# The nurse-patient relationship cognitive differences: Revelation for continuing nursing education

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**Abstract: Objects:** The study is aim to understand the cognitive differences of nurse-patient relationship between nurses and patients, and provide the basis for the implementation of targeted continuing nursing education. **Methods:** The self-designed questionnaire was used, which included the current characteristics, development trends and future expectations of nurse-patient relationship, and the responsible subject and reasons of discordant nurse-patient relationship. **Results:** There were significant cognitive differences between nurses and patients about the current characteristics, development trends and future expectations of the nurse-patient relationship. **Revelation:** It's necessary to set up the continuing education content to meet the needs of clinical nurses and patients, to increase nurses' skills training about the knowledge of Psychology and etiquette, to strengthen nurse-patient communication, to eliminate both asymmetric information, so as to establish harmonious nurse-patient relationship-oriented nursing continuing education system.

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The development of the doctor-patient relationship depends on the awareness of the disease and the mutual understanding of the doctor-patient relations both doctors and patients[1]. Understanding and analyzing the differences in the perception of the nurse-patient relationship between nurses and patients, we can carry out targeted training for nurses to reduce nurse-patient cognitive differences and build benign nurse-patient relationship.

## 1. Study population and methods

### 1.1 Study population

The survey study enrolled 150 inpatients (83 males and 67 females) and 150 nursing staff (150 females) who met the criteria, they were selected from medicine, surgery, pediatrics, gynecology and obstetrics wards of a tertiary hospital. Nurse inclusion criteria included registered nurses who engaged in clinical work for more than one year. Patient inclusion criteria included cooperative and conscious inpatients who can properly express the semantics, and had been in hospital more than one week. Patient exclusion criteria included primary school education, severe cognitive dysfunction, mental disorders. The study was approved by the hospital Ethics Committee. Written informed consent was obtained from all nurses and patients who participate in the study voluntarily.

### 1.2. Methods

#### 1.2.1 Research tools

The self-designed nurse-patient relationship cognitive questionnaire was used in the research, which was designed on the basis of literature reviewing, expert consultation and the information form depth interviews of nurses. The questionnaire had 11 items including the cognitive of the dispute reasons and resolving options, the characteristics of current nurse-patient relationship, the harmonious degree, the development trends and expectative relationship. Per item has 3-4 options(1-4points). According to the expert advice and the pre-survey results[2], the content validity of the nurse-patient relationship cognitive questionnaire for patient and nurse was respectively 0.852 and 0.864, and the reliability was respectively 0.715 and 0.724.

#### 1.2.2 Methods

The cross-sectional study was used in this study. The nurses on duty and inpatients were randomly selected from the 20 wards of the internal medicine, surgery, gynecology, pediatrics were randomly selected. The investigators were trained to use unified guidance language. The questionnaire was filled out by respondents personally. But if respondents were not capable to fill, the investigators should give explanation one by one, and the questionnaire was filled out by investigators depending on the oral answers of the respondents. The questionnaires were sent and retrieved through site. The returned questionnaires which was incomplete or not filled more than two items, and couldn't be added, is considered invalid.

### 1.3 Statistical analysis

Baseline demographic and clinical

characteristics were generated by descriptive analysis. Count data was described using frequency and percentage. Categorical variables were compared using the Chi-square. A two-tailed level of statistical significance of 5% ($p < 0.05$) was established. Calculations were carried out using the IBM SPSS statistical software, version 19.

## 2. Results

### 2.1 Questionnaire recovery and respondents

There were "nurse-patient relationship cognitive questionnaire for patients" and "nurse-patient relationship cognitive questionnaire for nurses", respectively 150 copies. As a result, 150 valid questionnaires of patient and 141 of nurse were retrieved, the efficiency is 100% and 94% respectively. The average age of the nurses in this studay was 31.14±2.28 years old (range:22–48 years old). The education degree includes bachelor (n=74), college (n=61), technical secondary school (n=6). Professional titles: nurse-in-charge (n=31), nurse practitioners (n=52), nurses (n=58). The average age of the inpatients was 58.11±1.2 years (range: 18–72 years). The education degree includes university or higher education (n=67), secondary schools (n=61), primary schools (n=22).

### 2.2 The cognitive of dispute responsible subject and dispute reasons between nurses and patients

The cognition of dispute reasons and resolving options in nurses and patients are not statistically different ($P > 0.05$). Nurse, patient and the hospital are the responsible subject of the nurse-patient disputes, the different cognitive of medical results is the main reason for the discordant nurse-patient relationship (Table 1).

**Table 1.** The cognitive compare of dispute responsible subject and dispute reasons between nurses and patients

| Item | Classification | Patients | Nurses | $\chi^2$ | *P* |
|---|---|---|---|---|---|
| Responsible subject | Nurses | 6(4.00) | 3(2.13) | 3.686 | 0.297 |
| | Patients | 7(4.67) | 2(1.42) | | |
| | Nurses and patients | 71(47.33) | 67(47.52) | | |
| | Hospital | 66(44.00) | 69(48.94) | | |
| Dispute reasons | Nurses technology | 5(3.33) | 3(2.13) | 5.134 | 0.162 |
| | Nurses attitude | 17(11.33) | 7(4.96) | | |
| | Hospitalization costs | 34(22.67) | 41(29.08) | | |
| | Different cognitive of medical results | 94(62.67) | 90(63.83) | | |

### 2.3 The cognitive of the characteristics of current nurse-patient relationship and expected relationship between nurses and patients

There were differences between nurses and patients about the characteristics of current nurse-patient relationship and expectations ($P < 0.05$). The patients considered the current nurse-patient relationship as relatives (40.00%) or friends (32.67%), and that the nurses considered the relationship mainly as a service relationship (63.12%). The study also showed that 60.67% of the patients expected kinship with nurses, while 58.87% of nurses expected being friends with patients (Table 2).

**Table 2.** The cognitive comparison of the characteristics of current nurse-patient relationship and expected relationship between nurses and patients

| Item | Classification | Patients | Nurses | $\chi^2$ | *P* |
|---|---|---|---|---|---|
| Characteristics of the relationship | Relatives | 60 | 3 | 101.210 | <0.001 |
| | Friends | 49 | 31 | | |
| | Service | 19 | 89 | | |
| | Others | 22 | 18 | | |
| Expected relationship | Relatives | 91 | 26 | 59.392 | <0.001 |
| | Friends | 44 | 83 | | |
| | Service | 6 | 3 | | |
| | Others | 9 | 29 | | |

### 2.3 The cognitive of the harmonious extent of current nurse-patient relationship and development trends between nurses and patients

There are different cognitive between nurses and patients about the harmonious extent of current nurse-patient relationship and development trends ($P < 0.05$). In the currentrelationship cognitive, 84.11% of patients felt it good, and 66.67% of nurses felt it general. In the development trends cognitive, 96% of patients believed it would be improved continuously,

no patients believed it would be worsen, while 65.25% of the nurses believed it would be improved continuously, and 14.18% of the nurses believed it would be worsen (Table 3).

**Table 3: The** cognitive comparison of current nurse-patient relationship and development trends between nurses and patients

| Item | Classification | Patients | Nurses | $\chi^2$ | *P* |
|---|---|---|---|---|---|
| Harmonious extent of current nurse-patient relationship | Well | 127(84.11) | 36(25.53) | 103.647 | 0.000 |
| | General | 22(14.67) | 94(66.67) | | |
| | Poor | 6(4.00) | 11(7.80) | | |
| Development trends | Continuous improvement | 144(96.00) | 92(65.25) | 46.338 | 0.000 |
| | Uncertainty | 6(4.00) | 29(20.57) | | |
| | Worsening | 0(0.00) | 20(14.18) | | |

3. Discussion

3.1 In group bias leads to nurse-patient cognitive differences.

The survey shows that (Table 1), 47.33% of nurses and 47.52% of patients believed that the nurses and patients both were responsible subject of the nurse-patient disputes, while 44.00% of nurses and 48.94% of the patients believed that the hospital was responsible subject. It indicates that the nurses and patients treated the nurse-patient relationship more rational with the rapid development of society and the rapid transmission of information, increasing of nurse-patient communication. Therefore, they have the same cognitive, but they have a different view about the relationship characteristics and expected relationship (Table 2). About the characteristics of current nurse-patient relationship, 63.1% of the nurses considered the relationship as service relationship, while 72.7% of the patients considered the relationship as relatives or friends relationship. In expectations relationship, 90% of patients expect to become relatives or friends with nurses, while only 77% of the nurses has the same expectation as patients. This is due to the social identity[3],which make mankind automatically affix a group's label to themselves to seek a sense of pride in the group, generate attachment for this group, and compare with other groups, thereby exaggerating ingroups similarity and differences between groups. Nurses and patients in the hospital were automatically classified in different groups, ingroup bias makes defferent positioning of the nurse-patient relationship both in nurses and patients, its cognitive differences was produced inevitably.

3.2 The asymmetric sources of information leads to cognitive differences.

The results in Table 2 show significant differences that 84.7% of patients and 25.5% of nurses believed that the current nurse-patient relationship is very good, 96% of patients and 65.3% of nurses maintain a positive attitude for the future development of nurse-patient relationship. This is due to the deferent information sources and channels between nurses and patients, leading to information asymmetry. Patients learn about the care and medical knowledge through friends or relatives during hospitalization, and from the news media, networks, or other ways, therefore there is a certain amount of bias and possibility to be induced. Yet nurses gain medical knowledge mainly through medical education and continuing education, and get experience about spending with patients from work. In order to get a good feeling in clinic, patients or their relatives expect that nurses would pay attention to them like relatives or friends, and they are eager to learn about the prognosis of their disease. The nurses have heavy workload and tight working hours because each nurse takes care of 6-8 patients per shift. Regardless of effort and time, they can not do the full exchange with the patients or their families, or pay careful attention to everything. The lack of awareness about this in patients lead to cognitive differences[1]. The survey results also show that 62.67% of nurses and 63.83% of patients think that the different cognitive of medical results is the main reason of nurse-patient disputes (Table 1). Patients need medical information, and hope to get the same one with nurses. So we can conclusion that health education for patients can reduce cognitive differences which due to the information asymmetry.

4. Revelation

4.1 It is necessary to design of continuing nursing education courses scientifically under the needs.

Nurses gain expertise, cultural knowledge and skills by continuing nursing education, and dominate the development of the nurse-patient relationship in clinic. Continuing education should meet the individual needs (perceived needs and the real needs of the educate) and organizational needs (career development needs, the hospital needs et al.)[4]. In most hospitals, continuing education curriculum is still "three bases" in the main, which can't meet the clinical needs[5-6].While the demand survey shows that 93.22% of the nurses believe that Humanity Education is necessary during nursing continuing education [7].

Thus, continuing education content should be set based on the needs of clinical nurses. In addition to the professional knowledge and skills, it is necessary to strengthen the psychological knowledge of the nursing staff, such as behavioral and cognitive, emotional control, as well as communication skills, empathy and other human knowledge training ,to improve nurses' awareness of the patient population and strengthen communication between the two sides to enhance the humanistic qualities of nurses to meet patients' expectations of affection, to dilute group consciousness of caregivers and patients.

In addition to the professional knowledge and skills, it is necessary to strengthen the psychological knowledge of the nursing staff, give training of communication skills and humanistic qualities include empathy, to improve nurses' awareness of the patient population and strengthen communication between the two sides, to enhance the humanistic qualities of nurses to meet patients' expectations of affection, to dilute group consciousness of caregivers and patients.

4.2 Emphasis on the effect, various forms of continuing nursing education should be carried out.

In china, continuing nursing education method is mainly confined to the traditional classroom lectures and self-study[8], it is difficult to meet the needs of clinical nurses. Actually, centralized training, stratified training and case studies, nursing rounds, multimedia, networks, and other forms can be considered. Meanwhile, the health education can become a way of continuing education[4], to improve health education capacity of nurses. The nurses can take targeted health education to patients, guide patients to get the disease knowledge and information through medical institutions, medical books, and other ways. So patient compliance will be improved. By which, it can not only eliminate the concerns of patients, but also enhance the confidence of patients, result in shorten cognitive differences of disease expectation and medical procedures between nurses and patients, and establish harmonious nurse-patient relationship oriented continuing nursing education system.

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