Abstract

Background: There is a popular belief that the professional-patient relationship is a prerequisite in the provision of psychosocial support. Studies suggest that professionals must know, or be familiar with, a patient in order to effectively provide psychosocial support.

Aim: To examine the association between familiarity and the provision of psychosocial care by professionals.

Design: A mixed method study involving participant observation, interviews, organisational, and documentary analysis was conducted over eight months in an inpatient hospice setting.

Participants: 38 nurses (registered and auxiliary) and 47 patients were included in a maximum variation sampling strategy. Data was analysed using both qualitative and quantitative techniques.

Results: The data disconfirms the belief that familiarity is either a necessary or sufficient condition for the provision of psychosocial support. Nurses familiar with patients did not necessarily respond to patients' psychosocial needs, and nurses with no prior contact with the patient immediately dealt with psychosocial needs.

Conclusion: Psychosocial support can be provided on a patient's first contact with a clinician and does not rely on building a professional-patient relationship. This suggests that high quality psychosocial care can be provided in the short timeframe available to palliative care clinicians.

Key words

Observation, professional-patient relations, nurses, psychosocial, familiarity.

Introduction

There is a global agreement that psychosocial care is a major focus of palliative care .[1-4.] It encompasses a wide range of highly specific clinical interventions, from treatments addressing diagnosed conditions (such as depression and anxiety) to the provision of routine support.[5-9] Psychosocial support should be provided on a daily basis and address a range of needs,[10-13] including quality of life, emotional wellbeing, safety, and a sense of hope.

The question is: what conditions are required for doing this? One popular view is that professional-patient relationships are prerequisites for the provision of psychosocial support.[14-22] But is this true? Studies referring to the importance of relationships are

largely based on self-report.[18-19,23-24] Very little research has tried to determine whether professional-patient relationships really are a condition of psychosocial care.

This study explored the provision of psychosocial support by nurses in a hospice, with the aim of determining whether being familiar with a patient is a necessary or a sufficient condition for the provision of psychosocial support in palliative care.

Methods

Observational research has provided important insights into palliative [22,24-28] and into nursing practice.[29-32] A mixed methods [33-36] study, largely based on participant observation (PO), supported by interviews, nursing documentation, participant demographics, and information on nurse-patient allocation, was conducted from September 2004 until May 2005, in a Scottish inpatient hospice.

Participant observation was carried out by an experienced, registered palliative care nurse (working as a supernumerary member of the team), who became familiar with ward practices prior to data collection in order to minimise researcher impact and allow unobtrusive observational data collection.[37-41] According to Gold's [42] classic taxonomy, the researcher adopted the role of participant-as-observer.

Using a mixed methods approach, where qualitative and quantitative data were collected using a concurrent-identical sampling design[34,] allowed a more robust exploration of psychosocial support. Strong conceptual consistency[34] was gained by using quantitative data and analyses to objectively define and strengthen qualitative findings.

Ethics

Ethical approval was given by the Local Research Ethics Committee (04/S0604/14), and the Research & Development Office. Data presented in this paper are anonymised, and pseudonyms applied, to preserve confidentiality.

Nurse participants knew the researcher prior to the study as a member of the hospice's education team, and were involved in discussions around the design of the study. Information sheets were distributed to all registered and auxiliary nurses working on the ward and 38 (88%) completed written consent forms.

The researcher discussed the study with all patients. Patients who were cognitively intact, and not considered to be in the last few days of life, were given information sheets outlining the research, encouraged to discuss these with their significant others and given a minimum of 24 hours to consider whether to participate. 47 patients (67.5% of those eligible) gave written consent.

Verbal verification of continued consent was sought at each phase of the study. The researcher wore a different uniform from other ward staff as a reminder of her PO role. In line with her nursing [43] code of practice, if a patient required assistance of a nurse, the researcher provided this if no other nurse was available: patients consistently received the same care as any other nurse on the ward would provide. Patients were informed if an interaction was recorded for research purposes, and given the opportunity to withdraw consent; this offer was never accepted.

Sampling and Data collection

Nurses were observed at various times throughout their day duty on the ward. Observations of nurses with different roles, caring for patients with different characteristics, occurred at different times (see table 1). Observed incidents constituted a large convenience sample, but with a high degree of variety.[37-38,41]

Nurses were selected from the duty rota. The selection of a nurse was determined by their availability for interview, in order to minimise recall bias. The researcher assisted the nurse with patient care. If a consenting patient expressed a psychosocial need, as defined by Thomas *et al*,[10] they became part of the study sample.

Table 1: Participant Characteristics

Patient Characteristics (n=47):		Nurse Characteristics (*n=38*):	
Age	Range: 38-91 years Mean: 65.1 years	Age	Range: 22-59 years Mean: 44.47 years
Sex	Male: 19 (40.4%) Female: 28 (59.6%)	Sex	Male: 0 (0%) Female: 38 (100%)
Average days spent in hospice at time of observation	Range: 1-221 days Mean: 31.7 days	Role	Registered General Nurse: 23 (60.5%) Auxiliary Nurse: 15 (39.5%)
Care aim	Assessment: 5 (10.6%) Rehabilitation: 2 (4.3%) Respite: 9 (19.1%) Symptom Control: 20 (42.6%) Terminal Care: 11 (23.4%)	Education in psychosocial care	None: 5 (13.2%) Study day: 5 (13.2%) Short course: 11 (28.9%) Module: 17 (44.7%)
Diagnosis	Cancer: 39 (83%) Neurological: 8 (17%)	Years of palliative care experience	Range: 0.5-19 years Mean: 8.7

At each appropriate opportunity, observations were recorded digitally, and immediately following completion of these episodes of care the researcher withdrew from the ward to transcribe the data. Subsequent semi-structured interviews of patients and nurses were based on the corresponding observations, and incorporated issues arising from ongoing data analysis.[44-47]

Patients were invited to describe their experience of the nurse's response, while nurses were asked to describe their understanding of what happened, and explain any constraints and influencing factors. Documentation and meetings data illustrated nurses'

perceptions of the support provided. Demographics and organisational records permitted the exploration of possibly associated variables.

Data collection stopped once the data and analyses produced rigorous findings.

Analysis

The following expressions are used as technical terms:

'Episode of care' – a clinically defined period of time when a consenting nurse worked with a consenting patient to provide a specific aspect of care.

'Case' – all data relevant to one episode of care: observation notes, interview transcripts, copies of clinical documents, records of meetings.

'Encounter' – one nurse's response to one psychosocial need expressed by one patient. Typically, there would be several encounters in each episode.

Descriptive analysis [47] was used from the beginning of data collection, with each case being entered into an NVivo electronic qualitative analysis software project. Cases were analysed to identify key concepts which were compared to generate propositions. For example, whether familiarity was a necessary condition for the provision of psychosocial support was explored by determining how the nurse responded to the patient's psychosocial need (dependent variable, 'response') and whether the nurse was familiar with the patient concerned (independent variable, 'familiarity'). 'Familiarity' was defined as whether the nurse had worked with the patient before.

Following the completion of data collection, variables were entered into an SPSS project and Chi^2 tested in order to determine whether variables, such as the nurses' experience or working hours, had an association with 'response' and to allow statistical verification of the qualitative findings, for example comparing familiarity to response.

Findings

Patients expressed psychosocial needs in 25 of the observed episodes of care (which lasted on average 90 minutes); 227 encounters were identified. Nurses were identified as immediately responding in one of four ways: attempting to deal with the need at the time ('dealing'); postponing dealing with the need ('deferring'); responding to another need ('diverting'); or failing to acknowledge a need

had been expressed ('ducking'). For the purposes of this paper, the dependent variable 'response' was treated as dichotomous, its values being 'dealing' and 'not dealing'. 104 (45.8%) of the encounters were classified as 'dealing'; the remaining 123 were classified as 'not dealing'.

Consistent with the literature, 37 of the 38 participating nurses claimed that their response to a patient's psychosocial needs was contingent on whether they were familiar with the patient. Familiarity was reported as facilitating psychosocial support, its absence as hindering.

However, the data showed that familiarity was neither a necessary nor a sufficient condition of a 'dealing' response. Responses to the 206 encounters in which level of familiarity (determined from the duty rota and daily patient allocation sheet) was known are shown in table 2 (χ^2=0.001, df=1, p=0.982). The likelihood of 'dealing' appears the same whether the nurses were familiar with the patients or not.

Table 2: Cross-tabulation of Dealing, or not, against Familiarity

Had the nurse worked with the patient before?	Dealt with the need at the time	Did not deal with the need at that time	total
Yes	76	82	158
No	23	25	48
total	99	107	206

The 'familiar' nurses dealt with the need 48% of the time (95% confidence interval: 40–56), and this figure (48%) was exactly the same for the 'unfamiliar' nurses (95% confidence interval: 33–63). The relative risk of dealing with the patient's need, conditional on familiarity, is therefore 1.007 (95% confidence interval: 0.528–1.923).

The analysis is complicated by the fact that several encounters comprised identical nurse/patient pairs, with nurses participating in a median of 5 encounters (range:

1–17) and patients in a median of 3 (range: 1–15). The analysis was repeated with a separate SPSS file containing only one randomly selected example of each nurse/patient pairing. Similar results to those in Table 2 were obtained ($\chi 2 = 0.022$, df = 1, p = 0.881), confirming the lack of association between familiarity and the 'dealing' response.

Importance of familiarity

Nurses accounted for the 'dealing' response by claiming that it was possible, or easier, if they already knew, or had a relationship with, the patient.

"I find it really difficult talking about these issues [dying], but it's easier now because I know him." Alexa (registered nurse)

"If you've washed them a couple of times you tend to know. Looking at their eyes, you know they're wanting to speak." Celia (auxiliary nurse)

Equally, nurses explained that it was difficult, or impossible, to deal with patients' psychosocial needs (PPNs) if they were not familiar with them:

"Normally ... I'm just trying to build up a rapport, initially, with that individual patient, because sometimes if it's someone you haven't worked with before they're very reluctant to go into anything in-depth because they don't know you as well." Evie (registered nurse)

"Flora [a patient] was quite blasé about it [her first attempt at discussing her hastening death] and I wasn't sure if she was a bit tongue in check, although I'm sure there was a lot in it ... but again that's when you don't know if that's their personality. Whereas, when you get to know them you know, maybe, that some of them will joke about dying ... although they are serious, they are laughing about it ..." Millie (registered nurse)

Although this was the account offered by nurses during interviews, the observational data did not confirm it. Familiarity was not a sufficient condition of 'dealing'.

For example, even when the nurse was familiar with a patient, she might still *fail* to deal with the PPNs. One patient, Stuart, had only recently been diagnosed with his condition. He was struggling to come to terms with his illness, and had made it clear that one of his

coping mechanisms was not to discuss his illness. Camille, a registered nurse, had looked after Stuart on many occasions before I observed them together. She felt she knew Stuart well and was aware of his wishes:

> "Doctors had spoken to his family yesterday ... but they said they're "not discussing it [his condition], because Stuart doesn't want to discuss it".' Camille (registered nurse)

However, while we were washing Stuart, two other members of staff – who were not ward nurses but had been asked to assess Stuart's understanding of his illness – came into the room:

> Halfway through bed-bathing Stuart, two other members of staff came into the room. As they came in, Camille stepped back from the bed into the corner of the room; she stayed there throughout their conversation. One of them asked some poignant questions about how much Stuart knew about his illness and tried to talk about what might happen to him. Stuart said: "But that's in the future and I'm not ready to talk about that yet." At which point the staff member looked across at Camille [as if to offer her the chance to participate in the conversation]. Camille said and did nothing. (Observation notes).

If the claim that familiarity prompts nurses to deal with PPNs, then Camille's familiarity with Stuart should have encouraged her to advocate for him by informing the other staff members that Stuart had expressed the wish not to discuss his illness. Instead, she 'ducked'.

Familiarity as a barrier to psychosocial support

It would appear, then, that familiarity does not guarantee that nurses deal with PPNs. It does not appear to be a *sufficient condition* of the 'dealing' response. Indeed, familiarity can actually inhibit the 'dealing' response.

Being overly familiar with patient preferences can be instrumental in a nurse 'blocking' PPNs. When nurses know a patient well, they learn how the patient prefers to do things, which can result in nurses doing things for patients without asking them. This *can* be helpful, but the nurses' assumptions can hinder psychosocial support.

This happened when Beatrice, a registered nurse, was helping Ralph out of bed. Ralph had been admitted for assessment of his mobility because his condition had deteriorated. Because this was Ralph's fifth admission to the ward, the nurses were familiar with how he normally transferred from bed to wheelchair. However, it was unknown whether he would be able to transfer in his usual way, and assessing this was important:

> Beatrice asked Ralph how he "liked to do things". As she was asking, she lifted up the banana board [a mobility aid] towards him and he said, "Oh, here we go again! People always do this before I tell them." His condition has changed since his previous admission. His deterioration in mobility is one of the main reasons for admission, and a main aim of his care is to assess, and, if possible, rehabilitate this. Ralph guided us in how he wanted to move, and managed

with no more assistance than on his previous admission. Once he was up in the wheelchair he asked for his foot-rests. Beatrice tried to put these on for him. I could see Ralph was not only trying to do this himself, but that it would be easier that he did this and Beatrice lifted his legs, as he was requesting. (Observation notes)

Beatrice's familiarity with Ralph resulted in her automatic insertion of the banana board and wheelchair foot-rests. On previous occasions this would have made Ralph's transfer faster. However, on this occasion, it prevented Ralph from discovering whether he could transfer independently:

"I wanted to ask you about when Beatrice was getting you up the other day and I was wondering about ... how we work with patients' independence." Hazel

"One of the reasons for my admission was to find out how independent I am still, because of the changes in my balance, and ... obviously there's been a deterioration in my condition. So, one of the reasons for the admission this time was ... for assessment ... to find my balance, to know where the limits are ... and what I can and can't do." Ralph

Beatrice did not meet Ralph's psychosocial need for independence and for an understanding of his changing condition. Familiarity can lead the nurse to make unwarranted assumptions, failing to recognise the patient's changing needs, thereby blocking rather than facilitating psychosocial support.

Psychosocial support without familiarity

In contrast, nurses might have *no* familiarity with a patient, but still deal immediately with psychosocial needs. Consequently, familiarity is not a *necessary condition* of the 'dealing' response.

This was most strongly evidenced when nurses had no knowledge of the patient. They were often observed dealing with PPNs when working with a patient for the first time, having received little information about that patient.

For example, after receiving only cursory information at handover, Chrissie, a registered nurse, explained her desire to work with Helen:

> "I spent a lot of time with Helen yesterday [while admitting her to the ward; Helen's first contact with the Hospice] discussing her difficulties with her families, how difficult it was to cope with her increasing dependence, and her fears of dying. I want to see if she wishes to continue discussing these today." Chrissie

Helen had told Chrissie: 'it was so good to be able to share things that she had been keeping closed in for a long time.' Chrissie said more about this conversation during her interview:

"I never asked her any questions about her admission; it was really all about the reasons why she came in, her anxieties, and her fears for other peoples' futures. It's almost as if she's been ready to talk. I think it would have happened anyway, but yesterday she was talking [about] her son, and things like that, I actually can really empathise with her and I was actually able to share that with her. You could see her opening up and becoming so comfortable with telling me that." Chrissie

Helen's openness with Chrissie could not have been due to familiarity, as her concerns were being voiced for the first time, and Chrissie and Helen had never met before. This suggests that nurses can enable patients to express psychosocial needs in the absence of familiarity, and that these needs can be immediately dealt with.

The question arises as to what nurses do to facilitate this openness.

In the encounters in which the nurse had no previous contact with the patient, but dealt with the PPNs nevertheless, inter-personal skills were used to encourage the patient to express their needs openly. Sybil, an auxiliary nurse, did this by asking patients about themselves:

"They'll tell you about the characters in their family, they'll give you a wee smile ... there's something funny about that, or maybe a quirk about that person. I think it helps me as a nurse to get to know the patient. It puts you at your ease with the person, and if you're comfortable, it makes it more comfortable for the patient, I think. If you feel awkward with them, well, they're not going to feel comfortable with you." Sybil

Sybil had stated that she 'needed to be familiar with a patient in order to provide psychosocial support'; however, she was observed dealing with PPNs, regardless of whether she had worked with the patient concerned before. What Sybil did, on her first contact with patients, was ask them about themselves and their lives, thereby forming an interpersonal connection.

Similarly, it was suggested by some nurses that they could feel familiar enough with the patient to provide psychosocial support from information gained from colleagues or documentation.

> "When I know that people have had significant conversations with other people, that I'm maybe not the first person to explore something quite sad or upsetting with them ... I've heard that's the way they cope, and that's their way of communicating. I feel comfortable then to go in; it's less risky for me."
> Annie (registered nurse)

In this statement, Annie suggests that, because she has heard from colleagues that patients are willing to discuss emotionally painful issues, she is more likely to respond to their psychosocial needs.

The impact of nurses' attributes on their immediate response to psychosocial needs

It is tempting to assume that nurses' individual attributes enable them to provide immediate psychosocial support, that an immediate 'dealing' response is mediated by experience, education, or something of that sort. However, this was not found to be the case.

Statistical analyses suggest that variations in nurses' responses were rarely associated with individual characteristics. For example, neither palliative care experience (table 3, χ^2=2.079, df=3, p=0.556), nurses' education (table 4, χ^2 =5.312, df=3, p=0.15), nor whether the nurse was working in the team to which she is normally allocated (table 4, χ^2=5.482, df=3, p=0.14), appeared to have any association with whether psychosocial needs were immediately dealt with or not.

Table 3: Cross-tabulation of dealing, or not, against total palliative care experience

	Total Palliative Care Experience (years)					Total
Combination of responses to dealing or not	<4	4-7	7-10	10-17	17-19	
Not dealing	16	21	26	21	18	102
Dealing	22	13	19	20	16	90
Total	38	34	45	41	34	192

Table 4: Dealing or not dealing: Encounters by extent of psychosocial education and whether the nurse was working in their "own" team

	Extent of Psychosocial Education					Nurses' Role Within Team				
Combination of responses to dealing or not	None	Study Day	Short Course	Module	Total	Bank	Other Team	Own Team	In Charge	Total
Not dealing	4	7	22	70	103	13	3	49	55	120
Dealing	9	7	28	51	95	5	3	56	39	103
Total	13	14	50	121	198	18	6	105	94	223

Some individual factors did appear to affect the nurse's response to PPNs. One was the number of shifts worked per week (table 5, χ^2=11.568, df=1, p=0.001). Nurses working a larger number of shifts were more likely to 'deal'. Another was the nurses' qualification (table 6, χ^2=6.069, df=1, p=0.014). Surprisingly, perhaps, auxiliary nurses were more likely to 'deal' than registered nurses.

Table 5: Cross-tabulation of dealing, or not, against shifts contracted to work per week

Combination of responses to dealing or not	Shifts Contracted to Work per Week		
	3 or less	3.5 - 5	Total
Not dealing	78	42	120
Dealing	44	60	104
Total	122	102	224

Table 6: Cross-tabulation of dealing, or not, against the role of the nurse

Combination of responses to dealing or not	Role of Nurse		
	RGN	Auxiliary	Total
Not dealing	96	24	120
Dealing	68	36	104
Total	164	60	224

Discussion

These data challenge the suggestion that familiarity with patients is either a necessary or sufficient condition for providing psychosocial support. Nurses *dealt* with the psychosocial needs of patients with whom they were *not* familiar, and *failed to deal* with the needs of patients with whom they *were* familiar. Nevertheless, the nurses continued to cite familiarity (or lack of it) as the reason for their response. Arguably, the idea that 'familiarity' is a basis for the provision of psychosocial support is a myth. The rhetoric about the importance of building a relationship with a patient [14-22] in order to provide psychosocial support could be abandoned. Psychosocial support has been observed to be an integral component of clinical care in areas where relationship building and attaining familiarity are not possible,[29] and additional observational research has shown that relationships are not central to the provision of nursing care.[16]

Previous studies [14-15,19-21] suggest that clinicians use interpersonal skills, such as making themselves available to patients and communicating openly about patient's priorities, to create familiarity and build professional-patient relationships. In this study, nurses reported using interpersonal skills to acquire familiarity; however, the observational data shows that the relationship-building stage can be bypassed. Being attentive to patients when psychosocial needs are expressed enables provision of immediate psychosocial support.[7,14]

Despite general agreement that psychosocial support should be an intrinsic component of the care offered by all practitioners [12], there is little empirical research into how this happens. Using observational data permitted an analysis of how nurses actually respond to PPNs, providing a more reliable and robust alternative to understanding the provision of psychosocial support than the more common strategy of eliciting of individuals' perceptions.[16]

Limitations

Participant observation by one researcher points to a significant limitation of this study. It was only possible to accurately record nurses' *immediate* responses to PPNs. It is unknown whether needs not dealt with were followed up later. It was impractical to observe night shifts as it would have been difficult to complete interviews at a suitable time following the episode of care.

Researcher bias is a particularly high risk in observational studies. However, various steps were taken to minimise this risk, including: combining qualitative and quantitative data to substantiate the findings; using interviews to verify what had been observed; spending time working as a nurse on the ward during the 10 month preparatory period; and sharing observational data with participants.

This is a study of one hospice, and the findings are therefore not generalisable to other specialist palliative care institutions (or to healthcare in general). Indeed, they are not definitive, even in the context of this one hospice, since the sample is relatively small, and the confidence intervals associated with Table 2 are quite wide. However, while the data do not establish the claim that familiarity is neither a necessary nor a sufficient condition for psychosocial support, they are certainly consistent with it, and this consistency suggests that further exploration of the relationship, if any, between familiarity and psychosocial support would be worthwhile.

Implications

The study gives an insight into the reality of how psychosocial support is put into practice – a reality which is at odds with what has previously been self-reported by both providers and recipients of care – and has identified factors which are associated with the provision of psychosocial support. It suggests that health practitioners should be suspicious of the claim that they need to develop a relationship with clients in order to provide psychosocial support.

Moreover, the study demonstrates that practitioners' individual characteristics are not associated with their response to PPNs, and although there is a suggestion that the amount of time spent with a patient may be associated with response, analyses of the

organisational findings (reported elsewhere) show this is not the case. Future studies could build on the data presented here by determining whether unmet needs are followed up subsequently, observing overnight care, and comparing different clinical areas. The awareness that familiarity does not necessarily facilitate psychosocial support could be used, in education and clinical supervision, to encourage practitioners in the belief that they can provide psychosocial support as and when the patient desires it.

Conclusion

The majority of nurses in this study believe that being familiar with a patient enables them to provide psychosocial support. However, it has been shown that psychosocial support can be provided on a patient's first contact with a clinician, and does not rely on building a relationship. The finding that 'familiarity' is not, in this sample, associated with the provision of psychosocial support – but other factors are – is a contribution to the building of this model, which can be used as a basis for future studies on psychosocial support. This paper demonstrates that high quality psychosocial care can be provided, even in the short timeframe that is sometimes available to palliative care clinicians.

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Declaration of conflicting interests

The authors declare that there is no conflict of interest.

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