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Published in:
Scandinavian Journal of Caring Sciences

Publication date:
2012

Document Version
Tidlig version også kaldet pre-print

[Link to publication](#)

Citation for published version (APA):
Andersen, L. S., & Birkelund, R. (2012). Patient–patient interaction – caring and sharing. *Scandinavian Journal of Caring Sciences*, 27(3), 608-15. [doi: 10.1111/j.1471-6712.2012.01072.x].

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Patient–patient interaction – caring and sharing

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Scand J Caring Sci; 2012

Patient–patient interaction – caring and sharing

Aim: The aim of this study is to provide an understanding of the significance of hospitalized patients' interpersonal interaction with fellow patients in an infectious disease ward in a large Danish hospital.

Method: A qualitative approach was selected using participant observation and semi-structured qualitative interviews. Six female participants at the age of 32–81 years with different types of infectious diseases accepted to participate in interviews. The analysis was carried out using Kvale's three levels of qualitative data analysis. Data were catalogued into two main categories with several subcategories representing significance of patients' interaction with fellow patients.

Results: The qualitative analysis resulted in two main categories: (i) *Caring for fellow patients* and (ii) *Sharing illness information with fellow patients*. Each of the main categories was elucidated through several subcategories.

Our findings clearly showed that interpersonal interaction with fellow patients was of utmost importance when it came to care and support and when they needed information about their illness. Typically, the interpersonal interaction was experienced as giving and referred to in positive terms, but occasionally, the opposite was experienced too. Less typically, the patients experienced interaction with fellow patients as a burden and referred to it in negative terms.

Conclusions: Patients' interaction resembled care as well as self-care. Patient–patient interaction was an important part of the social support system during hospitalization.

Keywords: Fellow patients, patients experiences, qualitative study, social support, patients' interpersonal interaction, peer support, caring, self-care, social comparison.

Submitted 7 November 2011, Accepted 29 June 2012

Background

The significance of interaction between health care professionals and hospitalized patients is commonly studied and discussed as a substantial concept in the nursing profession. Interpersonal interaction is inherent to nursing care and acknowledged as such (1–3).

Interaction has been studied in various settings and with different actors. Several studies have investigated interaction between discharged patients, fellow discharged patients, and carers in support groups (3–5) and interaction between patients and doctors or nurses (6). van Haastregt, de Witte, Terpstra, Diederiks, van der Horst and de Geus (7) documented that patients with a chronic disease and severely ill patients in particular benefitted from self-help group membership and from talking to people with a similar disease. In contrast to these findings, patients undergoing diagnostics did not discuss their disease and

experienced no social support from fellow patients although they participated in the process of understanding and handling their situation by communication verbally with each other (8). In social comparison studies, hospitalized patients compared state of health and that this was associated with uncertainty and anxiety (9, 10). Investigating surgical patients, fellow patients' effect on pre- and postoperative anxiety and recovery, studies indicated less postoperative anxiety and shorter postoperative stays for preoperative patients, who shared occupancy with postoperative roommates (11–13).

The findings above present diverging effects of patient–patient interaction. Although interaction was studied among patients in different settings, knowledge of patients' experiences and significance of patient–patient interaction was missing from these studies.

Few studies have investigated hospitalized patients' interpersonal interaction from the patients' perspective. Findings suggested that patients treasured interaction with fellow patients because it gave them a chance to keep abreast of progress through their fellow patient (14), and patients' interaction was a means of learning how to manage hospital life (15). Interpersonal interaction

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between patients was of great value. Together, patients undertook supportive work (16), developed supportive relationships (17) and shared 'experiential' information (18). Unfortunately, patients' informal communities entailed dilemmas because of the enforced togetherness (15, 19). Patient-patient interaction was experienced with ambiguity.

Existing research is widely performed with patients with cancer, but patients with other diagnosis may or may not have similar interaction patterns. Studying patients with infectious diseases, studies *have* investigated interpersonal interaction between patients and student nurses (20, 21), patients and doctors (22, 23), and patients and nurses (24), but not patients and patients. Exploration of patients' dyads during hospitalization from the patient's perspective is rare and needs further elaboration as to the significance of fellow patients when it comes to supportive work, supportive relationships and sharing of information.

There is a strong correlation between nursing care and interpersonal interaction. In nursing, interaction is often investigated to enhance nursing care (6, 20). Care is essential to the nursing profession and has been described by several nursing theorists and with different perspectives (25–28). Scheel (27) states that care is inherent to nursing and performed through interaction between the nurse and the patient. Virginia Henderson (28) and Dorothea Orem (26) take a practical and action-oriented approach in their nursing care theories. Both Henderson and Orem regard caring as grounded in the patients' needs and the nurses' accommodation of patients' needs. During hospitalization, caring for patients is regarded as the nurses' job.

Caring is imperative in nursing but also a fundamental human condition (25, 29). Inspired by the Danish philosopher K.E. Loegstrup, Kari Martinsen writes about care from an ontological perspective (25, 29). To Martinsen, care is the foundation of human relationship. Because care is fundamental to any human being, we normally care of people who need it. Being ill does not necessarily remove the urge to care for others who are in a similar situation (25). In this way, caring for each other is a basic condition to being human and expressed in our interaction with others. With this in mind, we question what characterizes hospitalized patients interpersonal interaction and whether care, as presented by Martinsen, is present among hospitalized patients.

The aim of this study is to provide an understanding of the significance of hospitalized patients' interpersonal interaction with fellow patients in an infectious disease ward in a large Danish hospital.

Methods

A qualitative design, including participant observation and qualitative interviews, inspired by ethnographic fieldwork

was applied in this study (30–32). The collected data were interpreted using Kvaales' three steps of analysis (33).

Data collection

Sampling and context. Hospitalized patients in a Department of Medicine at a large Danish hospital were invited to participate. The patients suffered from infectious diseases, for example, hepatitis, fever or infection because of a parasite. Participants included were inpatients with a minimum age of 18, both men and women and they spoke Danish. As a rule, all 16 inpatients on the ward participated during every observation day, but gradually they were excluded if they suffered from dementia or extensive mental diseases, or if they were too ill because of their disease. Six female patients accepted to participate in interviews. The included participants suffered from hepatitis and various bacterial infections that caused fever, pain and malaise (Table 1). The invited male patients did not wish to participate in observation or interviews. The ward had five twin bed rooms and six single rooms.

Participant observation. The investigator observed patients' everyday life in the ward such as how the patients spent time together and what they talked about (30, 32). The initial core questions were how do the patients interact with each other and what does it mean to them? The observations ranged from wide lens observation to survey the context, actors and activities in the department and subsequently observations of individual situations, where the patients interacted more intimately with each other. Participant observation included occasional informal conversation between patient and researcher. To ensure an emic approach, notes were written while observing, and furthermore, breaks were incorporated throughout the observation period. The breaks provided space for noting down the observations as realistically and objectively as possible, to assess the data and to reflect and gain insight into the various elements of patient interaction. Newly gained insight from reflection breaks was expanded and further clarified through more focused observations (30, 32). An etic field journal was produced concurrently to elaborate on thoughts, ideas and possible interpretations.

Table 1 Participants characteristics

Patient	Sex	Age	Number of admissions	Admission days	Cause of hospitalization
1	F	45	>1	4	Hepatitis
2	F	81	>1	7	Fever
3	F	32	1	3	Fever
4	F	58	>1	12	Bacterial infection
5	F	64	>1	8	Erysipelas
6	F	44	>1	5	Hepatitis

The field journal was used both in the interviews and in the analysis. Observed interaction was the underlying basis in the following interviews.

Observations took place in the patients' rooms, in the corridor, in the kitchen, in the hospital dayroom and in the smoking area. Each day, observation started in the kitchen or in the hall during breakfast serving. The investigator was present 2 days a week for 6 weeks doing observations and interviews in a time span from 7 a.m. to 10 p.m.

Qualitative semi-structured interviews. The main focus of the interviews was the patients' experiences with fellow patients during their stay in hospital. They were encouraged to talk about their experiences, using open and detailed questions to ensure the interpretation of their statements. To prevent preconceived understanding of patients' answers and to avoid manipulation towards specific answers, the interviewer served as conversational partner (31, 32, 34, 35). During the conversation, the researcher explicated any etic understanding preconceived during observations, and the patient was invited to elaborate on reactions or statements that had been observed during the participation observations. Each participant was interviewed once, and the interviews were between 25 and 45 minutes in length. The interviews were taped and transcribed verbatim within 24 hours using Windows Media Player.

Data analysis

Data consisted of both written participant observations and verbatim transcribed qualitative interviews. All data were processed equally. The material was coded, interpreted and analysed according to Kvale's three levels of analysis: self-understanding, critical common sense understanding and theoretical understanding (33, 34). At the self-understanding level, meaning was construed from the patient's statements, that is, the interpreted contents of the interview was summarized. At the critical common sense level, data were interpreted within a broader framework of understanding than the patient's own. In the first two levels, data were repeatedly read and interpreted with an emphasis on emerging themes within patients' interpersonal interaction. The themes were catalogued into a hierarchical structure with two core categories. The two core categories were further structured by elaborating subcategories. The findings were conceptualized by constantly comparing fragments of text to identify themes both within and across the findings with a focus on similarities and differences. To secure validity, a constant movement between fragment and original text was undertaken.

The third level of analysis included relevant theoretical perspectives. The forward analysis in this section exceeded the patient's self-understanding and also extended beyond the level of a critical common sense understanding. To

elaborate on the significance of patients' interaction with fellow patients, Kari Martinsens' philosophy of caring as a fundamental basic human condition (25, 29) and Dorothea Orem's self-care theory was applied (26).

To Martinsen (25), caring is fundamental to man's existence and is expressed in our interaction with fellow human beings. Caring is to help, and to take care of, by acting towards fellow men in the same way as you want them to act towards you. Caring is three dimensional; relational, as a human being you are always interconnected to other human beings; practical, caring is performed in relational reciprocity; and ethical, as human being you have an ethical claim to care for people weaker than yourself (25, 29).

To Orem, the purpose of care is to achieve self-sufficiency in self-care. Self-care is the ability to perform activities and meet personal needs with the goal of maintaining health and wellness of mind, body and spirit. Every mature person has the ability to meet self-care needs. Self-care deficit occurs when unable to self-care (26).

Ethics

All patients hospitalized were informed of the investigators presence and business. All patients were anonymous in the observations, field notes and in the interviews, that is, the patients were not mentioned by name, diagnosis or department anywhere in the study. The patients consented to the inclusion of small extracts of the conversations as citations when publishing the results. The patients gave informed consent to participate.

Findings: caring and sharing

The analysis resulted in two core categories: (i) *Caring for fellow patients* and (ii) *Sharing with fellow patients*.

In this study, all participants clearly emphasized the importance of interpersonal interaction with fellow patients when it came to care, support and illness information. Typically, patients experienced interaction with fellow patients as giving and referred to it in positive terms. Less typically, patients experienced interaction with fellow patients as a strain and referred to it in negative terms.

Caring for fellow patients

When patients talked about their experiences with fellow patients, they often used concepts such as 'helping each other' and 'talking together'. These concepts referred to patients helping each other with daily activities and emotional support.

Helping with daily activities. The patients helped each other in different ways. Long-standing patients became

information providers for new patients. They provided information about the ward layout such as living room and bathroom location, hospital routines such as meals and doctors rounds. Some patients even cleaned up the room to help fellow patients. A patient said: 'I will gladly help by taking the tray out if I am well enough'. Another said: 'we help each other a lot...where I am limited, she steps in'. From these and similar patient statements, it appears that the more fit patient wanted to help the less fit patient. Also, patients preferred to manage on their own as much as possible. A patient said: 'The nurse does not need to be involved in this'. Another patient said: 'I don't call unless I can't do it myself. One shouldn't become dependent on the nurse'. The patients expressed a need to be independent from the nurse. Instead, patients managed by helping each other.

Occasionally, the interpersonal interaction between patients was experienced as a strain. One patient said: 'I was very considerate. I helped her many times, but I couldn't go on doing that'. When giving help was experienced more like a task than a volunteer-friendly gesture, interaction was a strain. When the same patient changed room (and fellow patient) she expressed relief: 'It was a relief to move. Now I only have myself to think about'. This patient helped because she felt sorry for her fellow patient. Also, disagreements lead patients to experience each other as strains. Disagreements most often arose when they expressed different levels of consideration towards each other. They would disagree on the appropriate number of guests, when to turn the television on/off, television volume, when to turn lights on/off and when to open windows and doors. Although patients experienced fellow patients as strains, they rarely expressed how they felt to each other.

Emotional support. The participants clearly expressed concern for each other. They expressed a need to care for and support fellow sufferers emotionally. Emotional support was mainly expressed through conversation and occasionally bodily contact such as a hug or holding hands. A patient said: 'we can only help each other through talking...nothing else' and another added: 'it is an amazing comfort to be accommodated with a fellow patient who is empathic and allows you to cry when you need to'. Both giving and receiving help were expressed as rewarding. A patient who once shared a room with a deaf mute said: 'I always helped her to express herself. It was nice and it felt good to be able to help her'. For most patients, it was very important to comfort and support fellow patients, particularly if they had received bad news about their illness. After having received bad news, a patient experienced a fellow patient's sadness and anxiety and said: 'I gave her a big hug and told her that I did not know what to say. I wanted to help her, but at the same time, it depleted my strength'. The patients expressed a commitment to care for

and support each other. Often, they would say: 'If only I could do something to help you feel better' and 'It is a great comfort to have a good fellow patient'.

It was consoling for the patients to be accommodated with a fellow sufferer. Patients supported and comforted each other because they knew what the illness might bring. They were in the same boat, so to speak. Furthermore, fellow patients offered an immediate presence when needed and knowledge about the lived experience of being ill, a knowledge that the health care professionals were not experienced to possess. A patient experienced it like this: 'You lie there feeling anxious and you don't feel like calling the nurse. She will just reel off a lot of facts and figures that you don't understand. *We (the patients)* talk about what it means to us'. The interpersonal interaction between patients offered support and understanding from patients lived experience. To some extent, the patients experienced time spent with fellow patients therapeutic. A patient expressed it like this: 'It is good therapy, being able to talk that well to your fellow patient, that's simply the best. I have had a perfect stay when my fellow patient was accommodating'.

The patients experienced sensitivity and consideration among each other. Though, it was a delicate balance between consideration and inconsideration which most patients were very attentive to. One patient explained: 'You shouldn't burden your fellow patient with too much – it'll only make her more ill'. Another patient added: 'It is difficult to limit how much you want to listen to others'. Patients experienced fellow patients as a strain when they were insensitive to, or simply ignored, lack of surplus.

At times, talking to fellow patients offered worries and uncertainty. When a fellow patient had a test a patient explained: 'You get very worried, when it takes so long. Yes, I was worried about where you got to yesterday'. If something unforeseen or foreboding occurred to fellow patients, patients experienced concern. Two patients explained: '...he died during his operation and I am worried that the same will happen to me...' and 'I have seen it happen to other patients so I ask about it every time...I'm afraid it will happen to me...it has an impact on you'. Patients experienced anxiety when bad things happened to fellow sufferers because they were reminded that it could happen to them too.

Humour lifts anxiety. The patients agreed on the importance of having a sense of humour during hospitalization. Patients often experienced anxiety because of their illness. The anxiety diminished briefly when interaction with fellow patients was filled with humorous comments or jokes. Humorous interaction was experienced as uplifting and life affirming, as one patient said about a fellow patient: 'he was so happy and full of life...I could not believe that he was ill. Yes, his company gave me a kick'. The ability to change the sombre mood which often prevailed in the

patients' room was experienced as valuable. Also, laughing was experienced as a break from thinking about their illness.

One patient said: 'Yes, the odd bods have found each other – we have a sense of humour and it keeps us going... (laughs)'. Other patients said: 'it is a relief to laugh' and 'there are plenty of dark moments, so we try to find the bright sides together'.

Sharing with fellow patients

The patients had at least one experience with sharing both positive and negative incidents with fellow patients, but the positive ones were the most dominant.

Volunteer sharing. Observations showed that, initially, it was the long-standing patients who took initiatives to exchange experiences of their respective illnesses with the new patients. They shared experiences with examinations, symptoms and treatment vividly. Sharing symptoms experiences, one patient told another: 'I found out because it felt as if I was sitting on a ball' and another patient responded: 'My symptoms were fever, chest pains and I coughed a lot'. The shared knowledge was experienced reassuring: 'You speculate about what a (heart) valve looks like, and it is comforting to see that she is getting on so well with her new valve. You are always a little worried'. This was just one of many examples of patient sustenance achieved through fellow patients' experiences with illnesses. Sharing information was experienced as liberating and a way to share strategies for living with the illness. A patient pointed out: 'We share our experiences of coping. Just expressing our feelings, hearing the words have an effect'. Another patient said: 'We talk about the disease and we share thoughts which we do not even share with our family'. Often, fellow patients were preferred over family and healthcare professionals, when it came to illness-related talks. The patients expressed a need for information from fellow patients because such information provided insight into what might be expected from the illness. Information about the illness from fellow patients was experienced as different from that given by health care professionals. Fellow patients' lived experience enabled them to prepare themselves against the illness.

Knowing what to expect from the illness sometimes promoted anxiety among the patients, and several of them said: 'I was very worried last night...thinking', 'You just need to cry sometimes...it is okay to cry...' and 'You just lie in bed...scared...'. Knowing was experienced both frightening as well as informative.

Enforced sharing. The patients experienced privacy to be nonexistent in the patients' room. Conversations between patients and doctors, fellow patients, family members or others were constantly overheard. One patient said: 'You

could draw a full length curtain, and get some privacy, but you could still hear everything that was going on'. Even so, patients were rarely troubled about fellow patients over-hearing conversations. A patient explained: 'It doesn't bother me. I don't feel that my illness is something I should hide'. Another patient thought overhearing was perhaps an advantage for fellow patients: 'It doesn't matter if others hear what I have been through – it might help'. This was another way of passing information from patient to patient.

Patients rarely expressed privacy needs verbally. Instead, they turned their back on their companion and expressed a need to rest or to read. In this way, they showed that privacy was needed. They were very polite towards each other at all times.

The enforced information sharing was occasionally experienced as a strain. One patient expressed the following: 'Honestly, I would love to be in a single room. In that way I decide who I want to talk to and how much I want other patients to know about my disease and my life'. Talking about the information shared during doctors' rounds, a patient said: 'You have the doctor's confidentiality, but the others (the patients), they are just listening in on your private conversation'.

Discussion

Rigour

Fieldwork should be considered as a relevant and important method for gaining insight into patients' interaction during hospital stays. The strength of this fieldwork was the combination of observations and interviews. By combining the two, the researcher had the opportunity to validate observed data through questions asked during the interviews and vice versa. The study involved a relatively small number of formal interviews (n = 6). It has been argued that even a small number of interviews were qualitatively adequate – providing that the result was not viewed as a complete qualitative picture, but a picture of qualitative manifestations (33, 36). In this light, our study may be considered as a contribution to other similar studies investigating the significance of patients' interpersonal interaction. Also, it would be relevant to gather qualitative interview data from males, to study associations or disparities between sexes regarding the significance of interpersonal interaction.

Discussion of findings

According to our findings, patients exchange help and care, and they establish foundations for self-care through sharing illness information. Caring and sharing, the patients fulfilled needs of their own and that of their fellow patients'. Caring and sharing promoted the patients to maintain a sense of self-care while caring for the fellow

patients. To discuss findings in a care and a self-care perspective seems reasonable.

The 'job' of accommodating needs. The findings show that patients care for fellow patients, although they themselves are ill, and they help, support and inform each other. Also, patients regard caring for fellow patients as very important. These findings are in line with Martinsen's thoughts of caring as a fundamental human condition and also in line with the three dimensions of caring (25, 29). The patient community developed when the stronger patient acted as substitute 'caregiver' for the weaker fellow patient (29). The patients' community challenge may be when their roles change. The stronger patient may also need care but the weaker patient may not be able to accommodate this. According to Martinsen (25), relational reciprocity cannot be expected in caring – you care because it is a human condition to care for others. This may explain why patients care for fellow patients although they are ill themselves.

Nursing care may be expressed through different nursing actions accommodating the patients' needs (26). The findings showed that patients performed similar caring activity in their interaction. Patients added help, support and information to those received from healthcare professionals. In doing so, patients helped each other both physically and emotionally. In agreement with Isaksen and Gjengedal (15), patients cared for each other and wanted to help and encourage their fellow patients. The patients' interaction was similar to parts of the nurses' job of accommodation needs. Accommodating fellow patients' needs may be a significant strain for hospitalized patients if nurses are not available. In our study, hospitalized patients' were an important part of patients' support system. They cared for their fellow human being as the most natural thing to do – as a fundamental human condition (25). Accommodating needs, Henderson (37) accused Western nursing of being impersonal and technical rather than individualized and humane with caring deficit as a result. Also, lack of nurses' time may influence care. Orem states that nursing requirements cannot be met unless they are known and that such knowledge comes only through directed and controlled observation which necessitates contact and communication with the patient (26). This means that time is essential for the nurses to be able to acknowledge and to accommodate patients' needs. The patients' needs are still present even though they are not identified by the nurse because of lack of time.

In our findings, the patients did not express dissatisfaction with the nursing care. Additionally, studies have argued that nurses' and patients' view on care were different. If nurses did not assess patients' perceptions of caring accurately, the care delivered might not be congruent to the patients' expectations or needs (38, 39). Such an imbalance may impede care and also be a reason for turning to fellow patients to achieve sufficiency in self-care.

Acquiring expert knowledge to self-care. Interestingly, the patients increasingly turned to their fellow patient for help, knowledge and information instead of turning to the healthcare professionals. Healthcare professionals were perceived as less credible than fellow patients because they had not experienced similar illnesses. The fellow patients were the most obvious partners for conversation because of their lived experience. Fellow patients were perceived credible and accessible. The fact that the conversation partner suffered from a similar disease added to the reliability of the shared information. This is in agreement with similar studies where symptoms were compared, even among patients with widely differing medical diagnoses (13, 14). Healthcare professionals as less credible information givers have not been found in other studies, but both Album (14) and Kulik, Shelby and Cooper (13) suggest fellow patients as being the best informants because of the similar bodily experiences. Additionally, findings from Backstrom, Wynn and Sorlie (40), McIlfatrick, Sullivan, McKenna and Parahoo (41) and Andreassen, Randers, Naslund, Stockeld and Mattiasson (42) suggested that patients' experience of information and support given by fellow patients were even more important than that given by healthcare professionals. We cannot either support or reject these statements. Though, we do believe that fellow patients provided first-hand knowledge about illness-related issues, which accommodated patients' self-care needs.

The patients expressed a need for knowledge about the lived experience, which was not attainable from the nurses but from the fellow patients. Even so, the patients did not expect the nurse to provide this type of knowledge. By not providing the needed information, you may say that the nurse contributed to self-care among the patients as they found alternative ways to knowledge and information. Oppositely, it may be a self-care deficit as the patients did not receive the information they needed from the health care professionals. Whether the nurses were aware of this deficit remains to be explored.

Furthermore, it has been argued that nurses' caring behaviour influenced patient satisfaction (43–45). Maybe, it is not only the nurses' care, but also the interaction between patients which influence patients experience and satisfaction of hospitalization. Certainly, the interaction between patients and fellow patients during hospitalization encompasses elements of care and self-care, but it has not been acknowledged as such. Patients helped and supported each other because it was a natural and a human thing to do (25), and they sought information from the nearest source of knowledge and information – the fellow patient.

Implications for nursing practice

Our study confirms that knowledge about hospitalized patients' interpersonal interaction with fellow patients is

important. The patients care for each other by assisting with practicalities, they support each other emotionally and they share knowledge and information which enables them to manage their illness and life during hospitalization sufficiently. Furthermore, the interpersonal interaction provides opportunities of achieving self-care.

It is noteworthy that the patients had an almost blind faith in each other regarding the lived experience of illness. In addition to this, healthcare professionals were not expected to, nor able to, accommodate the patients' needs for this type of information.

So far, hospitalized patients' interaction has not been acknowledged as a specific focus area in need of attention in nursing in Denmark. In nursing education, we demand an implementation of knowledge through the inclusion of scientific articles as a part of the demand of scientific knowledge (46). An acknowledgement of interaction in nursing, as being more than interaction between the patient and health care professionals or relatives, is needed. We suggest both nursing educators and student nurses discuss our findings to strengthen the student nurses' knowledge and hereby their ability to facilitate actions to accommodate patients' needs. Also, an increased attention in the nursing education may provide an increased attention on patients' interaction with each other when practicing nursing.

In the practice field, the health care professionals need sufficient knowledge about the quantity and quality of hospitalized patients' interaction to accommodate the patients' needs. We suggest dialogue between caregivers on the subject of patient–patient interaction and how this may contribute to patients' experience of hospitalization. Also a debate of how to implement the knowledge as a part of the daily work would be recommendable. By visualizing the extent of patients caring and sharing, we raise the question of whether professional care accommodates the

patients' needs sufficiently. If not, how may health care professionals use fellow patients' resources, to what extent and what are the consequences? These questions need further investigation. Our study does not dispute the fact that nurses are primary caregivers, but we suggest an expansion of the traditional understanding of caregivers, in which fellow patients are included. More studies of patient–patient interaction during hospitalization are needed to expand our knowledge of patients' interpersonal interaction and how this interaction may be utilized in patient care.

Acknowledgements

The authors wish to thank all participants for spending time participating in our study during their hospital stay. We would also like to thank the nursing administration of the hospital and the wards' health care professionals for their assistance, understanding and participation.

Author contribution

Lene Søndergaard Larsen was responsible for the data collection, data analysis and writing of manuscript. Regner Birkelund supervised the study and participated in critically reviewing the manuscript.

Ethical approval

The project was approved by the Danish Data Protection Agency and the Regional Scientific Ethics Committee.

Funding

None.

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