Countering the stereotype of the unpopular patient


Abstract
Labelling theory and Stockwell’s seminal work on the unpopular patient can help inform nurses’ interactions with patients in the modern healthcare system. Today, older patients might be deemed unpopular because of their perceived personality, attitudes or communication, and because their needs fit poorly with the service available to them. These, and other factors, such as staffing levels, length of hospital stays, and patients’ expectations as consumers, help to influence what defines an unpopular patient.

Aims and intended learning outcomes
The aim of this article is to help readers take stock of risk factors that may lead to the labelling of older patients as unpopular, problematic, awkward or uncooperative. It also explores behaviour that is deemed challenging and which could quickly tarnish the patient’s reputation. To facilitate this, a brief review is undertaken of the sick role post-Parsons (1951) and labelling theory (Becker 1963, Scheff 2010). Consideration is then given to factors that might increase the likelihood that a patient is labelled in a negative way and points will be drawn from recent literature. Finally, suggestions are made about approaches to patient care that might reduce the risk that the patient is treated in a stereotypical way.

By reading this article and completing the time outs, you should be able to:

- Summarise why an understanding of the sick role and labelling theory is important when ensuring that older patients are not stereotyped.
- Examine the different factors that may increase the chances that an older patient is treated as a ‘type’ of person rather than an individual.
- Search for ways to approach the older patient that seem more compassionate.

Introduction
There are compelling reasons to revisit labelling theory and Stockwell’s (1972) seminal work on the unpopular patient. In the 1970s what determined whether patients were deemed unpopular was associated with their personality – were they cheerful or morose, grateful or grudging, optimistic or pessimistic? And whether nurses found the patient interesting to care for. Patients with unusual conditions amenable to imaginative care might be much more popular with staff.

Today, older patients might be deemed unpopular, not just because of their perceived personality, attitudes or communication, but because their needs and requirements fit poorly with the service available to them. The staffing/support mix may be crucial to minimising tensions (Hayes and Ball 2012). Shorter hospital stays, more acutely ill patients spending time in hospital often when they are vulnerable, frail and perhaps have dementia, can all produce a cocktail where communication suffers and patients might quickly become unpopular.

Patients today have become consumers, evaluating care services as a commodity rather than a collaborative process, as a result of media campaigns, documentaries and political recommendation, that is, what you should expect of the service (Binder 2008). Patients have been encouraged to complain and to litigate, at a time when nurses are challenged to do more with fewer resources. A variety of factors might help to shape what defines an unpopular patient today.

Patients and their role
While nurses deliver treatment, support, reassurance and guidance as part of care, the care relationship has...
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traditionally been conceived of as a transaction. Care is delivered in return for certain other things expected from patients. Just as nurses fulfil a role, so are patients expected to, and it is the extent to which patients fulfil role expectations that may determine whether they are respected and treated equally.

Parsons (1951) described the sick role, which patients were meant to fulfil. In exchange for meeting two main responsibilities:
- They must want to get better and demonstrate that in their demeanour.
- They must accept that healthcare staff know how to help them do this, they must co-operate.

Patients were granted two rights:
- Exemption from the normal responsibilities of living, especially work.
- Exemption from blame, for becoming sick in the first place.

Now do time out 1.

**The sick role**

**Time out**

Read Box 1, which describes the behaviour of one older patient in a hospital ward. She describes herself as a healthcare consumer. Do you think Parsons’s (1951) sick role expectations still apply here, and if not, what has changed regarding the sick role? What do nurses now expect of patients?

It may be doubtful whether most patients fulfilled all sick role expectations in the 1950s. Even if the patient was absolved of blame for becoming ill by healthcare staff, there were others who might still evaluate some sickness negatively, for example, late-stage syphilis among older people condemned as promiscuous when younger. Patients were able to co-operate with treatment and nursing care to varying degrees, in part depending on their intelligence and their confidence when asking doctors and nurses what to do that might assist in their recovery or rehabilitation. Patients with dementia therefore were no more well equipped to address sick role expectations. In the 1950s, as now, many older patients were retired from work, so it was rather ambiguous what responsibilities sickness relieved them from. If the patient was not absolved from the need to work, what expectations in retirement were they relieved of?

Parsons (1951) might be described as portraying the patient in unduly passive terms, but even so, compliance with the sick role may have still been hard to sustain. Anxiety, possibly discouraging consent or even admission to hospital, the wish to return quickly home to care for a spouse perhaps before the doctor signed the patient as ready, cultural fears about illness and what this signified, may all have made active co-operation difficult. Accepting that doctors and nurses knew best required trust and in the meantime there were beliefs, for example, concerning folk remedies, that might encourage older patients in particular to follow their own course of action.

Nonetheless, Parsons’s (1951) work alerted the nurse to the idea that there were boundaries for required patient behaviour. It suggested norms that would allow the nurse to censure patients if they did not comply with expectations. Subsequently, however, the patient role has been changing rapidly.

Patients are:
- Expected to be learners, inquisitive about the techniques that will sustain health and limit complications later on. This is difficult if the older patient expects to behave in a more passive way (Cameron 2013).
- Meant to act as partners, sharing in the diagnosis of needs and problems, and the planning of responses to the same; older patients might think that they are equal to well-educated doctors and nurses (Brataas et al 2010).
- Asked to divulge more information about their lifestyle, contextual material that will help healthcare staff to understand under what circumstances care will have to work later (McKay et al 2012). Older patients may be much more private about their personal affairs, seeing this as more dignified in a person of ‘senior years’.
- Encouraged to act as consumers, evaluating services in ways that would have seemed impertinent in the 1950s (Konschak and Jarrell 2012).
- Invited to act as fellow problem solvers: the nurse might facilitate problem solving, but be unable to resolve all issues on the patient’s behalf. Problem solving is especially important for older patients with chronic illness (Hill-Briggs 2003).

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**Box 1 Mrs Dickens**

Mrs Dickens is recovering in hospital after hip surgery for a fracture that she sustained while walking on an uneven pavement in a shopping precinct. An intelligent and analytical woman, she busies herself during the day talking to other patients about the importance of litigating against the council for her injury. She recommends to fellow patients that they consider their rights because society is too quick to take these away from older people.

She continues to experience modest pain after surgery but refuses some of the analgesia doses offered by the nurses on duty. She wishes to remain a ‘discerning consumer’. On some days, however, the shortfall in analgesia seems to limit what she is able to do with the physiotherapist to start to mobilise.

One nurse observes, ‘refusing the analgesia has consequences for us too. Mrs Dickens seems to require more of us to get comfortable precisely on those days when she insists on limiting the painkillers’.

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NURSING OLDER PEOPLE
Patients at the start of the 21st century are expected to be more proactive and, within the limits of health in old age, to share in the responsibility for achieving a successful recovery and thereby a viable independent lifestyle. For some older patients at least, this has seemed an abrupt change from the more passive sick role that they expected and possibly remembered from a hospital admission in previous decades.

More person-centred care involves new challenges. While nurses have often been at the front of promoting more individualised forms of care, they have not necessarily fully understood what this entails in terms of clinical skills of enquiry, or the demands that it makes on patients who might not understand why such information is sought. Insensitive questioning may theoretically seem impertinent rather than helpful.

Now do time out 2.

Labelling theory
While nurses would prefer to think of themselves as always supportive, caring and facilitative in their work, they nevertheless have the power to label patients in negative ways, which may have implications for their later recovery and rehabilitation. What was significant about Stockwell’s (1972) work was that she pointed out that nurses labelled patients prematurely and using criteria that gave patients little scope to redefine themselves afterwards. Patients who failed to show due deference and gratitude for what the nurse did might receive less attention in the future and might then be dubbed ‘bell pushers’. Nurses might start to question whether patients wanted to get better and might share their observations with others who had power over important rehabilitation decisions.

Labelling theory argues that certain individuals in society have the power to construct reality in ways that disadvantage the less powerful. It was not only that people such as doctors and nurses might determine access to vital services and facilities, it was that they could fundamentally define the less powerful person in ways that went on limiting their life opportunities.

This is profoundly important for older people who have already confronted negative attitudes towards old age, those associated with a perceived lack of productivity. Becker (1963) wrote about ‘outsiders’ and described the ways in which people once outside a circle of acceptable behaviour might not be allowed back in.

Scheff (2010) has written about efforts to avoid this type of problem when dealing with the reported symptoms and needs of patients. Scheff (2010) argues that symptoms should neither be prematurely labelled as wrong/spurious or unworthy, nor unquestioningly accepted as real. Rather, symptoms, for instance pain, anxiety, phobia, must be treated as perceptions that the patient and professional need to explore together.

Now do time out 3.

### Time out

#### Person-centred care
Think about your understanding of person-centred care. Has it required patients to share more of their private selves and has that always been well received? Imagine that you were trying to persuade Mrs Dickens (Box 1) to reconsider how she sees pain management. How must you proceed today compared to what might have been done by a nurse working in the 1950s?

### Time out

#### Labelling
Read Box 2. Is there anything about what Mrs Dickens says or does that could prompt you to label her in some way? What checks and balances in your reading of patients do you think help you to resist prematurely labelling older patients?

While labelling theory was written about widely in the middle of the past century, it remains an issue today. Mottram (2011), for instance, writes about the ways in which patients using day-surgery services tried to resist the sick role expectations of staff. They found it especially difficult to do and confusing, because staff were still applying sick role expectations that fitted better with longer periods of hospital stay. In practice, day surgery demanded of patients a much more active and well-organised response, at least, if they were to manage well on return home.

### Box 2 Mrs Dickens’s lunch
Mrs Dickens has been served a lunch of roast chicken, creamed potatoes, garden peas and carrots. The presentation on the plate is not especially appealing, but she pushes the unfinished meal away insisting that it is not the type of food that mends bones. Her father always said that fish was needed to mend bones and a good deal of cream. Everything today is skimmed, fat free and calorie reduced.

She starts to tell the care assistant loudly what she thinks a good meal is and wonders whether the hospital has ‘really got to grips with nutritional diets’. The care assistant seems dumbfounded and wonders what to do next. Should she ignore the observations or report to the ward manager that Mrs Dickens has a complaint?
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Older patients may be poorly equipped to respond in the proactive manner required by day surgery. Cracknell (2009), writing for doctors, is cautious not to talk about challenging relatives, referring instead to their challenging behaviour that needs to be swiftly and sensitively countered by healthcare staff. There remains a felt need for staff to define a significant part of the care transaction – even if at the same time much is written about more person-centred care.

Aronson et al (2013) highlight just how powerful labelling behaviour is in the US healthcare system. Writing about black and other minority ethnic groups searching for healthcare support, they observe that disadvantaged healthcare consumers may quickly respond to what they describe as ‘stereotype threat’. Stereotype threat describes the way in which disadvantaged individuals may adjust their behaviour to their own disadvantage even before labelling has occurred. Older patients in particular may be prone to stereotype threat because of learned assumptions about what it is to be ‘elderly’. Disadvantaged patients learn to expect less and to avoid potential conflict with healthcare staff. They may:

- Avoid healthcare consultations, taking up fewer services even though these are needed.
- Communicate in an impaired way, limiting what they ask or else fulfilling the stereotype expectations of healthcare staff, the better to limit what might seem intrusive debates and questions about their lifestyle.
- Fail to adhere to medical regimens and therefore experience more consequences and side effects when treatment is not appropriately used.

Now do time out 4.

4 Stereotype threat

Thinking back to the previous time out and events in Box 2, you may have already deliberated whether you might remonstrate with Mrs Dickens about her response to the care assistant. Perhaps you even thought her a bully? But have you witnessed other older patients, those you sense who hold back from expressing their displeasure associated with one or more of their challenging behaviour that needs to be swiftly and sensitively countered by healthcare staff. There remains a felt need for staff to define a significant part of the care transaction – even if at the same time much is written about more person-centred care.

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Now do time out 4.

Healthcare staff may start to exhibit ‘conservation of resources’ (Hobfoll 1989, An et al 2013). Instead of trying to work with patients’ expectations, to accommodate the diversity of need, they may start to conserve their resources of time and attention for those who are easier to deal with.

Some patients may be thought of as ‘poppets’ and others as problems (Dean 2012). While such conservation of resources has obvious consequences for patients who struggle to fulfil an expected role and to communicate in an expected way, it also has implications for the healthcare practitioner. He or she falls back on less responsive and imaginative ways of solving problems or addressing challenges. The ability of the practitioner to learn from and through practice is diminished. Not only will work seem more stressful as responses to patients then attract criticism, but the ability of practitioners to correct their behaviour may diminish as well.

Factors influencing the risk of labelling

A number of factors may increase the chances that nurses and others label older patients. From the outset, nurses have been exposed to some negative stereotypes of old age, those that professional training works hard to counter (Coudin and Alexopoulos 2010). Seeing individuals, for example, in terms of their productivity, rather than their experience and wisdom, and the assumption that older people are less productive and less valuable as a result, is one such risk.

While nurse perceptions and beliefs vary, the process of ageing could be conceived of as one of inevitable decline. Older people are more problematic, less ‘salvageable’, perhaps worth less investment of time and attention. Beyond old age, people with dementia may additionally be conceived of as incompetent and pitiable (O’Connor and McFadden 2013). Writing about black and other minority ethnic groups searching for healthcare support, they observe that disadvantaged healthcare consumers may quickly respond to what they describe as ‘stereotype threat’. Stereotype threat describes the way in which disadvantaged individuals may adjust their behaviour to their own disadvantage even before labelling has occurred. Older patients in particular may be prone to stereotype threat because of learned assumptions about what it is to be ‘elderly’. Disadvantaged patients learn to expect less and to avoid potential conflict with healthcare staff. They may:

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illness interpretation and coping. Older patients need more flexibility in finding ways to solve problems.

- Issues relating to inadequate information. There may be problems of information overload or shortfall, or else information is provided in a way that does not allow the patient to absorb what is now required. Versed in technical terminology, the nurse might quickly become exasperated by older patients who do not understand.

Now do time out 5.

5 Understanding patients

Look back to the two boxed excerpts describing Mrs Dickens's behaviour. Decide whether an understanding of her past life and possible previous experiences of health care are central to better understanding her and finding ways to respond to her abrupt and opinionated manner.

What may complicate the care relationship and increase the likelihood that a patient is labelled problematic is the fact that care often involves a third party. Gevers et al (2012) describe issues surrounding decision making for older patients who might be deemed incompetent to make their own choices, for example, those with dementia. Surrogate decision making involves more perspectives on what is right, desirable, urgent and commendable and the patient is witness to this.

Being treated as incompetent is threatening, and while patients might struggle to express their views, this does not necessarily mean that they have not formulated them. Issues may arise during the discharge of a patient, those that put the professional and lay carers in contest with one another, each trying to define the point at which a transfer of care is mandated (Almborg et al 2009). Under these circumstances, patients might be reminded that they represent a burden or responsibility and may search for ways to reassert themselves.

Insisting on what they (patients) want, what they can do and would prefer, then complicates the negotiations in which nurses and lay carers become involved. The patient input may quickly become seen as at best unhelpful and at worst obstructive and problematic. Yet patients do need to be active in lobbying for services, and especially when clarifying what constitutes a need. Maeng et al (2012) describe how proactive and articulate chronically ill patients were much more likely to later be satisfied with their experience of care. Not to express an opinion or need may be to save up problems for care and support later.

What complicates care and may quickly lead to feelings that patients and their families are making unreasonable demands often centres on what is realistically available from a given healthcare service. Teeri et al (2007) examined relatives’ expectations as they witnessed their loved ones being cared for in long-term institutions.

 Relatives placed a considerable emphasis on the physical integrity of patients; that which ensured they were clean and comfortable. Less emphasis was placed on psychological integrity. Here, however, there is potential for conflict. Patients arguably wish to be respected as individuals and much of what constitutes individuality is bound up with intelligence, personality, a personal sense of humour, values and attitudes. While nurses and relatives debate the quality of physical care, patients may be left frustrated with their psychological care and behave aggressively or obstinately in an attempt to elicit a response.

Nurses as well as lay carers may feel ill equipped to determine what constitutes challenging behaviour and to decide whether it has an identifiable and justifiable cause, or whether to treat it as in some sense typical of a problematic patient. Ornstein and Gaugler (2012) report a wide range of behaviours that might count as challenging (Box 3), and importantly these include extremes of activity and inactivity. Patients who are hyperactive or wander, and those who respond too little, remaining locked in a depressive and passive state, are unsettling for caregivers.

At issue here are challenges associated with managing activity when other responsibilities and duties impinge on the caregiver. The problematic patient is the one who demands considerable attention or else demands so little – possibly reminding the carer silently that needs are not understood nor attended to. Ideal patient behaviour exists between the two, that which is predictable, facilitates physical care activities and is familiar as part of social interaction.

Box 3 Challenging patient behaviours

- Aggression.
- Agitation.
- Apathy.
- Delusions.
- Depression.
- Emotional lability.
- Euphoria.
- Hallucinations.
- Hiding items.
- Psychosis.
- Sleep disturbance.
- Wandering.

(Ornstein and Gaugler 2012)
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Now do time out 6.

6 Routine of care

Review the daily routine of care where you work. This is often experienced as the working task – what must be achieved. Does an understanding of this help you to understand which patients seem problematic and why? Does hyperactivity in an older patient pose a challenge: what to do, how to sustain a safe environment? Does inactivity pose a challenge, perhaps because the patient engenders in you a suspicion that you do not understand them?

Schmidt et al (2012) describe just how distressed nurses are as a result of dealing with challenging behaviours in nursing homes. They describe more than 50 different behaviours that might seem challenging and report that nurses thought they had a lower quality of general health, reduced ability to engage in and sustain work, and a high burnout rate, where interest in the needs of others diminished. What is at issue here is that stressful care might increase the risk that a patient is deemed problematic. In exasperation, the nurse might exclaim, ‘why does he act like this?’ instead of, ‘what is worrying or upsetting this patient?’

Measures to promote respect for individuality

Pressures on care systems and finite resources of staff and equipment make it more difficult to care for patients, and increase the risk that some will be labelled as problematic (Biquand and Zittel 2012). Where the pressures of work increase, and opportunities to build a rapport with patients individually are limited, it is probably easier to think of individuals as types of human being. Shorter hospital stays, budget-driven changes to the skill mix of the care team and the requirement to move patients through the system quickly can mean that patients are portrayed in less compassionate ways. There is a pressing need then, and a professional/ethical requirement, to build narratives to set these against their own. Nurses may discover that they do not understand what motivates or sustains patients in their behaviour. Alternatively, narratives may be suggested that the nurse believes motivate and sustain the patient. Patient narratives may or may not work sympathetically with nurses’ narratives. Where they do not, patient and nurse working to a different purpose, then a possible source of why the patient seems problematic is found.

Now do time out 7.

In conducting a review of narratives it is important to recognise that some may be inaccurate – patients may misconceive a disease, a treatment or rehabilitation plan. To reveal a narrative is not necessarily to agree with it. There may be a need to correct misconceptions and this may include questioning assumptions made about what is possible in medical science or as part...
of the resources available. Discussing narratives then seems uncomfortable. It can serve to alert the nurse and the patient to premises made about what will be done, what will be available and who will resource different elements of care. But not to confront such narratives and to search for compromises may be to confirm the patient in a stereotype: ‘Oh, Mrs Dickens, she is just a consumer watchdog, nothing will please.’

Exploring narratives with patients arguably helps to make them interesting. As individuals explain how past life experiences have shaped their current interpretation of a problem now, this serves to mark out their individual way of responding and to lend greater integrity to their efforts. The nurse in these circumstances works towards respecting patients and reducing a labelling risk that Stockwell reported in 1972 (the uninteresting patient).

Revisiting the goals of nursing care Nurses make a vital contribution to the goals of health care, those associated with management of disease, risks of illness or infirmity and careful management of finite healthcare resources. It is right that they work with others towards targets that are mandated as part of healthcare policy and that are designed to provide minimum standards of care. But work towards respecting the individuality of patients, the avoidance of stereotypes, might also require that the nurse remembers other nursing goals.

Much of what it is to nurse a patient involves helping them to make their own decisions and to find ways of living that are acceptable and still safe, with regard to themselves or the wellbeing of others (Snellman and Gedda 2012). The nursing goal is often to facilitate patient insights, to help them in the discovery of working solutions that seem sustainable and dignified over time. Pressing patients towards objectives that they might realistically struggle to achieve, at least with given resources available to them, might not be the professional approach. If patients cannot be cured, if all conundrums cannot be resolved for instance, dealing with multiple problems in old age, then the legitimate goal of the nurse is to help the patient to live well – with a sense of integrity.

Where nurses remind themselves of such aims, the patient is often viewed less in terms of performance/achievement and more in terms of process. Attention focuses on what patients are trying to do, what exercises their thoughts and either contributes to or detracts from a purposeful way of living. Gentler evaluations of patients and their worth are likely to ensue. There is recognition of effort, bravery and imagination in what the patient does and conversations are likely to become more open. Communication of this more explorative and appreciative kind may quickly help the patient to feel more respected and to limit the risks of the stereotype threat (Aronson et al 2013). Such a reframing of attitude, appreciating patient efforts and journeying might not remove their challenging behaviour entirely, but it does reduce the risk that such behaviour labels the patient as unwilling, unable, as instinctively problematic in some way.

Now do time out 8.

Developing new alliances of care The third practical measure to minimise the risk that the nurse labels the older patient is the formation of alliances with other carers, especially those who have known the patient for a long time and who can brief the nurse on what motivates and sustains the patient (Hardin 2012). Traditionally the nurse is encouraged to form an alliance with lay carers, but here it is important to work with individuals that the patient trusts. Liaising with lay carers who are not trusted by the patient is unlikely to help because the nurse secures a less sympathetic insight into patient-perceived needs. It is important to ascertain, wherever possible, who the patient values as a carer and who might have the capacity and the commitment to play a role in their longer term support and rehabilitation. Lay-carer allies should know the patient well, and have an established and trusting care relationship with them.

While lay carers know a great deal about patients that enables the nurse to respect them as an individual,
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so do professional carers from the community. Patients experience current care through their memories of past care, so it is valuable to telephone professional carers to understand the patient’s longer-term experience of illness or disability. While patient casenotes summarise the bare essentials of the health record and treatments received, they seldom capture the way patients have interpreted their situation. Information relating to preferred ways of patient coping, what motivates and sustains them, is much more likely to come from practitioners who have seen the patient regularly. By learning more about the patient as an individual, there is a greater prospect that individuality will be protected during the next stage of their care.

Conclusion

More than 40 years ago Stockwell (1972) reported her research on the unpopular patient. It was a shocking revelation because nurses were confronted with the fact that ideals of care were not always met. In this article it has been argued that there remains a risk that older patients in particular may be treated in a stereotypical way. If anything, changes in the healthcare system, the economy and the limitations affecting the healthcare service may increase the chances that patients are thought of as behaving in a challenging way and then labelled as problematic. But it is argued that a changing care relationship – one where patients are required to be more proactive – also plays a part in increasing the chances that they will be evaluated negatively and perhaps then become unpopular.

Reviewing labelling theory starts the nurse on a process of re-examination. It leads to an appreciation of the risks of labelling and a search for factors today that may prompt a negative evaluation of patients. Patients are still expected to have a role and today that might be a more demanding one. The literature indicates why some difficulties can arise. Despite some patients presenting challenging and stressful behaviour, nurses can still retain a respectful and professional approach. Exploring and understanding narratives, working with supportive allies and remembering the goals of much nursing care can serve to minimise the risk that older patients become unpopular today.

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