The importance of nurse caring behaviors as perceived by patients receiving care at an emergency department

Gyða Baldursdottir, MS, RN, a and Helga Jonsdottir, PhD, RN, b Reykjavik, Iceland

BACKGROUND: Increased workload at the emergency department (ED) and the shortage of nurses may leave some patients without proper care. The importance of patients’ perceptions of caring is vital when organizing nursing practice under such circumstances.

PURPOSE: The purpose of the study was to identify which nurse caring behaviors are perceived by patients in an ED as important indicators of caring. The nurse caring behaviors were categorized in terms of relative importance with respect to demographic variables and perceived illness. Watson’s theory of caring was used as a theoretic framework for this quantitative and descriptive study.

METHOD: A 61-item questionnaire designed on the basis of Cronin and Harrison’s Caring Behaviors Assessment tool, which reflected the 10 carative factors of Watson’s theory, was mailed to 300 ED patients. The response rate was 60.7%.

RESULTS: Results showed that subjects scored the items “Know what they are doing”, “Know when it is necessary to call the doctor”, “Know how to give shots, IVs, etc.”, and “Know how to handle equipment” as the most important nurse caring behaviors. The subscale “human needs assistance” was ranked highest.

CONCLUSION: In line with several previous studies, subjects considered clinical competence to be the most important nurse caring behavior, which further emphasizes the notion of caring as a moral stance integral to all interactions with patients. (Heart Lung® 2002;31:67-75.)

Declining quality of hospital care is of great concern to patients and health workers alike. Hospitals are increasingly functioning with far too limited resources. Increased demand for cost-effective hospital management and steadily growing numbers of older patients, who present new and more complex health problems, has raised concerns as to where health care service is going. Rising numbers of patient admissions to hospitals, cuts in the number of hospital beds, and an increasing shortage of nurses only aggravate this situation and thrust much of management’s frustrations to the hospital units where there is limited margin for increased productivity.1-4

This situation exists particularly in emergency departments (EDs). Rising patient admissions, longer stays in the ED because of lack of hospital beds in medical and surgical units, and premature discharge have made nurses question their capacity to meet the needs and expectations of patients. Increasing workloads make nurses prioritize care to the most seriously ill patients, which risks leaving some patients neglected; however, neglect is unacceptable to both nurses and patients. Increasing patient consumerism only adds to the prevailing pressure on health care workers, leaving little or no leeway for mistakes.5-7

Patients’ perceptions of how they want to be cared for is reflected in many studies on quality of care.6,8-16 Complaints of poor attitude among health care workers toward patients appear to be increasing in Iceland because of the perception that health care professionals are increasingly distancing themselves from patients and giving...
impersonal care. It is, therefore, of the utmost importance to know how Icelandic patients perceive hospital nursing care and to compare these results with previous studies on the subject, because nursing care is the single most significant factor in the patient’s perception of high-quality hospital care.

LITERATURE REVIEW

Caring as a concept

Caring as an essential element of nursing is widely accepted among nurses. Nurses’ caring approach is believed to enhance the patient’s health and well-being and to facilitate health promotion. As yet, no universal definition or conceptualization of caring exists, but several have been put forward. One of these is Watson’s theory of caring.

Underlying Watson’s theory is a value system on the basis of deep respect for the wonders and mysteries of life. Recognition and acknowledgment of the value of caring in nursing practice come before and presuppose actual caring. The essence of the theory is reflected in Watson’s proposition of caring as the moral ideal of nursing, in which the result is enrichment and protection of human dignity. This ideal involves values, will and commitment, knowledge, caring actions, and consequences. These premises guide nursing practice and are manifested in it, particularly as they relate to the nurse being responsive to the uniqueness of each individual and to the preservation of feelings for others.

The following 10 carative factors, combined with a scientific knowledge base and clinical competence, guide nursing actions to promote health, prevent illness, care for the sick, and restore health: humanistic-altruistic system of values; faith-hope, sensitivity to self and others; helping-trusting, human care relationship; expressing positive and negative feelings; creative problem-solving caring process; transpersonal teaching-learning; supportive, protective, and/or corrective mental, physical, societal, and spiritual environment; human needs assistance; and existential-phenomenological–spiritual forces.

In addition to Watson, many researchers have conceptualized the caring of nurses from a variety of perspectives. In an attempt to synthesize the different perspectives into a coherent structure, Morse et al. analyzed the content of 35 authors’ definitions of caring and the main characteristics of each perspective. Five categories of caring were identified. The first category describes caring as a human trait, reflecting caring as “a part of human nature, and essential to human existence.” In the second category, caring is regarded as a moral imperative or ideal and referred to as a fundamental value in nursing. The emphasis is on preserving the individual’s dignity or integrity. The third category emphasizes that the nature of caring has its origin in emotional involvement and compassionate or empathic feeling for the patient’s experience. This perspective reflects nursing as a female profession with historical roots in religion. The fourth category considers caring to be an interpersonal relationship and indicates that caring is a mutual endeavor of the nurse and the patient, encompassing both the feelings and the behaviors that occur within relationships. Caring as a therapeutic intervention is the last category; it is patient-centered and action-oriented. As Morse et al. pointed out, it is difficult to locate writings on caring in the nursing literature that encompass only 1 of these categories. Watson’s theory may primarily be considered a moral ideal, but it also stresses the notion of caring as an interpersonal relationship and therapeutic intervention.

Nurse caring behaviors

Cronin and Harrison were the first to develop an instrument that they named the Caring Behavior Assessment (CBA) tool, on the basis of Watson’s theory, that reflects Watson’s carative factors. The instrument consists of 63 nursing behavior indicators distributed across 7 subscales, instead of the 10 described by Watson. The subscales are humanism/faith-hope/sensitivity, helping/trust, expression of positive/negative feelings, teaching/learning, supportive/protective/corrective environment, human needs assistance, and existential-phenomenological/spiritual forces. The tool was used in this study as the operationalization of the caring concept.

Four previous studies using the CBA instrument have been done, all in the United States (Table I). Thus this is the first international study using the CBA tool.

As Table I shows, the item “Know what they are doing,” which belongs to the humanism/faith-hope/sensitivity subscale, scored highest as a single item in 4 of 5 studies and “human needs assistance” rated highest as a subscale. The study that deviated from the group showed that patients with HIV/AIDS regarded “treat me as an individual” as the most important item. According to Mullins, the results indicated that, because of the nature of the disease, persons with HIV/AIDS might be in more need of being accepted and cared for.
with respect and dignity than various other groups of patients.

**STUDY PURPOSE AND RESEARCH QUESTIONS**

The purpose of the study was to identify nursing behaviors that patients perceived to be indicators of caring in the ED and to categorize these indicators in terms of relative importance.

The following research questions are the basis for the study:

1. Which nurse caring behaviors are perceived as most important and least important by patients in the ED?
2. Do patients’ perceptions of nurse caring behaviors differ according to demographic factors, that is, age, residence (capital city vs outside the capital city area), educational level, gender, and perception of illness?

**Theoretic definitions**

The definition of caring used in this study is the one used by Cronin and Harrison, originating from Watson. “Caring is the process by which the nurse becomes responsive to another person as a unique individual, perceives the other’s feelings, and sets that person apart from the ordinary.” The definition of nurse caring behaviors was developed by Cronin and Harrison, referring to “Those things that a nurse says or does that communicate caring to the patient.”

**Assumptions**

The following assumptions were made:

1. Basic components of nursing care provided in the ED where the study took place are the same for each patient, regardless of which nurse provides the care.
2. Potential participants are able to identify the professional status of the nurses as distinct from both licensed practical nurses and nursing students.

**METHODOLOGY**

**Study design**

This study was a nonexperimental, quantitative, descriptive study using an instrument developed and applied earlier by Cronin and Harrison. Although in part a replication study, this study differs from Cronin and Harrison’s work in that it was conducted on the basis of a much larger sample size with a broad range of illness experiences and age spectrum. This study was also carried out in a health care system different from the previous one (ie, in Iceland). The University Hospital in Reyk-
Nurse caring behaviors

Baldursdottir and Jonsdottir

jávik, Iceland (UHI) was chosen as a place of entry, the ED in particular because of the variety of patients who visit it, many of whom are entering the hospital, a strange and unfamiliar environment, for the first time.

Sample and setting

The population was defined as adult patients who received service in the ED at UHI. The sample was a nonprobability convenience sample of adult patients (18 years or older) who received care in the ED at UHI during a 1-month period and were discharged from the ED without being admitted to another hospital unit. Patients admitted to other hospital units were excluded to avoid influence from care received at other units.

A list with the names of prospective participants was obtained from the ED at UHI after approval from the Ethical Committee of UHI. Three hundred patients who were admitted to the ED during 1 month fulfilled the above criteria. The instrument, in the form of a questionnaire, was mailed to their homes.

Instrumentation

The instrument that was used for data collection was a questionnaire developed by Cronin and Harrison, the CBA tool, described earlier. Cronin and Harrison10 established face and content validity of the CBA tool using a panel of 4 content specialists who were familiar with Watson’s theory. Internal consistency reliability was determined by using the study sample responses to calculate Cronbach $\alpha$ for each of the 7 subscales. Cronbach $\alpha$ ranged from 0.66 to 0.90. In the present study, internal consistency reliability was determined in the same way, with reliability coefficients ranging from 0.69 to 0.89.

In translating the CBA tool from English to Icelandic, attempts were made to account for translation equivalency, congruence in value orientation, and careful use of colloquialism.33 Three bilingual nurses who were familiar with the topic made the translation into Icelandic. Two bilingual persons were then asked to make sure that the Icelandic version was understandable for a layperson. Then 2 bilingual persons, a nurse and a non-nurse familiar with the topic, but not familiar with the English version, back-translated the Icelandic version. Finally, the group of 7 persons refined both translations.33,34 The group agreed that 2 items should be omitted from the Icelandic version: The first item is “Ask me what I like to be called,” because in Iceland everyone is called by his or her given name and not by family name, regardless of whether known to the person by whom he or she is being addressed. The second item is “Visit me if I move to another hospital unit,” which was not relevant, because to be included in the study one had to be discharged home after the ED visit. The items in each subscale ranged from 3 to 12, and the 2 dropped items in the Icelandic version were both from the same subscale, helping/trust, which contains 9 items in the present study instead of 11 as in Cronin and Harrison’s study.10

The instrument, now consisting of 61 items, was pilot tested with 20 patients aged 20 to 75 years, but these results were not incorporated into the main study. Several minor comments were submitted and some used for revision, such as suggestions about the layout of the instrument.

Procedure

Subjects were requested to rate their perception of each of the nurse caring behavior items on a 5-point, Likert-type scale of relative importance. In addition, patients were given an opportunity in the questionnaire to make brief additional remarks to the open-ended question of whether there was anything else that nurses could say or do to make the patients feel cared for. Demographic information on age, residence, gender, and education was collected as well. Responses to the open-ended question did not add new perspectives to the responses in the questionnaire itself and have been omitted from this article.

Two weeks after being discharged, every patient in the sample received an envelope in the mail that contained the following:

1. A questionnaire
2. A letter from the first author that explained the study and requested the patient’s consent to participate in the study. If the patient decided to answer the questionnaire and return it, this was considered to be signed consent.
3. A return envelope, stamped and addressed, for the patient to return the completed questionnaire.

Two weeks later, a follow-up letter and a new copy of the questionnaire were sent to the patients, urging the return of the questionnaire. After 2 more weeks, a third and last letter and a new copy of the questionnaire were sent out, again urging a return.

The mailing of 300 questionnaires resulted in a 60.7% (n = 182) response rate usable for data analysis. Of the 300 prospective participants, 56.7% (n = 170) were women and 43.3% (n = 130) were men. Of
the 182 usable questionnaires, 57.1% (n = 104) were from women and 42.9% (n = 78) were from men participants.

**Data analysis**

Mean scores and standard deviations were calculated for each questionnaire item to find the most and least important nurse caring behaviors and item variability. All items were then grouped into subscales and the overall mean for each individual was calculated for each subscale. Overall item means for each of the subscales were also calculated to determine the rank distribution of the subscales. The nonparametric Mann-Whitney U test and Kruskal-Wallis one-way analysis of variance were used to examine response to the CBA, according to the demographic variables of age, gender, residence, educational level, and perceived illness. The level of significance (α) was set at P < .05.

**RESULTS**

**Ratings of CBA items**

For each of the 61 items in the CBA tool, mean scores and standard deviations were calculated. Summaries of the 10 most important and 10 least important behaviors are listed in Tables II and III. Means ranged from a high of 4.94 for the most important item (“Know what they are doing”) to a low of 3.15 for the least important item (“Talk to me about my life outside the hospital”).

---

**Table II**
The mean and standard deviation (SD) for the 10 most important nurse caring behaviors

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Know what they are doing</td>
<td>4.94 (0.28)</td>
</tr>
<tr>
<td>2. Know when it is necessary to call the doctor</td>
<td>4.93 (0.26)</td>
</tr>
<tr>
<td>3. Know how to give shots, IVs, etc.</td>
<td>4.91 (0.39)</td>
</tr>
<tr>
<td>4. Know how to handle equipment</td>
<td>4.91 (0.36)</td>
</tr>
<tr>
<td>5. Answer my questions clearly</td>
<td>4.85 (0.41)</td>
</tr>
<tr>
<td>6. Treat me as an individual</td>
<td>4.83 (0.40)</td>
</tr>
<tr>
<td>7. Give my treatments and medication on time</td>
<td>4.83 (0.43)</td>
</tr>
<tr>
<td>8. Do what they say they will do</td>
<td>4.80 (0.45)</td>
</tr>
<tr>
<td>9. Be kind and considerate</td>
<td>4.77 (0.53)</td>
</tr>
<tr>
<td>10. Check my condition very closely</td>
<td>4.77 (0.52)</td>
</tr>
</tbody>
</table>

**Table III**
The mean and standard deviation (SD) for the 10 least important nurse caring behaviors

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Talk to me about life outside the hospital</td>
<td>3.15 (1.23)</td>
</tr>
<tr>
<td>2. Touch me when I need it for comfort</td>
<td>3.78 (1.19)</td>
</tr>
<tr>
<td>3. Praise my effort</td>
<td>3.81 (0.99)</td>
</tr>
<tr>
<td>4. Know when I have “had enough” and act accordingly (for example, limiting visitors)</td>
<td>3.87 (1.08)</td>
</tr>
<tr>
<td>5. Help me understand my feelings</td>
<td>3.88 (1.12)</td>
</tr>
<tr>
<td>6. Be sensitive to my feelings and moods</td>
<td>3.99 (0.95)</td>
</tr>
<tr>
<td>7. Ask me how I like things done</td>
<td>4.02 (0.94)</td>
</tr>
<tr>
<td>8. Encourage me to talk about how I feel</td>
<td>4.03 (1.00)</td>
</tr>
<tr>
<td>9. Help me plan for my discharge from the hospital</td>
<td>4.03 (0.99)</td>
</tr>
<tr>
<td>10. Encourage me to believe in myself</td>
<td>4.09 (0.96)</td>
</tr>
</tbody>
</table>
Ratings for the CBA subscales

When items had been grouped into the 7 subscales, a mean for all items in each subscale was calculated for each patient. The overall subscale means and standard deviations for each subscale were then calculated on the basis of the patient means. The subscale rating is shown in Table IV, demonstrating that “Human needs assistance” is the most important subscale and “Expression of positive/negative feelings” is the least important.

Differences in perceptions of caring

Seven subscales that measure nurse caring behaviors were compared with perceived illness and 4 demographic variables: gender, residence, age, and education (Tables V and VI). The results of a Mann-Whitney U test on the subscales, in relation to gender and residence, demonstrate that women score significantly higher than men in subscales 1, 2, 3, 5, and 6 (Table V) and that no significant residential differences were found with respect to any of the subscales.

The results of the Kruskal-Wallis one way analysis of variance on the subscales in relation to age, educational level, and how the subjects perceived their illness (Table VI) showed significant age differences for every subscale (ie, the higher the age of subjects’, the greater the importance of nurse caring behaviors). Significant educational differences were found for subscales 1, 3, 4, and 7. Subjects with low educational levels scored significantly higher on these 4 subscales. No significant differences were found for subscales 1 to 7 with respect to how sick the patients perceived themselves to be.

Table IV
Ratings for the CBA subscales

<table>
<thead>
<tr>
<th>Rank</th>
<th>Subscale</th>
<th>No. of items</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Human needs assistance</td>
<td>9</td>
<td>4.68 (0.379)</td>
</tr>
<tr>
<td>2</td>
<td>Supportive/protective/corrective environment</td>
<td>12</td>
<td>4.41 (0.655)</td>
</tr>
<tr>
<td>3</td>
<td>Teaching/learning</td>
<td>8</td>
<td>4.38 (0.612)</td>
</tr>
<tr>
<td>4</td>
<td>Humanism/faith-hope/sensitivity</td>
<td>16</td>
<td>4.35 (0.483)</td>
</tr>
<tr>
<td>5</td>
<td>Helping/trust</td>
<td>9</td>
<td>4.32 (0.523)</td>
</tr>
<tr>
<td>6</td>
<td>Existential/phenomenological/spiritual forces</td>
<td>3</td>
<td>4.27 (0.784)</td>
</tr>
<tr>
<td>7</td>
<td>Expression of positive/negative feelings</td>
<td>4</td>
<td>4.12 (0.756)</td>
</tr>
</tbody>
</table>

Table V
Results of subscale comparisons by sex and residence

| Subscale                                                        | Sex      | Residence | U   | P   | U   | P   |
|                                                               |          |           |     |     |     |     |
| 1. Humanism/faith-hope/sensitivity                           | 2966 .002* | 1383 .446 |
| 2. Helping/trust                                              | 3268 .025* | 1510 .859 |
| 3. Expression of positive/negative feelings                  | 3132 .008* | 1142 .059 |
| 4. Teaching/learning                                         | 3500 .112 | 1360 .383 |
| 5. Supportive/protective/corrective environment              | 2886 .001* | 1521 .899 |
| 6. Human needs assistance                                    | 2939 .002* | 1214 .123 |
| 7. Existential/phenomenological/spiritual forces              | 3353 .054 | 1.356 .383 |

*P < .05.

U, Mann-Whitney U test.
DISCUSSION

Results of this study show that the single most important item perceived by subjects is “Know what they are doing,” which supports results from 4 of the 5 previous studies that have used the CBA tool.10,13,14,16 These results also support several qualitative studies carried out in different settings.11,12,35-37 In all of these studies, patients prioritized the clinical competence of the nurse. These results support Watson’s notion27,28 of caring as being manifested in actions for and on behalf of patients, in which the result is enrichment and protection of human dignity. In accordance with these results, the subscale “human needs assistance” ranked highest in this study, as in several others.10,13,14,16 The “human needs assistance” subscale contains 9 items, 5 of which belong to the 10 most important nurse caring behaviors found in this study. The prominence of assistance with fulfilling human needs in the findings indicates that the nurse reveals the moral stance of caring through actions that are taken to respond to the uniqueness of each individual, primarily the gratification of unmet physical needs and the monitoring of patients.27,28 Caring is therefore not something the nurse reveals after finishing basic nursing care; rather, in quality nursing practice, caring and competence necessarily coexist.25

Although substantial differences in means exist between the 10 most important nurse caring behaviors (4.77-4.94) and the 10 least important ones (3.15-4.09), it is not appropriate to assume that the 10 least important items are unimportant for the patients. These items certainly are important because they also yield relatively high scores. Despite this, behaviors related to physical care and monitoring of patients are prioritized, whereas aspects related to emotional and spiritual needs were seen as less important, as has been discussed earlier.

Age correlated significantly with scores on all subscales. The older the subjects, the more important were the nurse caring behaviors. This finding may be explained by the fact that with increasing age, the need for health care increases. Elderly people may generally feel vulnerable and thus may be particularly sensitive to receiving attentive assistance. For people who are at higher risk of getting diseases it may be of particular importance to know that their health care providers are professionals who are competent and ready to take care of them.

Female participants scored significantly higher than male participants in 5 of 7 subscales, which accords with the notion that females have a better conception of caring than males.39,40 Significant differences were also found on 4 subscales with regard to educational level, in which subjects with lower education scored higher on the importance of nurse caring behaviors. This may be linked to the fact that females scored higher and they might, on average, have received less education than males. Results from this study, with regard to age, gender, and educational level, differ from Cronin and Harrison’s study,10 in which no significant differences were found. This difference may be explained by the small sample size and relative homogeneity of the sample in Cronin and Harrison’s study.

Table VI

<table>
<thead>
<tr>
<th>Subscales</th>
<th>Age (df = 7)</th>
<th>Education level (df = 5)</th>
<th>Perceived illness (df = 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\chi^2$</td>
<td>$P$</td>
<td>$\chi^2$</td>
</tr>
<tr>
<td>1. Humanism/faith-hope/sensitivity</td>
<td>24.3</td>
<td>.001*</td>
<td>11.1</td>
</tr>
<tr>
<td>2. Helping/trust</td>
<td>17.2</td>
<td>.016*</td>
<td>7.5</td>
</tr>
<tr>
<td>3. Expression of positive/negative feelings</td>
<td>23.0</td>
<td>.002*</td>
<td>12.0</td>
</tr>
<tr>
<td>4. Teaching/learning</td>
<td>19.6</td>
<td>.007*</td>
<td>11.3</td>
</tr>
<tr>
<td>5. Supportive/protective/corrective environment</td>
<td>21.8</td>
<td>.003*</td>
<td>7.0</td>
</tr>
<tr>
<td>6. Human needs assistance</td>
<td>20.6</td>
<td>.004*</td>
<td>5.9</td>
</tr>
<tr>
<td>7. Existential/phenomenological/spiritual forces</td>
<td>41.2</td>
<td>.000*</td>
<td>16.7</td>
</tr>
</tbody>
</table>

Kruskall-Wallis one-way ANOVA.

df, Degrees of freedom.

* $P < .05$. 
No significant differences were found among subjects with regard to residence or the way in which subjects perceived the seriousness of their illness. This finding is different from the findings of Huggins, Gandy, and Kohut, who demonstrated that patients who were classified as “non-urgent” had higher expectations than patients in the emergent group. The results of this study indicate that, irrespective of the seriousness of their illness, patients feel the same need to be cared for. Professionals should be aware of this need because there is a tendency to minimize patients’ complaints if they are not considered to be seriously ill. Patients are, however, entitled to high quality care, regardless of the professional’s perception of the seriousness of their illness.

LIMITATIONS
This study was limited to patients who received service at 1 department at 1 hospital. Furthermore, the sample was a convenience sample; therefore results cannot easily be generalized to the ED population at large. However, the results of this study are in many ways similar to and, to a large extent, supportive of the results of comparable studies elsewhere. Participation is also limited to persons who can read and write the Icelandic language and are 18 years of age or older, thus excluding a considerable portion of the patients (ie, children and their parents). The most seriously ill patients are likely to have been transferred to other units of the hospital and were therefore excluded from the study.

IMPLICATIONS AND RECOMMENDATIONS
The results are useful in their own and in similar settings because they can be used by staff nurses to improve practice in various ways. They are also significant to administrators in finding new avenues of service that encourage exploration of what patients consider important with regard to high-quality care.

This study is conducted on the basis of theoretic perspective, which defines caring as a moral stance that presupposes clinical competence in nursing practice. The results support this position and should be used in a wider context to acknowledge patients’ needs for caring and the understanding of their expectations of the nursing profession. From this perspective the results are valuable not only for clinical practice but also for nursing education.

Time constraints and high workload have been the main concerns of nurses with regard to insufficient caring for patients. These results do not support the belief that more time is necessarily needed in order to care. However, a caring moment can be created when the nurse is morally conscious and authentically present with patients in fulfilling their unmet needs, utilizing his or her knowledge base and clinical competence.

Further studies that use the CBA tool are recommended to study how patients who stay for more than 24 hours at the hospital perceive nurse caring behaviors. Patients’ perceptions of nurse caring behaviors in settings outside the ED would also be useful, as would comparisons of the perceptions of patients who have been in a hospital more than once with patients who are experiencing their first hospital stay.

Studying children as patients to find out which of the nurse caring behaviors they and/or their parents perceive as important could yield interesting results and provide insight into whether children have special needs with relation to caring. It could also be interesting to combine a study like this with a qualitative study in which interviews would give insight into the various aspects of caring.

Nurses maintain that caring increases patients’ well-being. More general studies are needed to explain the ways that caring affects patient’s outcomes and to demonstrate the effectiveness of caring on patient’s outcomes. Caring is an integral component of nursing and studies on caring should be at the forefront of future nursing research.

REFERENCES
17. Olafsdottir AG. Fra forsjarhyggju til samrads [From institutional scheming to public consultation]. Morgunbladid (an Icelandic newspaper) 1996;March 1:30-1.