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Patient Behaviors: A Grounded Theory Typology

Amélia Didier, PhD, RN. HESAV School of Health Sciences, HES-SO University of Applied Sciences and Arts Western

Alvita Nathaniel, PhD, APRN-BC, FAANP. Professor Emerita, School of Nursing, West Virginia University, USA, Past Editor at the Grounded Theory Review and Fellow of the Grounded Theory Institute

Helen Scott, PhD. Mentor in classic grounded theory and fellow of the Grounded Theory Institute, Chichester, UK

Maya Zumstein-Shaha, PD, PhD, RN, FAAN. Bern University of Applied Sciences, Department of Health, Switzerland University Witten/Herdecke, Faculty of Health, Department of Nursing, Germany University of Bournemouth, Faculty of Health & Sciences, United Kingdom

Abstract

This classic grounded theory study uncovered both a basic social process theory and an emerging typology of patients based upon their behavior as they react and adapt to the healthcare environment. The theory emerged in the context of care of 32 hospitalized patients and their interactions and relationships with interprofessional healthcare teams. The patients' main concerns were to constantly ensure protection of their own personhood in order to receive optimal care. When striving for optimal care, patients can develop specific types of behaviors to the respective healthcare environment and in response to healthcare professionals' attitudes

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and behaviors towards patient expectations. Patients tend to exhibit one of three types of behavior. Thus, a typology of these behaviors emerged: propitiation, vigilance, and confidence. Types of patient behaviors are differentiated by their position on the control continuum, their level of trust in healthcare professionals, and their past experiences. The typology of behaviors has the power to show patients' levels of empowerment and the way they are engaged in their own optimal and humanized care.

Keywords: humanism, caring, personhood, patient experience, patient role, healthcare professionals' attitudes, empowerment

Background

Respect for others combined with an ethic of care are the foundations of most healthcare professions. Yet, healthcare professionals who are caught up in day-to-day work may unconsciously think of an individual patient as *good*, *difficult*, or even *bad.* Reasons for such perceptions may include the way patients react to the specific healthcare context and the requirements they are facing. Understanding the different types of patients' behaviors can alert providers to problems that may arise and may help them to be better prepared to provide needed support, appropriate interventions, and advocacy. Awareness of types of behaviors and the social/psychological forces that influence patient behavior shape the way health professionals view individual patients and contribute to improved health care delivery. This paper is based upon a study that culminated in a previously published grounded theory article, *Protecting personhood: A classic grounded theory* (Didier et al., 2023/2024). As analysis on protecting personhood progressed, a typology of patients' behaviors also emerged. This paper offers a brief background on the original study but focuses on the description of the typology of

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patients' behaviors.

The role of the patient in the healthcare system has undergone considerable change in the last few decades. Unlike in the past, patients and their families today are encouraged to participate, collaborate, and be partners in the current healthcare system (Abelson et al., 2022; Vanstone et al., 2023; WHO, 2017). In a paternalistic model of care, the behavior of the patient has long been considered a criterion for casually attributing labels such as "good patient," "difficult patient" (Grocott & McSherry, 2018; Jadad et al., 2003; Michaelsen, 2021; Molina-Mula & Gallo-Estrada, 2020) or even a "bad" patient (Khalil, 2009). This kind of duality and labeling is outdated in the person-centered or partnership-orientated healthcare systems of today. Passivity is no longer the standard for the patient role. However, this paradigm change may not be that straightforward. Patient participation may be influenced by various factors such as patients' own beliefs about their roles, their levels of literacy and health conditions, the healthcare professionals' beliefs and attitudes, the predominant cultural traditions, and current healthcare policy. To optimize their health outcomes, patients need to be given the opportunity by healthcare professionals to seize their new role (Didier et al., 2020). However, both patients and healthcare professionals need support to do so (Martin & Finn, 2011). Healthcare professionals need to understand patients' behaviors toward the care received and the patient-healthcare professional relationship in order to respond adequately. Therefore, a study was initiated with the goal to understand more about hospitalized patients' perspectives on nursing and interprofessional healthcare delivery.

Method

Design

A classic grounded theory (GT) design was selected for this study. This design allows

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for patients to openly express their concerns during hospitalization and to freely speak from their own perspective. Participants' main concerns and how those concerns were addressed and processed were elicited. The classic GT method required the analyst to remain close to the data, to limit interpretation, and to determine patterns in the data. Concepts and their relationships emerged through the process of constant comparison of raw and coded data. Further, relationships between concepts were identified through the process of theoretical coding.

Participants/Sampling Methods

This study was conducted in two adult surgery departments (neurosurgery and ear, nose, and throat surgery) in a university hospital in the German-speaking part of Switzerland. The sample consisted of 32 adult patients, comprised of 15 women and 17 men, with a mean age of 54 years. Most patients were Swiss; only three patients originated from Southern or Eastern Europe, and two patients were from Western Europe. Participants were patients undergoing elective (n = 17) as well as emergency (n = 15) procedures. The average length of stay was 5.2 days (minimum: 1 day, maximum: 12 days). Participants were cared for by interdisciplinary healthcare teams, which included physicians, nurses, nursing assistants, physical therapists, occupational therapists, dieticians, chaplains, and others.

Human Subjects Protection

This study was conducted according to the comprehensive framework governing research involving humans in the form of the Swiss Federal Human Research Act (2011) and its accompanying ordinances (Federal Assembly of the Swiss Confederation, 2024). The processing of personal and sensitive data is protected by the Federal and Cantonal Data Protection Act (Federal Assembly of the Swiss Confederation, 2024). The study protocol was

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submitted to the local ethics committee. However, the data collected did not include health-related data. Therefore, the study did not fall under the Human Research Act (Federal Assembly of the Swiss Confederation, 2014). Each participant received written information on the study, had time for reflection, and turned in a signed consent form. All data were deidentified, and confidentiality was guaranteed to study participants. Participants' names included in this paper are pseudonyms.

Data Collection and Analysis

Data were collected through individual face-to-face interviews. Interviews began with the following grand tour question about patients' experiences with healthcare delivery: "How was your experience in the interprofessional care environment?" As is appropriate with classic GT, follow-up questions to clarify issues allowed participants' perspectives to be more thoroughly explored. Different steps of classic GT, which were followed iteratively, included simultaneous data collection and analysis, open and selective coding, constant comparison, theoretical sampling, memoing, and sorting. These steps facilitated the emergence of the participants' main concern and the core category of the substantive theory.

The core category is of central importance in GT because it "accounts for most of the variation in the pattern of the participants' behavior" (Glaser, 1978, p. 93). As such, the core category constitutes the fundamental pattern of a phenomenon; it has explanatory power, and all other concepts are linked to it (Glaser, 1978). More importantly, grounded theory

> revolves around the main concern of the participants whose behavior continually resolves their concern. In studies of process, their continual resolving is the core variable. It is the prime mover of most of the behavior seen and talked about in a substantive area. It is what is going on! It emerges as the overriding pattern. (Glaser, 1998, p.

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The Theory and Related Typology

Both a basic social process theory and a typology emerged from this grounded theory study. Although this paper focuses on typology, it is helpful to briefly describe the companion theory, which was previously published (Didier et al., 2023/2024).

The Theory of *Aufgehobenheit,* or Protecting Personhood

The concepts of the theory are organized around the core category, which is represented by a German term, "Aufgehobenheit." For this term, there is no equivalent term in the English language. The concept emerged from the data. During the study, investigators noted that when patients perceived that they were receiving safe and protective, thus optimal care, they had a feeling of *aufgehoben*, which relates to feeling safe and being cared for. *Aufgehoben* depicted optimal care moments during interactions between patients and healthcare professionals. Feeling *aufgehoben* during care moments with healthcare professionals had the power to transform any encounter with the healthcare professionals into a positive, special, and dynamic experience. As the investigator conceptualized the process, the adjective *aufgehoben* was transformed into the noun *Aufgehobenheit* to stress its potential as a process and core concept. The substantive theory that emerged explains how patients activate processes to protect and maximize their personhood to receive optimal care. Thus, to make the concept more relatable, the phrase, *protecting personhood*, was chosen as the English term to represent the core category of *Aufgehobenheit*. The terms are interchangeable with *Aufgenhobenheit*, preferable in the German language and protecting personhood, depicting the concept in English. During the process of collecting and analyzing data for the *Aufgenhobenheit* theory, the investigators also identified the emergence of three distinct types of patients' behaviors.

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This paper describes that typology.

The Typology

Patients exhibited three distinct types of anticipatory behavior in their quest to obtain optimum care: propitiation, vigilance, and confidence. Patients were found to share common characteristics and strategies. Depending on individual patients and their experiences, these characteristics and strategies could be more or less present. In combination with the patients' experiences, the characteristics and strategies determined the stance the patients may take.

Stance

Patients' behaviors seem to be positioned on a continuum of control, either internal or external. Patients' positions on the continuum can be thought of as their stance. Stance is a social/psychological dimension of the three types of patients' behaviors. Movement along the continuum of control can be influenced by the person's experiences and/or by the level of anxiety or trust they have developed towards healthcare professionals and/or the healthcare environment, all of which may be interrelated.

Thus, stance encompasses a combination of attitudes and behaviors adopted by patients based on previous experiences. The stance adopted is related to control, trust, or mistrust. Moments of care and the way patients are treated or perceive they are treated by healthcare professionals will be decisive in patients' stance and the way they view the healthcare system and the environment. The stance will eventually inform patients' interactions with healthcare professionals. Some will vest responsibility to others, i.e., the healthcare professionals, and some will strive to maintain control. Stance is relevant to each type of patients' behaviors.

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The Stance of Vesting Responsibility. The definition of the concept *vest* is to turn over, confer, or bestow something to someone else. For the purposes of this study, the term *vest* refers to turning over control to another person, specifically a healthcare professional. Vesting responsibility means that the patient fully relies on the healthcare professionals and trusts in the hospital processes and procedures. This means patients consider they have no need to bother about anything for the care takes place automatically without any investment on their part. They trust healthcare professionals and follow their advice. Something bonds the patient to the healthcare professionals – a kind of trust that is built between the healthcare professionals and the patient. Patients feel safe in healthcare professionals' hands and believe that they do their best to meet expectations. These patients are willing to do what is recommended. Trust is enhanced through the feeling of *Aufgehobenheit,* that is, when the patient feels cared for, safe, and reassured, i.e., protected. This is how one can understand the concept of vesting responsibility as explained by Cindy: "Exactly, I am here now, and I must do what the physician tells me to do. If one does so, everything runs smoothly… He [the physician] is right, he knows his job, I do not." Patients who vest responsibility agree to take a back seat because they have observed the competencies of the healthcare professionals. They know healthcare professionals are concerned with patient safety and well-being, and that they will do their best. At this end of the continuum, patients feel safe in the hands of the healthcare professionals. They feel cared for and protected. Trust is enhanced by and in turn contributes to the feeling of *Aufgehobenheit*; when a patient feels cared for, safe, reassured and considered as a person.

The Stance of Keeping Control. Patients who do not fully vest responsibility do not necessarily mistrust healthcare professionals. They simply need to have guarantees to be sure

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that things are optimal. The need to maintain control is specific to patients who have lived non-optimal care moments with a rupture in the relationship between themselves and the healthcare professionals. These patients are keen to make suggestions to the healthcare professionals to improve their condition. They "track" information and care process. One participant, Jürgen, helped to conceptualize the concept of keeping control: "Maybe, [the role of the patient] is like a catalyst. I have the feeling that the patient's demand is like an indicator for both groups [nurses and physicians]. The urgency of the demand determines the level of urgency for both groups to communicate or not. If you say: 'Hey, now!' It will be done. If you just say, 'Please transmit it,' it is interpreted as less important." Through keeping control, patients are not passively waiting for the care to happen or the healthcare professionals to take action. Jürgen "forces" communication between the healthcare professionals because he really wants them to respond to his needs or his demands. This is due to his prior experiences, and partly due to his personality: he may be someone who needs to know and to control every piece of information. Keeping control is ensured by observing and assessing what is happening in the care environment. Another participant, Tino, explained that "errors happen because of haste, of fatigue, or maybe because of lack of attention… that is why it is important to keep control yourself." This patient is extremely vigilant; this is partly due to the fact that he had one issue concerning safe care while in the hospital. Thus, if safety is lacking, full *Aufgehobenheit* is not possible—his personhood is not protected. The patient is making sure that he is contributing to a safe environment. However, through his stance, the vigilant patient shows that he is expecting to recover within a safe and caring environment. He expects and needs to be protected, reassured, and respected. The patient is conscious of being a patient, but he is a person with wishes, needs, and fears, and these have to be addressed. *Aufgeho-*

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benheit (protecting personhood) responds to all of these aspects related to his expectations. It is something that happens between the patient and healthcare professionals, which the patient perceives and that feeds back into the person's feelings and stance. Most patients want to contribute to an optimal care environment, even when they outwardly display a controlling stance. The sense of *Aufgehobenheit* will be nurtured, shrunken, or disrupted according to the behavior/attitudes of the healthcare professionals toward patients and their needs. If *Aufgehobenheit* is disrupted, patients might feel bad or perceive themselves negatively, as if they were not able to fully protect their personhood.

Each patient develops his/her own attitude depending upon their expectations and care experiences, the *Aufgehobenheit*-generating healthcare professional behaviors, and the unfolding of interactions between patients and professionals. Before being admitted to the hospital, patients think about their future hospitalization; for example, each hopes to be treated like a person, which is encapsulated in the core category of *Aufgehobenheit*. Such an expectation, whether fulfilled or not, will contribute to the type of patient that the person being admitted becomes. Patients may evolve and move into different types of behavior based on their experiences and expectations.

Types of Patients' Behaviors

During data analysis for the *Aufgehobenheit* theory, a typology of patients' behaviors emerged. To ensure parsimony of the theory, the typology was initially set aside. While all patients seek to protect their personhood, different types of patients are distinguished by their position on the continuum of control, their level of trust in healthcare professionals, and their past experiences. The following typology includes three types of patients' behaviors that anticipate or strive for *Aufgehobenheit*: propitiation, vigilance, and confidence.

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Propitiation. Propitiation means to appease someone or make them happy by doing a particular thing or acting in a certain way. Patients who propitiate have accepted their role as patients and are anticipating it. These patients adopt the stance of vesting responsibility. They will act and play the role they believe healthcare professionals expect them to play in order to create or ensure the best conditions for "everything to run smoothly" and for receiving the best care. They agree to act like patients according to their own interpretation of what that entails; namely, patients are conciliatory. With this behavior, these patients hope to receive good care. Healthcare professionals will likely view these as "model" patients. They actually consider themselves to be in charge of creating the best atmosphere. For example, one patient said,

> What it means? It means that during that time I will not get coffee at four o'clock when I ask, or I will have to do it myself. Sometimes, you have to be satisfied with what you get. The food is not like at home. That is logical. I have to accept it.

This participant has anticipated that he will have to bear constraining, unfamiliar conditions. He has anticipated a change and believes he must adapt to his patient condition to receive optimal care. Through his attitude, he wants to ensure an optimal environment. The responsibility for optimal care is shared between patients and healthcare professionals. Hence, the concept of "model" is comprised of the fact that patients not only feel responsible for the way they are treated but also behave accordingly. They consider themselves as co-constructors of an optimal environment. The "model patient" has thoroughly observed and assessed healthcare professionals' patterns of reaction to patients' demands. Therefore, they know how to react so as not to "annoy" healthcare professionals and to satisfy their own concept of the model patient role.

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Patients who propitiate take measures to maximize their chances of creating an optimal environment and, thus, their chances of receiving optimal care. These individuals will be less sensitive to the variations in the environment, for they are trying to control these through their own behavior and attitude. Their behaviors and attitudes are related to a pragmatic personality, to the positive experiences of care moments, and/or to the awareness of healthcare professionals' behaviors and attitudes during care moments. These patients generally relate the unfolding of the care moments to their own behavior and attitude or expectation. Lydia explains it in these terms:

> …as a patient, you can have a considerable power. You can have it. […] And as a patient, you learn quite quickly, if they ask, 'Would you like to stay in bed or would you like to stand up?' […] And if I say 'no' in this same situation, in that case, it will be interpreted like a negative…. Despite that it is a very clear answer. And some day, you will earn the reputation of a difficult patient. If I say yes, in that case, I will be easier to deal with.

However, the behavior and attitudes of patients who propitiate do not correspond with passivity. They are aware of the variations in the environment. Nevertheless, these patients do not seem to be upset because they anticipate that they might need to adjust. They ask for clarification when necessary, and they do so in a diplomatic way. Interestingly, some patients have tried to be model patients without perceived success or the expected results. When patients experience less optimal, unresolved disruptive care moments, they may become vigilant towards their environment or anxious about future care moments. A non-optimal care moment that is resolved immediately or at a future time will allow (or again allow) the patient to adopt a positive stance towards the care environment. She/he might even become a model

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or confident patient, meaning that the patient trusts the care environment and the healthcare professionals again – but only to a certain degree.

Vigilance. Patients who exhibit vigilant behavior anticipate care moments with some apprehension. Reasons for this apprehension may comprise the personality of the patient who is controlling-vigilant by nature, anxious regarding hospitalization, or anxious by nature. Patients in this group may also be apprehensive due to a first or bad experience of care moments, which has not been resolved because there was no opportunity for reconciliation. Contrary to model patients (who propitiate), vigilant patients are very aware of and sensitive to any variation in the care environment, assessing everything or adopting an attitude that shows that they are distrustful: taking personal measures (personal resources, negative anticipation). Vigilant patients will be on the alert during entire hospitalizations. They adopt a stance of keeping control. These patients need to have guarantees that their care is in safe hands. Paula explains, "When I arrive at hospital… well… for the first three [hospitalizations], I guess I cannot remember anymore, but I need to be reassured." She mentioned right from the start that she is an anxious person. In the past, she had experienced challenging moments. Thus, she needs to be reassured by healthcare professionals: "I was afraid of arriving in that operating room, like in 2012. I had an anxiety attack, I believe, or whatever, but I was trembling. I just was not able to help it. I did not like that at all." Without guarantees, vigilant patients neither feel in safe hands nor feel cared for. They start anticipating negative moments and subsequently remember only negative experiences.

Confidence. Patients who exhibit confident behavior have experienced positive care moments, recently or in the past. They may have also experienced negative care moments, but these were resolved. Confident patients are mostly familiar with the environment and are

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confident about their hospitalization and recovery. A vigilant patient can transform into a confident patient if her/his concerns are adequately addressed. Confident patients tend to entrust responsibility for their care and treatment and place it into the hands of healthcare professionals more readily than vigilant patients. However, if they need some clarification, they will be more assertive than propitiating, or model, patients. Therefore, they may adopt either stance—vesting responsibility or keeping control. Contrary to vigilant patients, who might be anxious, confident patients have previously had success in trying to resolve negative care moments. Just like model patients, they consider themselves as co-creators of good care. However, they are not necessarily concerned with pleasing the healthcare professionals at all costs. Olivia is an example of a confident patient. She stated, "The patient should participate. He should accept what is happening to him. He should have the opportunity to ask questions, how, why, and yes, to participate and not just think, 'that is okay.' Not just take things like they come. And I see, I have the problem. Hence, I should take responsibility for not agreeing with every single thing." Anticipating confident patients do not just accept everything and are not concerned with pleasing healthcare professionals. They assume responsibility for being assertive and critiquing or for discussing issues they do not agree with. As noted above, patients move on a continuum. Specifically, Olivia is an example of a patient who is vigilant and anxious by her nature but has become confident during the hospitalizations because she mostly had positive experiences. One negative experience was repaired through a successful process of reconciliation. The patients develop specific behaviors, attitudes, and feelings depending on their experiences.

Discussion

This paper briefly described a classic grounded theory study that culminated a

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grounded theory: *Protecting personhood: A classic grounded theory* (Didier et al., 2023/2024) and the unexpected finding of a typology of patients' behaviors, which is separate from, yet supports and enhances the theory of *Aufgehobenheit*, also known in the English language as protecting personhood. Knowledge of different types of patients' behaviors and their motivations has the potential to improve healthcare delivery and outcomes. In particular, the study raises questions about professionals' perceptions of patients and illusions created by the different types of behaviors. The stance is related to the reaction of the person, it does not define the person but is a part of the person and is evolutive. The propitiating "model patient" is characterized by a natural tendency to anticipate the moments of care and to "over-adjust," generally ready to follow the lead of healthcare professionals in order to obtain optimal care. These patients perceive responsibility for experiencing good care moments as much as the healthcare professionals. Despite the fact that this appears as a top-down relationship, the patient is making a choice. He is playing model, but he is not passive. This contrasts with the normative approaches to relationships of certain sociologists such as Durkheim (1858-1917), Weber (1864-1920), Parsons (1902-1979) or psychiatrists as Freud (1856-1939). Parsons criticized the theory of the sick role (Parsons, 1975), defined the patient-professional relationship as one of obligations and duties (Milton, 2004), and paid little attention to the experience of the persons who live with an illness (Frank, 2013). In those approaches, the patient is passive as a child facing powerful parents (Milton, 2004). In this GT, the patient is seen as an empowered person who, however, decides to adjust according to his/her interpretation. *Vigilant Patients* generally have bad experiences of healthcare in the past. Therefore, they are on their toes, tending to expect the worst. Therefore, they are suspicious, trying to detect any problems that threaten the delivery of optimal care. These patients empower themselves in the

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sense of Freire, who is the founder of the pedagogy of the oppressed (Holmström & Röing, 2010). They do not wait, but they strive to keep their personhood intact or restore their personhood along with their sense of safety and caring (Didier et al., 2023/2024). These patients believe in the very value of caring. The importance of caring has been highlighted by Watson (2018). Similarly, the importance of values such as trust, respect, empathy and compassion has been emphasized by Buber (1965) or Mayeroff (1971) and is evident in the international codes of ethics for most healthcare professionals (ICN, 2021; International Federation of Social Workers, 2018; International Federation of Sports Physical Therapists, 2014; Nursing & Midwifery Council, 2015; Sasso, 2008; World Federation of Occupational Therapists, 2024; World Medical Association, 2022; World Physiotherapy, 2022).

The types of patients' behaviors are not permanent, as the Aufgehobenheit theory highlights, and is also emphasized by others (Groves et al., 2023). Healthcare professionals, particularly nurses, have the potential to influence the patients' behaviors by empowering them and allowing for reconciliation with patients' sense of personhood. Patients who feel safe and in caring hands, can unfold into *confident patients* provided nurses advocate for them. Similarly, nurses may help other healthcare professionals to be attentive to patients' expectations and perceptions. *Vigilant Patients* are more challenging to care for. However, they are excellent signposts for gaps in healthcare or other safety-limiting processes. Patients from this group can challenge healthcare professionals concerning their ethical responsibility. As a consequence, healthcare professionals can improve on this and provide adequate care for the patients. Understanding the processes leading to patient's types of behavior can move healthcare professionals toward including patients as part of interprofessional teams, sharing power with them, and subsequently reducing or limiting altogether patients' anxieties and distrust due to

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bad experiences (Didier et al., 2023/2024; Groves et al., 2023). The newly discovered theory of *protecting personhood* and the related typology of patients' behaviors are supported by the theoretical findings of Groves et al., (2023). Patients' sense of security and safety may be enhanced or hindered depending on the level of trust patients have developed within the relationships with healthcare professionals (Groves et al., 2023). Patients who have lived through unresolved negative experiences are more likely to develop distrust or an attitude of negative anticipation towards the healthcare system and the professionals as they do not feel in safe and caring hands, notwithstanding the social construction they have towards healthcare professionals' competencies (Hovey et al., 2011).

The classic grounded theory method was appropriate for this study because it focused on patient perceptions and patterns of behavior. As pointed out by Donaldson and Crowley (1978), "Concern with the patterning of human behavior in the interaction with the environment in critical life situations…" (p. 113) falls at the praxis of healthcare professions, particularly nursing.

The typology of patients' behavior has implications for the human-centered caring dimension of healthcare. "Being with", "caring about", and "caring for" are cornerstones of the healthcare professions. Caring about one another can lead an individual to *be with* another person in her/his world (Mayeroff, 1971; Swanson, 1991). Similarly, the nursing theorist Watson (1988), wrote that, "All of human caring is related to inter subjective human response to health-illness; environmental-personal interaction; a knowledge of the nurse caring process; self-knowledge, knowledge of one's power and transaction limitations" (p. 901). Watson suggests that caring is mindful and reflective, and it is delivered with conscious intentionality and compassionate concern (Watson, 2002, 2018). However, when patients focus

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their strategies on pleasing healthcare professionals and these professionals, in turn, gravitate toward those who make their lives easier, healthcare and more importantly patients can suffer. In such cases, healthcare professionals do not have the opportunity to really encounter patients and acknowledge their respective worlds.

Although nurses, physicians, and other healthcare professionals within an interprofessional healthcare team may applaud "model" patients (who propitiate), Buber (1965, p. 76) suggested that interhuman communication is threatened by what he termed "the lie", which emerges when people strive to "seem" a certain way—thereby stifling genuine dialogue. So, rather than proceeding from their real fears and concerns, "model" patients proceed from how they wish to seem to the staff, thus creating a barrier to authentic communication. Nurses and other healthcare professionals may be especially susceptible to the gravitational pull toward these patients. In their theory of the *Awareness of Dying*, Glaser and Strauss (1965) found that staff have certain expectations of patients. They expect patients to behave with dignity and refrain from displaying their emotions—whereby staff might judge whether patients are dying in a model or "acceptable" way—a way that diminishes the staff's discomfort yet leaves little room for caring relationships. This can produce a false perspective on the part of the staff as these patients invest energy into how they are perceived, rather than the self-focused task of healing. When professionals recognize this barrier to communication, strategies can be developed to improve understanding between themselves and patients, thus increasing the likelihood of improved healthcare outcomes (Grocott & McSherry, 2018). The other two types of patients' behavior can also have implications for professional and patient communication patterns.

The vigilant patient's reaction exemplifies the paramount significance of the experi-

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ence of the patients regarding their sense of protecting personhood (Didier et al., 2023/2024). Past and present experiences of patients have the power to shape their trust or mistrust in healthcare professionals or healthcare institutions (Groves et al., 2023). The newly discovered theory of protecting personhood and the related typology of patients is supported by the theoretical findings of Groves et al., (2023), who also found that patients' sense of security and safety may be enhanced or hindered depending on the level of trust the patients have developed within the relationships with the healthcare professionals. Patients who have lived through bad experiences are more likely to have distrustful attitudes or negative anticipation towards the healthcare system and professionals as they do not feel in safe and caring hands, notwithstanding the social construction they have towards healthcare professionals' competencies (Hovey et al., 2011).

Conclusion

This typology of patients' behaviors can help raise awareness of patient processes and interpersonal communication within the healthcare setting. Thus, the quality of healthcare may be improved. Since the typology emerged as a secondary and unexpected outcome of a larger study, further research may lead to modification, refinement, and expansion. Future studies are necessary to further understand and clarify distinctions among the three types of behaviors and to determine whether there are other types of behavior that did not emerge from this study. Also, studies are needed to identify indicators, properties, and dimensions of the three types of behaviors. This study opens the door to a greater understanding of healthcare communication and offers an exciting opportunity for future research.

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