The concept of confidence – the nurse's perception

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The purpose of this paper is to investigate a nurse's understanding of the concept of confidence and what a nurse thinks affects the experience of confidence in the patient relationship.

The project has a hermeneutic design using a research interview method. Nine nurses were interviewed. A hermeneutic approach was used in the analysis of the data. Interpretation of the data was linked to Segesten's model for confidence. Analysis of the data generated two major themes in relationship to the comprehension a nurse has of confidence. One theme was 'to feel comfortable, be relaxed'; the other was: 'feeling secure'.

The result shows that nurses' definition of confidence is dependent on two security-creating factors: the significance of a professional network of co-workers and the importance of confirmation of professional role and competence.

Keywords: interaction, nurse, patient, confidence, safety, cancer, care.

INTRODUCTION

Receiving a serious diagnosis can awaken different emotions in patients. Viney categorizes some of the emotions as: uncertainty, insecurity, anger, feelings of helplessness, depression, isolation and humour (Burton & Watson 1998).

Cancer is a generic term for malign tumours with abnormal cell growth which may result in death. This may cause the patient to experience that her/his life/existence is at risk. It becomes a question of life or death, a case of living or not living. The patient's feeling of security is threatened. 'Confidence is the individual's awareness and assurance of a certain ordering of things' (Segesten 1994, p. 3). That which is taken for granted – our existence in the world – will no longer be taken for granted. Energy is directed towards being on guard, exercising caution and being on the defensive.

A nurse's most important starting point for treatment is the patient's awareness of her/his diagnostic condition. The basis of care should be the creating, moving meeting. That which characterizes the process in this meeting is 'being with'. That is to be there with the other in the other's world (Mayeroff 1990). In this meeting lie important elements whereby a nurse attempts to take care of the patient's confidence.

Professional ethical guidelines for nurses build on the principles in the International Council of Nurses' ethical code. The code underscores that nursing is based on compassion, care and respect for underlying human rights (The Norwegian Nurses Organisation 2001, p. 3). The nurse should be courteous towards patients who are perhaps anxious and affected by sickness and pain. This creates a demanding situation for a nurse, if she/he is to meet the situation in a way that makes the patient feel met and taken care of in a good manner. Martinsen touches on the demands of being a nurse. She says that a nurse should dare to be a fellow human being (Martinsen 1990, 1997). To dare require a form of courage in connection with entering into the individual patient's situation. Therefore an important question is: will a nurse have the courage to meet insecurity in the patient if the nurse herself/himself, for whatever

reason, feels insecure in the relationship. Several investigations have shown that nurses, to a certain degree, do not involve themselves sufficiently in the patient's situation. Furthermore, another study reports nurses express a need for a gradual process towards security and coping (Havn & Vedi 1997).

Review of literature

A literature search was undertaken in the following databases: MEDLINE and CINAHL. Search words were nurse–patient interaction, confidence, safety, cancer and care.

Proximity, listening, sensitivity and sympathy are basic elements in communicating with and meeting the suffering patient. If these elements are not present in communication, it will be technical and empty (1999). Nordtvedt and Grimen (2004) stated that many studies show that patients' confidence in health workers and the health service is falling in western countries. Brataas (2001), in her doctoral thesis, considered cancer patients' perception of nurses' communication and found that the experienced patients did not receive enough help from the nurses. They missed having more information and communication from the nurses. This was important to enable the nurse to act more professionally solution-oriented.

Research articles show that nurses experience insecurity in having to address emotional issues with patients (Faulkner 1995; Booth *et al.* 1999; Kruijver *et al.* 2001; Odland 2002). Research also shows that inner and outer factors influence the nurse's ability to meet the patients' needs. Angeles-Llerenas *et al.* (2003) looked at nurses' attitudes and values in communication with cancer patients and found that nurses who themselves accepted death and had a religious conviction had a greater capacity to be genuinely available and to meet the patient's deepest needs. McLoughlin (2002) studied patients under palliative treatment and their experience of interaction with specialist nurses. The informants expressed great satisfaction with the care they received from the specialist nurses. Some of the reasons for this were that the specialist nurses had greater competence and could explain patients' questions about information they had received from the doctor and other questions the patients might have had. Kasén (2002) maintains that nurses think that it is significant for their development that they can influence the forming of the nursing relationship. She states that external factors such as comradeship at work and leadership are important factors which will affect a nurse's relational development. Authors focus on the importance of the ward nurse creating confidence for the nurses on the ward. The ward nurse's relationship with the nurses on the ward is the major variable with regard to the staff's attitudes and morale (Flannery & Grace 1999; Atsalos & Greenwood 2001; Brooks & Swailes 2002). Michie *et al.* (1996) undertook an investigation looking at factors which could contribute to stress among nurses. At the same time they studied patients' experience of the care they were receiving. The patients were mostly satisfied with the care they received, while the nurses, on the other hand, expressed stress relating to several factors: to have to relate to patients and relatives and the conflict between their private affairs and work. In addition, they felt stress in connection with confidence and competence in their own role.

Findings from the literature show that there has been little specific focus on nurses' conception of confidence and their experiences of factors which contribute to creating confidence in their relation with the patient. Two major impressions appear from the literature study. The first is patients' lack of a sense of sincere availability from nurses in the relationship. The other is external factors which have significance for nurses' engagement in work practices.

The literature does not mention that what nurses themselves think is important for them to feel secure in their work practices. Therefore the study of the literature legitimizes the undertaking of an investigation focusing on nurses' understanding of the concept of confidence and nurses' reflections concerning security in their relations with the patient.

The purpose of this paper is therefore to investigate the perceptions nurses have of the concept of confidence and what circumstances influence nurses' experience of confidence in her/his working practice.

METHOD

The project has a hermeneutic design using a qualitative research interview method. 'Qualitative analysis is the non-numerical organization and interpretation of data in order to discover patterns, themes, forms and qualities found in field notes, interview transcripts, open-ended questionnaires, journals and diaries' (Brink & Wood 1989, p. 336). The goal of the research interview is to gather knowledge about the interviewees' world by asking questions (Kvale 2001, p. 33).

Criteria for the selection of participants

A selection was chosen from nurses with full-time employment based on the probability that this group of nurses to a greater degree would have experience of continuity in the follow-up of patients.

The nurses had been employed on the same ward in an oncology/cancer care setting for a minimum of 1 year. This gave them a background of experience in relation to being in situations which had been a challenge for them. They would therefore be able to say something about how they had experienced receiving support and help while attending to the needs of patients in demanding situations.

A selection was made of 10 nurses from two departments/wards. As a qualitative interview was to be partaken, it was important not to have too large a selection. The reason for this was the time needed for working with and analysing the material collected. Nine nurses presented themselves for the interview and were interviewed.

Access to the field

Permission was sought to undertake the investigation from the senior nursing officer of the hospital concerned. An agreement was entered into with the charge nurse for each of the two departments, and they made a random selection of informants from the two departments. The informants were described according to gender, department and seniority. A time for the interviews was agreed upon.

Data collection

Kvale (2001) maintains that it is the inter-human interaction in the qualitative research interview which produces scientific knowledge, and that the result of the interview is dependent on the researcher's knowledge, sensitivity and empathy (Kvale 2001). He states that the advantage of the qualitative research interview is the openness between the interviewer and informant.

The interviewing period lasted over 4 weeks. The interviews were recorded and took place within a pre-arranged time limit of about 1 h. The informants were informed before the interview that their participation was voluntary, and they had the opportunity to withdraw at any time whatsoever during the process. They all consented to being interviewed and to having their interview taped and transcribed.

In collecting the data, the researcher focused on the theme and certain prepared questions. Interview guidelines were used based on 10 questions. The researcher attached importance to having questions that were sufficiently explicit, so that they would not be misunderstood, and that they were precise enough to allow supplementary responses. Openness and the creation of confidence in the interview situation were also important matters which

were considered. The researcher also stressed the need for sensitivity and empathy through an intimate and trusting atmosphere. Participants could speak uninterrupted, without being influenced in any direction, until they themselves felt that the question was answered. When necessary, questions were sometimes asked for clarification.

Method of analysis and interpretation

A hermeneutic approach was used in the analysis of the data, so that the reading of the text was interplay between the whole and the parts. The data were analysed in relation to three levels: self-understanding, critical understanding based on common sense and theoretical understanding (Kvale 2001, pp. 144–145). By self-understanding, Kvale means that the interpreter formulates in a concentrated form 'that which the interviewees themselves have understood as the meaning of their responses'. Concerning critical understanding based on common sense, he says that the interpreter can have a broader understanding than the interview person, but nevertheless remains within a framework of a generally reasonable interpretation. With theoretical understanding the researcher uses a theoretical framework. This is instrumental for a deeper interpretation than with self-understanding and critical understanding based on common sense (Kvale 2001, p. 145).

An entry was made in a log immediately after each interview. The taped material from the interviews was transcribed. The data material from the open questions were read, interpreted and analysed several times by the researcher. The questions were grouped together in relation to three research questions in the interview guidelines in order to see if any pattern was apparent. The interviewee's responses were condensed and abbreviated, along with being categorized in relation to the occurrence or absence of phenomena/themes.

The interpretation is coupled to two major components in Segesten's (1994) model for confidence:

1 External confidence consisting of material confidence, environment confidence, knowledge confidence, relational confidence, 'the others' confidence and dependability confidence.
2 Pseudo-confidence consisting of 'act-as-if' confidence and ignorance-confidence (Segesten 1994).

The reason for choosing Segesten's model of confidence is that this model describes the core of confidence and lack of confidence from a nursing science perspective.

The project was approved by the Norwegian Social Science Data Services. Permission was granted to interview 10 nurses from two different wards.

RESULTS

Analysis of the data generated two major themes in relation to the comprehension – a nurse has – of the concept of confidence. The first theme was *'feeling comfortable, being relaxed'*. The second was: *'feeling secure'*. Relevant quotations were selected to illustrate the two subthemes from the informants' responses.

The two themes emphasize the distinction which is made in the English definition of confidence where one does not have, as in the Scandinavian languages, one all-embracing concept, but instead one has different descriptions of the feeling in the situation, e.g. 'security' and 'confidence'. 'To feel confident' means to be without doubts and be convinced in one's opinion, belief and expectation. Confidence means trust, assurance and self-reliance. 'To have confidence' means to attach belief to and to depend on. Secure: lat. securus, se-cura = 'care' = safe, free from danger (http://www.m-w.com/dictionary/).

Being comfortable and being relaxed

Being comfortable and being relaxed are described in different ways by the informants, as is the translation of the English word 'confidence'. That is to say to attach belief to, to depend on, to put one's trust in or to have confidence in something.

One of the informants says that confidence is an inner feeling. This feeling is described as the bodily sensation of experiencing calm. *'For me confidence involves an inner feeling that I feel calm – that I feel comfortable in a situation'*. The informant gives a further qualitative description of the emotional consequence of calm, as feeling comfortable. Another informant states: *'Confidence is when one feels that one is at ease in the situations one faces, or performs in. When you feel that you can cope with something'*. These informants claim that confidence results in a bodily, qualitatively good feeling.

The informants emphasize in different ways how the emotionally experience of being comfortable finds a physical expression. *'Confidence is that you will feel that you are not uneasy about not doing the right things. So that you, if you have a problem – that you feel relaxed, that you feel that you cope with things and are free from stress'*.

The informants point out another important factor, which must be present to be able to experience confidence. This factor is a professional network of co-workers. They describe this professional network of co-workers as something more than their colleagues' daily presence. In order for a nurse to have a situation-decisive experience of being comfortable through believing in and trust herself/himself, she/he is dependent on that the professional network of co-workers is open, trusting and accepting. This results in the nurse being valued for what she/he is, and it gives her/him a place to share experiences. One nurse states: *'Have people you can rely on, people you know you can talk with if things are difficult. Especially in relation to the job, I'm thinking about. Colleagues with experience. It's being – not having to be afraid and anxious throughout the day. People who care about me – sincerely'*. A professional network of co-workers can be regarded as an assurance that someone is there for you when you experience demanding patient situations. Not least those connected to life and death situations. *'That I have support from my professional co-workers. I see that as very important. It's what I wish most of all anyway. That I'm not standing alone with problems I think are difficult to handle. For there is a cancer disease where you are – an illness which can have tragic consequences'*.

Some nurses describe this as a, in a figurative way, bodily experience of having someone you can lean on. *'And having colleagues around me then, I think that's also important, both nurses and doctors, that I have them as a support'*.

Another nurse expresses how the certainty of having a professional network of co-workers really is a contributing factor in relation to be able to remain calm. *'And there are situations which I maybe don't cope with completely, so there are others in the team who you maybe can talk with a bit. That we are a team regardless of who else is there, so I am never nervous about it, for I always feel that I have backup from the others'*.

The nurses describe the experience of being comfortable and being relaxed as an inner emotional and physical feeling through believing in, depending on, trusting in and being assured of themselves and the others.

Feeling secure

Being secure is described by the informants in similar ways to the definition of the English word 'secure'; that is, having a feeling of security, free from danger. In relation to feeling secure and free from danger, the informants focus on the importance of having knowledge and mastering clinical skills.

One informant explained being secure in this way: *'Confidence is knowing what you should do, for example'*. One of the other informants gives a more complete description of a demand for knowledge and expectations of the basis of knowledge for herself/himself: *'It's like, maybe that I know that I can – like knowledge – so that*

I know I have knowledge. Yes, if there is a patient who gets different types of cytotoxin – or radiation therapy – that you know that you know all about that and can answer all the questions'. A nurse is concerned about being able to cope with the accomplishment of the procedures, while at the same time she/he puts demands on herself/himself to be able to answer any professional questions from the patients. It is evident through the statements that nurses put high demands on their own knowledge in connection with treatments, such as procedures: *'Knowledge too, if you think of practical things. Procedures and the like – managing them. There are probably many patients who have questions about that too, that you can do that'.*

Nurse training sets requirements for theoretical competence. It would, however, appear that the nurses on an active cancer ward are faced with even greater challenges, as they are constantly expected to learn new forms of treatment which require both professional competence and technical prowess. This is confirmed by one informant who states: *'I see in the concept of confidence that I am secure in what I am doing with the patients. Yes, let's say for example, procedures, then, that I know how the procedures should be carried out. That I don't have with me a note where it says what I should do about something, that I can know it by heart, inside and out, backwards, so that I understand it'.* Another of the informants notes how nurses' real knowledge about the patient's treatment can influence nurses' experience of security and being free from danger: *'So there probably is a danger with cytotoxins, so that probably influences your feeling of confidence'.*

Nurses are professionally and legally responsible for the care that is given to the individual patient. This influences how a nurse defines confidence. For a nurse to be confident, free from danger, not only she/he is dependent on possessing professional knowledge, and being able to master and carry out technical procedures, but also she/he is dependent on receiving feedback about her/his professional role. Several of the informants emphasize the importance of feedback as a confidence-creating factor: *'That you get feedback about how you are as a nurse, how you fit in the group and how you fulfil your role. For it's clear that if, as we said, get good feedback, then that will probably contribute to greater self-confidence and, yes, greater confidence in relation to that'.* Individual informants point to the charge nurse as being central in relation to affirming nurses and giving them feedback about their work practice: *'That you have a supervisor who sees you, and gives feedback about how you are doing your job'.* The opportunity for feedback is consequently an important element in relation to how a nurse defines confidence.

With regard to feeling secure, free from danger, the informants focus on the importance of having knowledge and coping with clinical skills, together with being dependent on receiving response about their professional role.

Comments

Through the two major themes which appear in the analysis of the nurses' perception of the concept confidence, the nurses identified different dimensions of the concept of confidence.

The two major themes – 'being comfortable, being relaxed' and 'feeling secure' – can in turn be linked to one of the main components in Segesten's (1994) model for confidence, relational confidence and knowledge, and control confidence. Pseudo-confidence, which constitutes the second main component in this model, is mentioned by only one of the informants.

Being comfortable and being relaxed are important factors in relation to how the nurses define confidence. They state that being comfortable and being relaxed give them an emotional and physical feeling. The emotional feeling is sensed as a physical condition of calm, of being at ease and being free from stress. The nurses describe in this way that a body which is not on the defensive is not on edge. In other words, their energy not only is directed towards being on guard, thus focusing their attention inwardly towards their own self, but also can be directed towards the other – in this case, the patient. 'Confidence is the individual's awareness and assurance of a certain ordering of things' (Segesten 1994, p. 3). Being comfortable and being relaxed by believing in oneself, trusting oneself in the situation is given a physical description by the informants.

The emotional and physical feeling of being comfortable and being relaxed appears to be dependent among other things on relational factors such as the individual nurse's trust in a network which the nurse knows is there. The nurses in the investigation underline the importance of relational confidence. Relational confidence, says Segesten (1994), is linked to a network of people who one knows exist. She calls attention to the importance of the fact that people are always searching for a relationship where they are believed and met in a positive manner. For nurses this involves the nurse–patient relationship being present with the others in the others' world. This necessitates that the nurse reflects the others' feelings, as well as the ability to cope with the theoretical and technical factors.

What characterizes relational confidence (Segesten 1994) is openness, mutuality, accepting attitudes and opportunity to contact each other. 'One looks for a relation where one is positively received and believed, where one does not have to be guarded, where one feels respected and not under scrutiny as different' (Segesten 1994, p. 13).

Knowledge confidence and control confidence deal with having knowledge, how roles are described, what one can expect and what is demanded. This applies also to affirmation (Segesten 1994). In this material, the nurses account control confidence to the dependence on knowledge. This is based on the fact that the patients are concerned with what they can expect and what is demanded of the nurses. It puts great demand on the nurse's own competence in relation to both having knowledge and coping with the technical aspects of different forms of treatment. Nurses put high demands on themselves, so that the knowledge they possess can enable them to be utilized in such a way that they can answer any questions the patients might have.

The nurses explained that they are in situations where great demands are made on their knowledge, technical proficiency and relational skills. In order to describe confidence nurses need to clarify their understanding of what in the situation creates insecurity, whether this is knowledge-related, proficiency-related or of a relational character. Segesten (1994, p. a13) states that 'control confidence deals with understanding, anticipating, handling and controlling the situation one lives in'.

Knowledge confidence and control confidence 'deal also with confidence in the known' (Segesten 1994, p. 16). In meeting with unknown people, with different personalities, with different diagnoses, with different degrees of malignancy, nurses must also regularly relate to unknown forms of treatment, all of which affect the patient's total experience of their situation. This appears to influence how the nurse defines confidence in the form of feeling secure.

Knowledge confidence and control confidence deal also with affirmation (Segesten 1994, p. 16). The informants express in the material that to be able to feel secure in the situation it is important to receive affirmation for what they do. They are concerned with receiving feedback on what is expected of them and the demands which are placed on them.

The nurses' definition of confidence in the form of security reflects Segesten's ideas of knowledge confidence and control confidence. The results make clear that nurses are dependent on affirmation regarding their competence, whether it is understood as being of a professional or technical nature.

DISCUSSION

The nurses in this material define confidence as a qualitatively good bodily experience characterized by feeling comfortable and relaxed. The experience of feeling comfortable and relaxed appears to be dependent on the nurses believing in themselves, as well as believing in a network of people who will support them.

Confidence through feeling secure in relation to mastering a situation, according to the nurses in this study, is dependent on professional knowledge, skills and role expectations, at the same time as being dependent on receiving affirmation regarding their own competence.

The Framework Plan for Nurse Training (2004) states that the students at the end of their training should be able to 'participate in specific and specialized caring responsibilities, procedures and the use of technical medical equipment' (The Framework Plan for Nurse Training 2004, p. 6). This implies that expected nurses are able to continually acquire knowledge about the distinctive and specialized caring responsibilities, procedures and the use of technical medical equipment. In addition, the nurse should be courteous towards patients who may be anxious and affected by sickness and pain. 'Confidence and trust will be prior conditions for the patient to receive alleviation of their suffering. Without confidence and trust the patient will not experience contentment' (Nåden 1999, p. 119).

Confidence as a feeling of being comfortable and relaxed is described by the informants as a bodily sensation of being defensive, not being on edge. In the same manner as the patient, the nurse must submit/dedicate herself/himself to the situation. By trusting the others, we expect that they will treat us well or that they will do what is right for us in the situation.

In her/his dealings with the patient it is natural that the nurse makes some cognitive evaluations in relation to trust. This will include the nurses' reputation with regard to skills and knowledge, as well as role expectations (Smith 2005). Trust will therefore in some cases be dependent on the nurse undertaking a risk analysis of the situation.

The nurse is faced with the patient's and her/his own expectations and values. Smith (2005) believes that 'trust' will first be relevant in social relations, but only if at least one participant is exposed to an element of risk from the other's conduct. Uncertainty in relation to the other's conduct is central in relation to the perception of trust. Smith refers to an investigation concerning patients undergoing treatment. Here the informants gave the following comments in relation to the concept of trust:

'honesty, openness, responsiveness, having one's best interest at heart, and willingness to be vulnerable without fear of being harmed' (Smith 2005, p. 303). Furthermore they state that the patient's need for help makes the patient himself vulnerable in relation to the others conduct towards things the patient values. The same can be said about the nurse. The nurse is disposed towards the patient where she/he expresses her/his actual competence. A risk analysis needs to be carried out so it can contribute to reduce the nurses' experience of uncertainty.

Trust contains a moral, an affective and a cognitive element (Smith 2005). All these elements will be present to a greater or lesser degree during a meeting with the patient. The nurse is professionally at the disposal of the patient; and at the same time as being disposable, she/he is confronted with her/his own vulnerability.

The Framework Plan for Nurse Training (2004) also says that the student by the end of her/his training should have the competence to act in relation to: 'perceiving and acknowledging a professional and personal responsibility for one's own actions and judgments and perform in a way which strengthens the patient's and society's trust in the profession and the respect for the nursing service' (The Framework Plan for Nurse Training 2004, p. 7). This makes the situation demanding for the nurse by requiring a high professional competence in a system where the patient is defined as a user and where the demand for effectiveness is increasing.

It is necessary for health workers to trust one another to be able to carry out their profession. Trust touches the very nerve of the health service. The health service's primary relations would not have come about without trust (Grimen & Nordtvedt 2004). Nurses should support the patient's positive emotions of confidence and security. Through the nursing process the nurse should strengthen the patient's own motivation and commitment in her/his own healing process. The purpose of this is that the patient strengthens her/his own view of himself as a resourceful person. This implies that the patient has expectations and makes demands on himself, venturing into the demand of being a participant and meeting challenges, thus strengthening her/his own ego. The staff's emotional commitment is seen as an assumption of the will to provide empowering care and a will to participate in the relationship. Close and significant others constitute important resources in the form of motivation and commitment for both the nurses' and patients' existence (Gustafsson 2004).

It appears that the nurse, in risk-filled situations professional relationships involve, counts on trust from a network which she knows will support her, in order to be able to feel comfortable and relaxed. Fellowship with others contains that which gives life meaning and which provides the strength to go further in relation to great challenges. This can result in that the nurse to a greater degree is made dependent on a professional network of co-workers which is open, trusting and accepting, where the nurse will be valued for what she/he is and where there is room to share experiences (Smith, 2005).

Segesten (1994) points out that what signifies relational confidence is openness, mutuality, accepting attitudes and opportunities to meet each other where one knows that she is respected and not treated as 'being different'. The consciousness of being able to lean on others and being able to handle situations and incidents with others in the team is seen to be important in relation to the nurse's feeling of confidence. Being able to lean on someone in both the literal and figurative sense appears to constitute a confidence factor in regard to the nurses' opportunity to express her/his vulnerability; at the same time this promotes the nurse's trust in her/his own self-assurance. That in turn increases professional competence. A study shows that reflection in the company of colleagues allows a nurse to develop and mature (Gustafsson 2004).

Grimen and Nordtvedt (2004) describe four features which are seen to be important trust-creating factors. These are the health workers' ability to communicate, their competence and their willingness to follow up the patient. Smith (2005) maintains that to be able to present ethical actions, communication skills are needed; supervision along with expert helps with ethical dilemmas. All these are important tools in relation to influencing the nurse's experience of confidence.

For a nurse to be confident, free from danger, not only she/he is dependent on possessing professional knowledge, able to master and carry out technical procedures, but also she/he is dependent on the opportunity of receiving feedback about her/his professional role. 'To be affirming or to be affirmed causes positive consequences for our self-appreciation and self-esteem both as patient and carer' (Gustafsson 2004, p. 13). 'Feedback might be very hurtful, but it provides opportunity for growth by driving us to a higher level of excellence' (Kerfoot 2005, p. 156).

Affirmation involves the patient feeling calm, safe and increasing in self-confidence (Gustafsson 2004). The same applies to the nurse. The liberating dialogue where both parties know freedom and trust in their own and the other's competence forms the foundation of the affirming relationship (Gustafsson 2004). Self-esteem is the most important factor for the staff's ability to cope with their work situation (Gustafsson 2004, p. 395). Self-confidence

is important for the nurse's willingness to maintain high professional standards (Ronsten *et al.* 2005).

Nurses are professionally and legally responsible for the care given to the individual patient. This has consequences for how nurses define confidence. It is therefore important that nurses experience that there is a possibility of receiving confidence-creating incentives, such as affirmation of their professional role. Confidence-creating incentives can influence the professional self-awareness.

Validity and reliability of the study

To determine the validity of the findings the results were reviewed. Reliability is concerned with consistency, stability and repeatability (Morse 1991). The researcher was not working as a practitioner at the time the research was conducted. The interview guide was read and commented on by the second author. The informants were asked identical questions. The taped material from the interviews was transcribed. A part of the interviews were read by the second author. The data material from the open questions was read, interpreted and analysed several times by the researcher.

Conclusion

The material illustrates that nurses' definition of confidence in the interaction with the patient is dependent on the nurse facing up to the patient's and her/his own expectations and values.

The informants claim that confidence is a bodily feeling like being comfortable and being relaxed. This is dependent on the nurse having trust in herself/himself and trust in a confidence-creating professional network of co-workers to share experiences with. It seems important to give the nurse time to reflect together with colleagues. This allows the nurse to develop and increase her confidence in relation to the patients. Confidence through feeling secure in relation to managing the situation shows that nurses are on the one hand dependent on professional knowledge, skills and role expectations; and on the other, they are dependent on affirmation of their own competence. Affirmation is underlined as very important in relation to the nurse's perception of confidence. To improve patient care, the nurse has to create a reflecting and affirming relationship with her colleagues. The result shows the significance of two confidence-creating factors in relation to how the nurses define confidence: the significance of a professional network of co-workers and the importance of confirmation of the professional role and competence. These two factors seem important for the ward nurse to be aware of if nursing practice is to be enhanced and patient care improved.

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