu như không để ý tới người quan sát. Chúng tôi sẽ không quan sát cuộc giao tiếp nhằm đánh giá chất lượng mà để hiểu được các phần và các khía cạnh khác nhau của cuộc giao tiếp đó đặt trong hoàn cảnh chăm sóc. Người phiên dịch tham gia vào quá trình khảo sát nhằm giải thích những lời nói trong cuộc nói chuyện khi nghiên cứu viên cần. Trong một số lần quan sát, nghiên cứu viên có thể sẽ hỏi người tham gia nghiên cứu một số câu hỏi về cuộc giao tiếp trước đó và phiên dịch sẽ trợ giúp khi đó.

The researcher will during the observations make short notes in two notebooks, in order to capture different aspects of the communication. These notes will contain short memorandums describing characteristics of the communication. This means that the researcher may write down short notes on what you say or how you act in a conversation. These notes will not aim to contain extensive desciptions on the patients' health matters. However, sometimes brief descriptions of the patients' health may be included in the notes in order to capture all aspects of the communication. The short notes will be helpful as the researcher extends her memorandums into full field notes in the afternoons following the morning observations.

Những ghi chú này sẽ mô tả những đặc điểm của cuộc giao tiếp. Như vậy, trong khi phỏng vấn, người nghiên cứu có thể sẽ ghi lại ngắn gọn những gì anh (chị) (tham gia nghiên cứu) nói. Những ghi chú này không nhằm mục đích mô tả hoặc ghi lại vấn đề sức khỏe của bệnh nhân. Tuy nhiên, đôi khi nghiên cứu viên sẽ ghi lại những mô tả ngắn về sức khỏe của người bệnh chỉ để đảm bảo nắm được tất cả khía cạnh của cuộc giao tiếp. Những ghi chú này sẽ giúp người nghiên cứu viết lại thông tin thu nhận được một cách đầy đủ sau đó.

The memorandums from the observations and the full field notes will be handled in such a way that no unauthorised person will have access to them. The result from this study will be presented in a thesis at Advanced Level at the University of Gothenburg and may also be used in further research leading to publication in scientific journals. The data from this study will be made anonymous before any publication so that participants in the study will not be able to be recognized in the result.

Những ghi chú qua cuộc khảo sát và những thông tin được viết lại đầy đủ sau đó sẽ được lưu lại và không ai được phép sử dụng trừ người có trách nhiệm. Kết quả của nghiên cứu sẽ được công bố trong luận án tại trường đại học Gothenburg và có thể được sử dụng trong nghiên cứu xa hơn và đăng trên các tạp chí khoa học. Chúng tôi sẽ giấu tên người tham gia trong kết quả của nghiên cứu.

The thesis is scheduled to be completed in January 2011. Following this, the participants may e-mail the researcher in order to receive a copy of the thesis, in English, via e-mail if they so wish. Copies of the thesis will also be sent to the ward when the thesis is finished.

Theo kế hoạch, đề tài sẽ được hoàn thành vào tháng 1/2011. Như vậy, những người tham gia nghiên cứu có thể gửi email cho nghiên cứu viên để nhận bản copy luận án bằng tiếng anh qua email nếu muốn. Bản copy luận án cũng sẽ được gửi tới khoa điều trị, nơi đề tài được thực hiện, khi hoàn thành xong.

Participation in this study is voluntary. You may at any time withdraw your participation in this study, without giving any explanation. You may then, if you so wish, ask for none of the previous observations of your conversations to be used in the study. If you wish to withdraw from the study, this will not affect the care or treatment you as a patient is being given at this ward. No economic reimbursement will be given out for participation in this study.

Sự tham gia trong nghiên cứu này là tự nguyện. Anh (chị) có thể dừng không tham gia vào nghiên cứu bất cứ lúc nào, và không cần phải đưa ra bất kì lí do giải thích. Anh (chị) có thể đề nghị không dùng những khảo sát trước đó về cuộc giao tiếp của mình trong nghiên cứu này nếu muốn. Trường hợp người tham gia là bệnh nhân, nếu anh (chị) muốn rút khỏi nghiên cứu này, sẽ hoàn toàn không có ảnh hưởng gì tới sự chăm sóc hoặc điều trị đối với anh (chị) tại bệnh phòng. Và hoàn toàn không có chi phí nào dành cho những người tham gia trong nghiên cứu này.

Responsibility
Người chịu trách nhiệm

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Consent form
Mẫu chấp thuận tham gia nghiên cứu

I hereby state that I have been given infomation about the observation study of communication between training nurses and patients, that I have been able to ask questions about the study and have them answered and that I consent to participation in this study:
Tôi đã được biết mọi thông tin về nghiên cứu, và tôi đồng ý cho phép nghiên cứu viên được phỏng vấn và sẵn sàng trả lời những câu hỏi được đưa ra về nghiên cứu này. Tôi tự nguyện tham gia vào nghiên cứu:

Place and date:
Địa điểm và ngày tháng:_____

Full name:
Họ và tên:_____

Signature:
Kí tên:_____

Appendix 4: Participant information and Consent form for interviews

UNIVERSITY OF GOTHENBURG

Information for research participants
Thông tin dành cho người tham gia nghiên cứu

Background of the Study
Cơ sở của nghiên cứu
Communication is one of the most important tools that the nurse uses in her daily work with patients. Studies of how nurses and patients communicate may provide important insights as to what characterize this interaction. To this date, no research on how Vietnamese training nurses communicate with patients has been published. It is therefore of interest to study this topic.

Giao tiếp là một trong những kĩ năng quan trọng nhất mà người điều dưỡng sử dụng trong công việc chăm sóc bệnh nhân hàng ngày. Những nghiên cứu về cách giao tiếp giữa điều dưỡng và bệnh nhân đã đưa ra những hiểu biết sâu sắc khi mô tả sự tương tác này. Cho đến nay chưa có nghiên cứu nào được công bố về lĩnh vực giao tiếp với bệnh nhân của điều dưỡng học việc tại Việt Nam. Vì vậy chúng tôi rất mong muốn được tiến hành nghiên cứu về lĩnh vực này.

The aim of this study is to describe how Vietnamese training nurses communicate with their patients. You are being asked to participate in this study as you are a training nurse at this ward.

Mục tiêu của nghiên cứu này là tiến hành mô tả cách giao tiếp với bệnh nhân của điều dưỡng Việt Nam đang trong quá trình học việc tại cơ sở y tế. Anh (chị) sẽ được yêu cầu tham gia vào nghiên cứu nếu anh (chị) là điều dưỡng học việc tại bệnh phòng.

Conduction of the Study
Cách thức tiến hành nghiên cứu
After making observations of communication at your ward, the researcher would like to conduct an interview with you and two other training nurses from your ward. As the interview will be conducted in Vietnamese, a translator will also be present at the interview. The translator will translate the questions made by the researcher and also translate your answers back to English for the researcher during the interview. The interview will be tape-recorded and later transcribed verbatim into English by another translator.

Sau khi hoàn thành khảo sát nghiên cứu tại khoa phòng bệnh, nghiên cứu viên mong muốn được thực hiện phỏng vấn anh (chị) và 2 điều dưỡng đang học việc ở cùng khoa đó. Buổi phỏng vấn sẽ có phiên dịch tiếng Việt cùng tham gia. Phiên dịch sẽ dịch các câu hỏi của nghiên cứu viên và các câu trả lời của anh (chị) sang tiếng Anh cho nghiên cứu viên. Buổi phỏng vấn sẽ được ghi âm lại và sau đó sẽ được chuyển nguyên văn sang tiếng Anh.

In this interview you will be asked to tell about one episode where you feel that the communication with a patient has been particularly good and one episode where the communication has been less good. The researcher will, through the translator, ask you follow-up questions in order to receive rich answers to her questions. It is important for the research that you can speak as openly and freely about the communication as possible. The researcher and translator want to learn from you and will not in any way pass judgement on your story. The interview is expected to take 30-60 minutes to conduct and may be conducted at a suitable location of your choice.

Trong buổi phỏng vấn, anh (chị) sẽ được yêu cầu kể về một hoàn cảnh/tình huống giao tiếp với bệnh nhân đặc biệt tốt và một chưa được tốt của anh (chị). Nghiên cứu viên sẽ, thông qua phiên dịch, hỏi anh (chị) những câu hỏi liên quan để thu thập được nhiều thông tin nhất có thể. Điều quan trọng đối với nghiên cứu này là anh (chị) có thể cởi mở và thoải mái nói về vấn đề giao tiếp. Nghiên cứu viên và phiên dịch mong muốn học từ anh (chị) và không đánh giá câu chuyện được kể. Cuộc phỏng vấn có thể kéo dài 30 – 60 phút và thực hiện ở nơi mà anh (chị) thấy thuận tiện.

The tape-recordings and the trancripts from the interviews will be handled in such a way that no unauthorised person will have access to them. The result from this study will be presented in a thesis at Advanced Level at the University of Gothenburg and may also be used in further research leading to publication in scientific journals. The data from this study will be made anonymous before any publication so that participants in the study will not be able to be recognized in the result.

Băng ghi âm và những sao chép của buổi phỏng vấn sẽ được lưu giữ mà không ai trừ người có trách nhiệm được sử dụng. Kết quả của nghiên cứu sẽ được công bố trong luận án tại trường đại học Gothenburg và có thể được sử dụng trong nghiên cứu xa hơn và đăng trên các tạp chí khoa học. Dữ liệu của nghiên cứu sẽ giấu tên người tham gia trước bất kì công bố nào về kết quả của nghiên cứu.

The thesis is scheduled to be completed in January 2011. Following this, the participants may e-mail the researcher in order to receive a copy of the thesis, in English, via e-mail if they so wish. Copies of the thesis will also be sent to the ward when the the thesis is finished.

Theo kế hoạch, đề tài sẽ được hoàn thành vào tháng 1/2011. Như vậy, những người tham gia nghiên cứu có thể gửi email cho nghiên cứu viên để nhận bản copy luận án bằng tiếng anh qua email nếu muốn. Bản copy luận án cũng sẽ được gửi tới khoa điều trị, nơi đề tài được thực hiện, khi hoàn thành xong.

Participation in this study is voluntary. You may at any time withdraw your participation in this study, without giving any explanation. No economic reimbursement will be given out for participation in this study.

Sự tham gia trong nghiên cứu này là tự nguyện. Anh (chị) có thể dừng không tham gia vào nghiên cứu bất cứ lúc nào, và không cần phải đưa ra bất kì lí do giải thích. Và hoàn toàn không có chi phí nào dành cho những người tham gia trong nghiên cứu này.

Responsibility
Người chịu trách nhiệm

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Consent form
Mẫu chấp thuận ‘’ m gia nghiên cứu

I hereby state that I have been given info.....on about the interview study of communication between training nurses and patients, that I have been able to ask questions about the study and have them answered and that I consent to participation in this study:
Tôi đã được biết mọi thông tin về nghiên cứu, và tôi đồng ý cho phép nghiên cứu viên được phỏng vấn và sẵn sàng trả lời những câu hỏi được đưa ra về nghiên cứu này. Tôi tự nguyện tham gia vào nghiên cứu:

Place and date:
Địa điểm và ngày tháng:_____

Full name:
Họ và tên:_____

Signature:
Kí tên:_____