

Features of Suffering Perceived by Japanese Patients in a Stable Condition: A Text Analysis

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Abstract

Objectives: We performed a text analysis of telephone consultation content regarding features of suffering (thoughts that patients cannot express to nurses) perceived by Japanese patients in a stable condition. **Methods:** Semi-structured interviews were conducted by 8 telephone counselors who listened to patients' suffering. Interview content was recorded verbatim, text was organized, and a text and association analysis was conducted (cluster analysis, bubble plot analysis, and a co-occurrence network analysis). **Results:** Seventy-two conversations were obtained and analyzed. It was confirmed that suffering as perceived by stable, Japanese patients had consistent concerns such as "lack of inference," "privacy issues," and "nurses' not intervening on patients' behalf." Additionally, expectations of patients when patients are suffering are extremely diverse and were not characterized by specific tendencies. **Conclusions:** Emotions have a complicated influence in the context of Japanese patients' suffering. It is necessary to consider the cultural background of expression in Japan to treat patients' suffering.

Keywords

Nurse-Patient Relationship, Emotion, Suffering, Text Analysis, Culture

1. Research Background and Significance

1.1. Patient Satisfaction and Nursing Quality

Patient satisfaction in facilities such as hospitals is related to the quality of nursing care and should be emphasized [1] [2]. Sustained high patient satisfaction is essential for the survival of medical institutions; when patients are unsatisfied, they do not recommend that medical institution to family members, friends, or colleagues [3] [4] [5] [6]. In other words, nurses play a vital role in influencing patients' satisfaction within the health care team [7]. Additionally, nursing is

part of a comprehensive medical system and the process and structural factors influence patients' satisfaction with nursing care [8]-[15].

1.2. Nurse-Patient Relationship

Nurse-patient communication is said to support patient-centered care, evidence-based practice, and the application of quality improvement [16] [17] [18]. Interpersonal relationships based on the nurse-patient relationship are important for nurses when evaluating, planning, and intervening with patients [19]. As Peplau [20] noted in her nurse-patient relationship theory that, nursing is an educational means and a developed strength that promotes the advancement of nursing, and mutual relationships are key. To favorably maintain mutual relationships, it is important to understand patient suffering and nurses' empathic involvement.

1.3. Suffering Arising from Nurse-Patient Conflict

Bissell and colleagues [21] suggest maintaining a positive relationship between patients and medical staff means "to cultivate a mutual relationship and distinguish understanding" and states that conflict will occur if mutual relationships cannot be smoothly maintained. Robbins [22] defined conflict as "a process that begins when one party recognizes that the other party has adversely affected or is about to affect important matters for him/her."

In a series of studies focusing on conflicts between nurses and patients under circumstances where patients' mind-body condition is treated as "stable" (*i.e.*, "not tense," "not in a terminal stage," and "no mental illness" [23] [24] [25] [26], there was an underlying sense that patients were unable to express themselves to nurses. In these studies, suffering was understood as the state of a patient who could not convey his/her thoughts on medical treatment. In other words, suffering occurs when patients cannot express themselves to nurses. To effectively understand suffering, we used interviews rather than scale measurements. Analyzing the contents of interviews was deemed suitable for this study.

1.4. Purpose

We conducted a text analysis of telephone consultation content regarding features of suffering (*i.e.*, thoughts that patients cannot express to nurses) perceived by patients in a stable condition.

2. Methods

2.1. Participants

Among the 20 telephone consultants, participants comprised eight telephone counselors belonging to a non-profit organization based in Osaka, Japan.

2.2. Data Collection

We determined that it would be difficult to interview patients directly and obtain

their real feelings; therefore, we utilized consultation content with telephone counselors.

Semi-structured interviews with telephone counselors were conducted (November 2013-February 2014). We focused on conflict with nurses as events as examples of suffering. Interviews referenced the framework of Robbins' [22] conflict process and primarily comprised the following: 1) Under what situations and conditions did conflict between a nurse and patient arise? 2) What were the underlying factors in the conflict? 3) When conflict arose, what response did the patient desire from the nurse?

Interviews were held in a quiet, private room for approximately 40 minutes. Interview content was recorded with an IC recorder with permission from the participants and all content was recorded verbatim. The data from 40 individuals from prior telephone consultations [27] was also added to the analysis. This additional content was received after a telephone consult with the non-profit organization that acquired the data through interviews. In other words, we added data that was obtained in a comparable way as the interviews in this study. The interviews with the eight counselors and additional 40 examples that were added resulted in 72 episodes. Saturation was observed in the analysis process, resulting in sufficient data.

2.3. Ethical Considerations

We explained that data obtained from this study would not be used for any purpose other than research, that individuals would not be specified, and that data would be strictly managed and destroyed completely after study completion. Cooperation was voluntary and there was no disadvantage to not providing consent, which would also not impact the evaluation of the telephone consultation. This study was conducted with approval from the ethics review committee of our affiliated university.

2.4. Analysis Process

IBM SPSS Text Analytics for Surveys was used for text analysis for Japan and a morphological analysis of sentences was performed. After carefully reading the text, researchers organized the language expression variations containing the same meaning (e.g., the meaning of utterances such as "nurse," "nurses," "staff," "she/he," etc. were unified under "nurse"), which made the morphological analysis reliable. Next, to perform a statistical analysis, words were given a number value based on the number of occurrences. The text-mining analysis software R, KH coder was used and relationships and features among the text that appeared were analyzed through cluster, co-occurrence network, and bubble plot analyses.

3. Results

3.1. Participants' Attributes

Telephone counselors were all aged 65 years or older, female, and had mean ex-

perience of 6.7 years (standard deviation = 4.12 years) in telephone consulting. Obtained data consisted of 32 conversations; therefore, after adding the 40 conversations from a prior study, total data comprised 72 conversations. After confirming that these were consistent with this study's purpose, all were targeted for analysis.

3.2. Analysis Methods and Results

In the hierarchical cluster analysis, words surrounded by squares are characteristically few. Particularly, words low in the hierarchy and in a low position are characteristically connected.

In the bubble plot analysis, the same color indicates the same group. Circle size represents occurrence frequency. In this graph, the intersection of dimension 1 and dimension 2 (0, 0) is the center and the distance from the center becomes a characteristic.

In the co-occurrence network analysis, items with a high occurrence are shown in order of pink, white, and blue (from darker to lighter colors). Items connected by lines have a co-occurrence relationship and thicker lines indicate deeper relationships. Particularly, words connected in isolated positions from the whole are understood as a characteristic.

3.3. Features of Suffering Perceived by Japanese Patients in Stable Conditions

Hierarchical cluster, bubble plot, and co-occurrence network analyses results revealed the following characteristics. The important results in the following figure are indicated with a star and a circle

Features involving setting and situations included the following (**Figures 1-3**): "lack of inference" and "timing problems." An example of a timing problem is "the nurse does not respond to calls in a timely fashion."

Latent factors when patients perceived suffering revealed the following features (**Figures 4-6**): "privacy issues" (e.g., personal information) and "nurses' not intervening on patients' behalf." (e.g., nurses' do not help keep rooms quiet).

Japanese patients' expectations of nurses when suffering in a stable condition revealed no particularly strong relationships (**Figures 7-9**). In other words, results showed that the words were extremely diverse.

Because there are no features, stars and circles are not included in the figures.

4. Discussion

Analysis revealed several situations that were associated with patients' suffering. These are described below.

4.1. Setting and Situational Features

4.1.1. Lack of Inference

Original text case: *"Even if the patient reached the scheduled time for discharge, he/she was unable to be discharged and received no explanation from the nurse"*

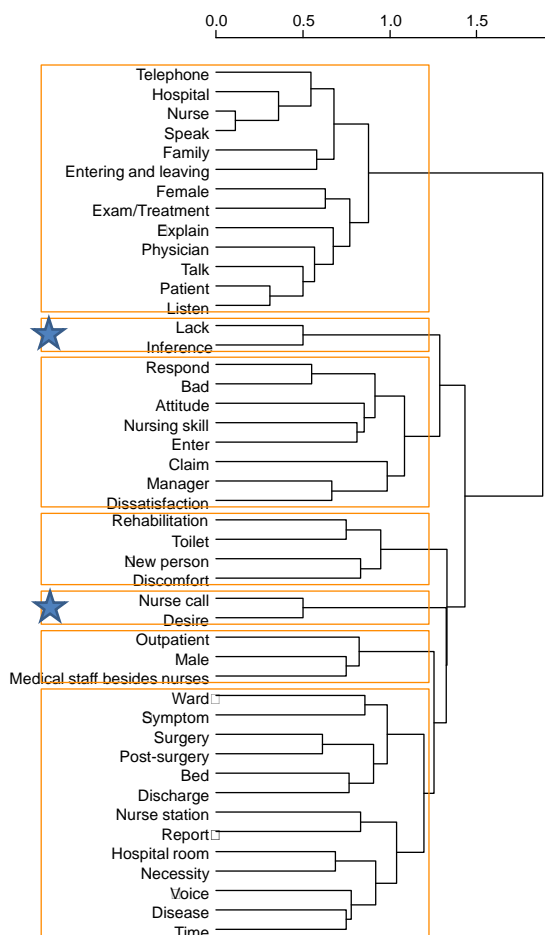


Figure 1. Hierarchical cluster of settings and situations of suffering perceived by patients in a stable condition.

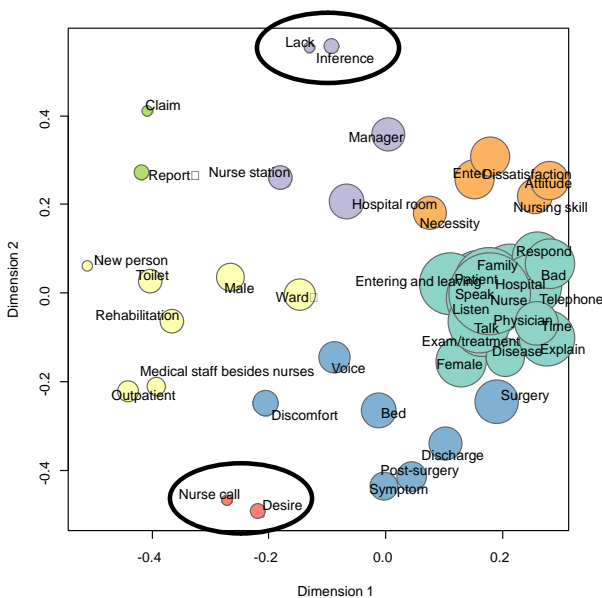


Figure 2. Bubble plot of settings and situations of suffering perceived by patients in a stable condition.

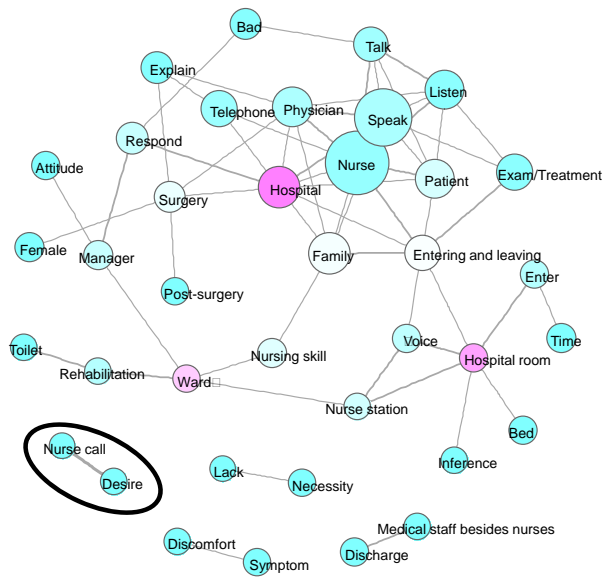


Figure 3. Co-occurrence network of settings and situations of suffering perceived by patients in a stable condition.

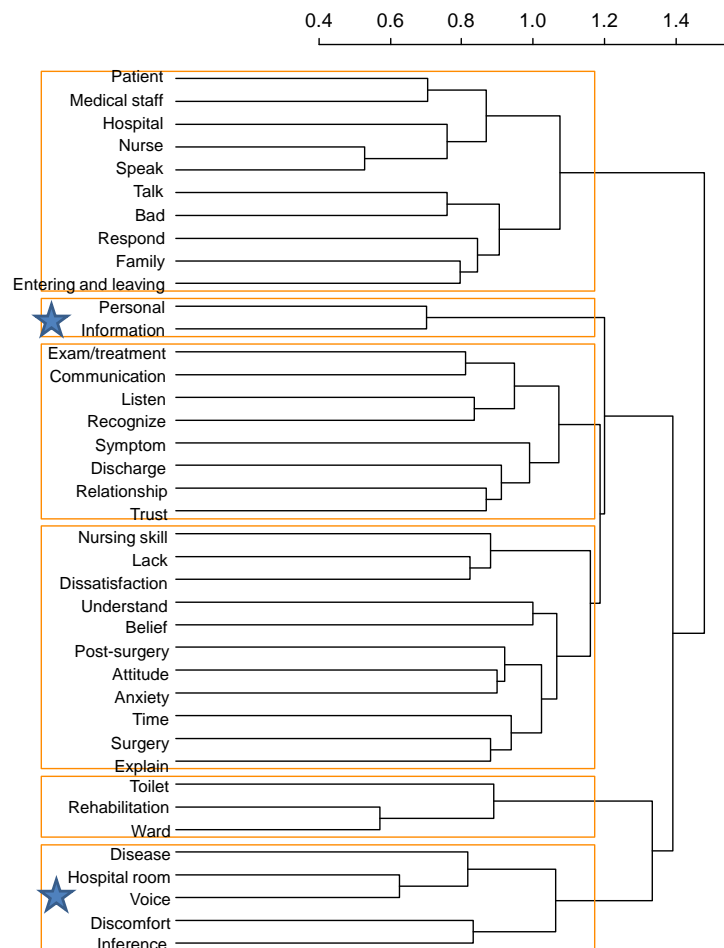


Figure 4. Hierarchical cluster of latent factors in suffering perceived by patients in a stable condition.

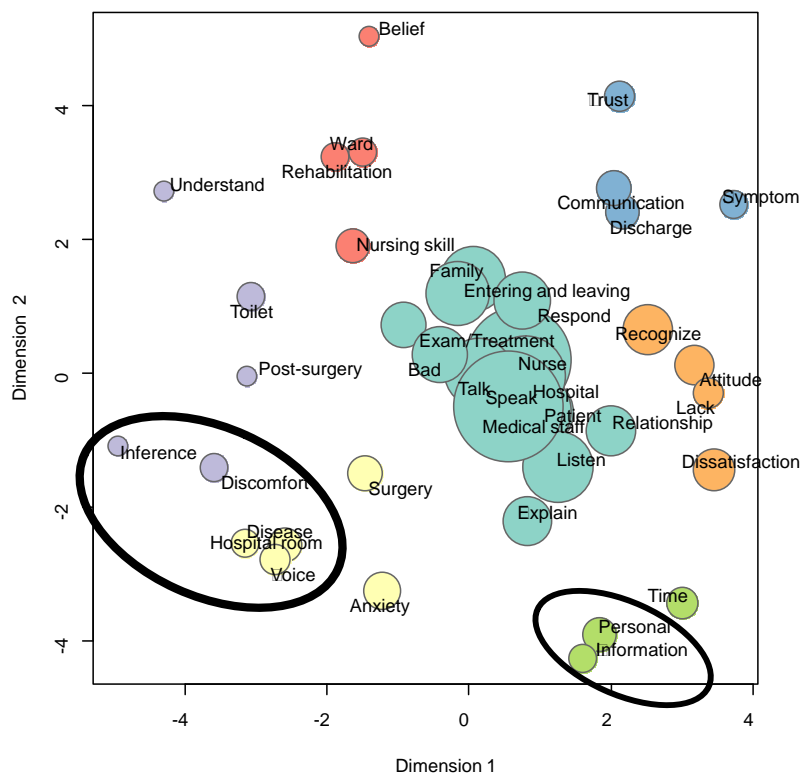


Figure 5. Bubble plot of latent factors in suffering perceived by patients in a stable condition

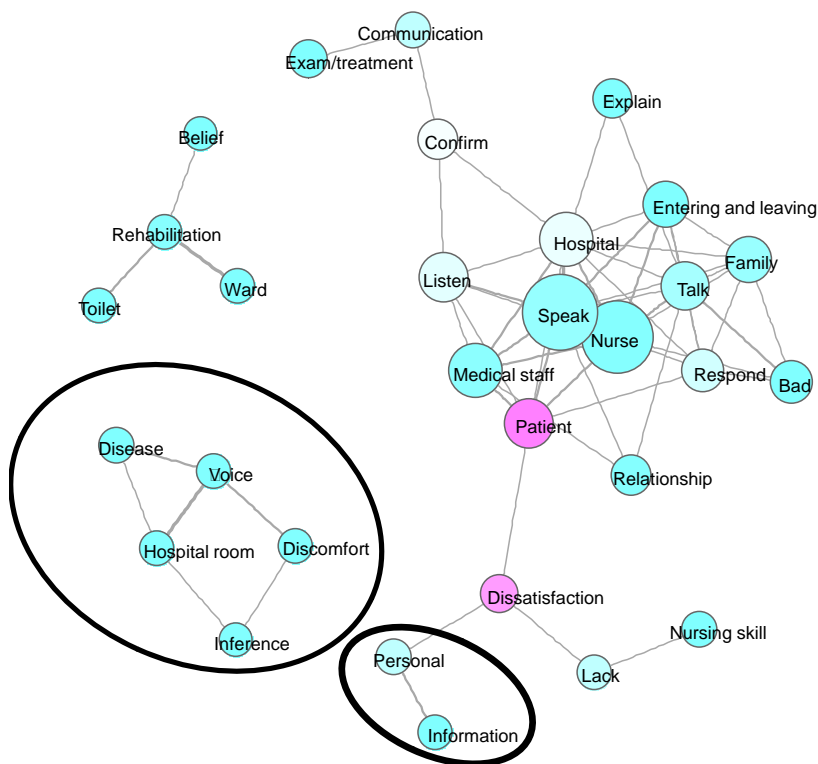


Figure 6. Co-occurrence network of latent factors in suffering perceived by patients in a stable condition.

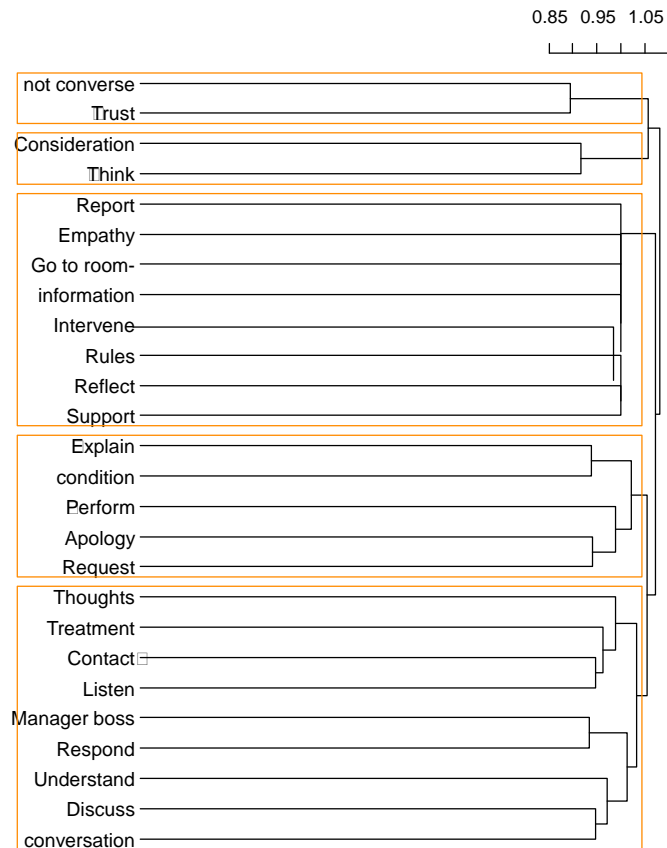


Figure 7. Hierarchical cluster of Japanese patients' expectations of nurses when suffering in a stable condition.

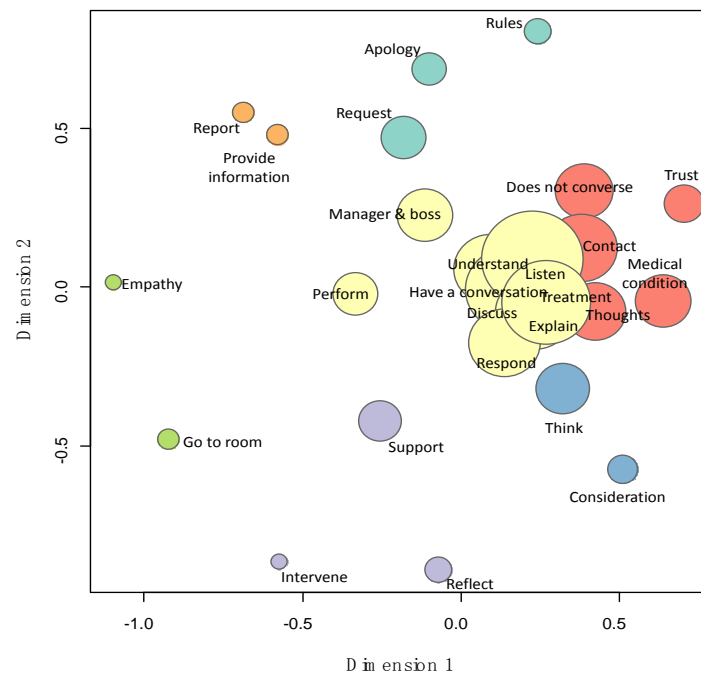


Figure 8. Bubble plot of Japanese patients' expectations of nurses when suffering in a stable condition.

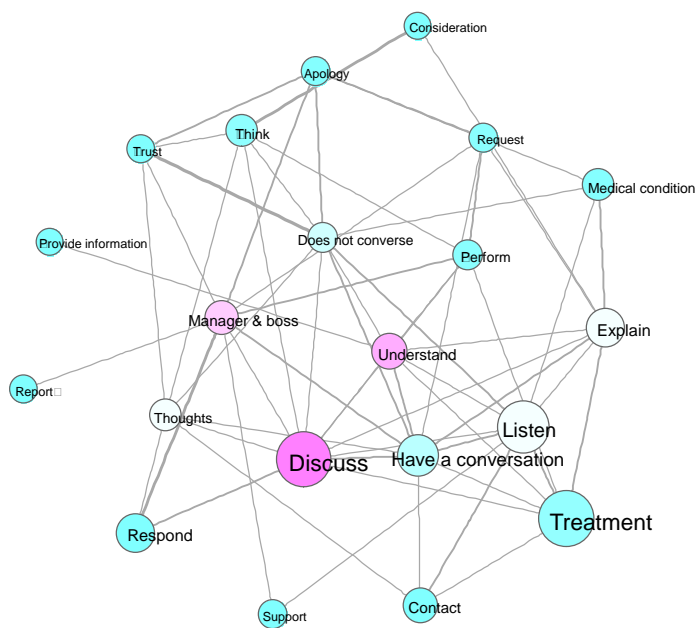


Figure 9. Co-occurrence network of Japanese patients' expectations of nurses when suffering in a stable condition.

regarding this.”

As an interpretation of this, the patient is preparing for the next scheduled discharge time. However, the nurse does not infer the patient's irritated affect and he/she provides no response (explanation). The nurse is busy performing care for other patients and recognizes that other patients are a priority. Therefore, the patient suffers while waiting patiently without declaring his/her thoughts of the irritation. The patient's irritation becomes the focus. Affect is a generic name indicating various feelings a person experiences; it is closely related to emotion and mood [28] and clearly indicates how a person feels [29]. Although the patient is irritated (affect), he/she cannot clearly and logically convey this to the nurse. In other words, when a situation cannot be understood objectively, the affect of the involved parties increases. Affect is subjective, and it has been suggested that it is impossible to adequately convey the properties of affect in language [30].

4.1.2. Timing Problems

Original text case: “*The nurse did not notice that a nurse call was made from the toilet and the patient was left waiting in the toilet for quite a long time. There was no apology for this that satisfied the patient.*”

As an interpretation of this, the patient's experience of being kept waiting in the toilet caused fear. However, it was a busy period for the nurse and the nurse recognized that the response was slightly delayed. Consequently, there is a gap between the nurse and patient regarding time. When the patient perceives and inappropriate gap, he/she feels suffering. There is an existing gap between nurses who are actively busy throughout the day and patients whose activity level is de-

creasing due to treatment; this also influences how events are understood. When taking an action-research approach, the process of learning through living experience includes the potential to reduce the gap between theory and practice [31] [32] [33]. By having a real sensation by entering the lives of others, one can move toward a solution. However, it is suggested that if it is impractical to enter a patient's life, nurses must use their imagination.

4.2. Latent Factors in Suffering

4.2.1. Privacy Issues

Original text case: *"I cannot leave my bed and when I mentioned that there was something I wanted to consult with the nurse about, the nurse said in a voice loud enough for the other patients and visitors in the room to hear: 'What's the matter? Please go ahead and tell me, whatever it is.' The nurse didn't consider that I wanted to speak privately."*

As an interpretation of this, although the patient was asked by the nurse, it was without consideration, and the patient endured feeling discomfort.

4.2.2. Nurses' Not Intervening on Patients' Behalf

Original text case: *"In situations where my physical strength is extremely depleted, such as fever, etc., voices of other visitors in the same room are very noisy. I want the nurse to notice this and warn them (on my behalf)."*

Although the patient's condition was stable, he/she had a fever. Therefore, he/she is very uncomfortable when it is too noisy. In this case, the patient was concerned that if he/she warns the visitors, it will harm his/her relationship with the other patients in the room; therefore, he/she would like the nurse, who is neutral, to warn them. The patient recognizes that these warnings are the nurse's responsibility. If this is not enacted, it becomes a latent factor in the patient's suffering.

Therefore, this factor is related to affect control such as suppression; concentration; and retention of a condition, urge, or emotion [34]. Although affect control is a socially necessary skill, it is thought to lead to suffering if it exceeds the patient's personal range of control. Suffering is a personal perception or experience; since humans perceive the experience of suffering in unique ways [35], it may be difficult for another person (in this case the nurse) to notice. Therefore, a "lack of the nurse's awareness" became a latent factor in the patient's perceived suffering.

4.3. Japanese Patients' Expectations of Nurses

Since no particularly strong relationships were shown, it is believed that patients' expectations are thought to be very diverse and without patterns. For patients to receive high-quality care, it is extremely important for nurses to understand patient suffering [36] and Millar [37] points out that communication is a core element of this. In other words, a nurse is required to sense the patients' expectations from communication one who is unable to do so is thought to cause pa-

tient suffering. In contrast, it is also necessary to determine patients' feelings through their non-verbal communication.

4.4. Cultural Factors

In Japan, individuals are taught to coexist and not harm others. They are also taught to avoid expressing affect such as personal thoughts and emotions. Expressing one's thoughts and emotions indirectly rather than directly is an art and uses a variety of expressive methods. Consequently, there is an expectation that one wants to and wants other to infer truth. That is, words such as "attentiveness" and "concern" that express Japanese spirit [38] are at the foundation and the space between people that creates a positive atmosphere (in Japanese, *awai*) is a characteristic of Japanese communication. However, the existing problem is that Japanese nurses are following Western teaching and communication. These cultural factors are not applicable to Japanese patients, and nurses are not perceiving their suffering effectively.

4.5. Clinical Contributions

Patients' in stable conditions have their thoughts easily overlooked. However, by understanding the characteristics of patients' perceived suffering and using basic communication skills, the nurse-patient relationships can be improved and high-quality nursing care can be provided. Communication that reaffirms diverse cultural backgrounds is necessary.

4.6. Study Limitations and Future Prospects

Rather than separately examining the perceptions of nurses or patients, it is necessary to concurrently verify conflicts and other situations that arise between nurses and patients and to conceptualize both nurses' and patients' perception of suffering.

5. Conclusion

Features of suffering perceived by Japanese patients in a stable condition included factors such as "lack of inference," "privacy issues," and "nurses' not intervening on patients' behalf." These were shown through a text analysis, which suggested that emotion has a complicated influence. Moreover, the Japanese culture of expression influences patients' suffering; however, it seems that Japanese nurses tend to forget this.

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