

# Nurses' feelings of 'ownership' of palliative care patients: findings from a qualitative case study

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**Background:** Partnership working between nurses and other health care professionals is encouraged, as is the building of professional relationships with patients and carers. It is suggested these relationships may give nurses control and a sense of ownership of patients; this may affect otherwise valued aspects of teamwork. Issues of ownership were explored in a study of referrals within community palliative care services.

**Subjects and Methods:** Influences on referrals were studied within three primary care organisations using a qualitative case study strategy (incorporating interviews, observations and documentary analysis). Framework analysis techniques were used to facilitate within case analysis and cross case pattern matching.

**Results:** Forty-seven interviews were conducted with a range of generalist and specialist palliative care professionals (nurses, doctors, allied health professionals), and 10 interviews with patients. Nurses in particular discussed concepts of ownership of patients. This had positive and negative effects: restricting access to a range of services, but promoting personal continuity of care. Doctors described responsibilities towards patients, which could complicate teamwork with competing feelings of responsibility and ownership from different team members.

**Discussion:** Issues of ownership had an impact on the way nurses conducted their work, motivated by desires to both provide personal continuity to patients and to use knowledge about patients to enhance functional authority within the team. Understanding how these issues impact on care provision is essential when working towards best quality care.

**Keywords:** palliative care, ownership, primary care, nursing, referrals, teamwork

## Introduction

Nurses and other healthcare professionals work in

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particular ways to provide palliative care to patients. For example, the concept of team is central to most people's understanding of what it means to provide palliative care, and is a core component of many definitions of palliative care.<sup>1-3</sup> Partnership working between professionals is promoted as a valuable way of achieving effective multi-agency and multi-disciplinary team working.<sup>4,5</sup> There is a clear

assumption that interdisciplinary collaboration will bring about more efficient and effective work and consequently that patients will receive better care.<sup>6</sup>

Alongside the centrality of the team concept in palliative care, building an individual professional relationship with patients and families is also perceived as important by patients,<sup>7-9</sup> nurses<sup>10-14</sup> and doctors.<sup>15</sup> Relationship building has been suggested as an essential antecedent of high-quality palliative care, facilitating communication and holistic competent care.<sup>10,16-18</sup> Such relationship building appears particularly important to nurses,<sup>19</sup> who emphasise participating in patient's everyday lives, and reflect on the value of being 'let into someone else's life'.<sup>20</sup> Nurses discuss how such relationships give them freedom to nurse in the ways they want, and control over who could care for 'their' patients, possibly in direct competition to the teamwork concepts many claim to adopt.<sup>20</sup>

Concepts of team and relationship building in palliative care may be related to concepts of ownership.<sup>21</sup> Ownership is under-researched, yet could be important in understanding the way professionals work: potentially conferring advantages to caring professionals, or affecting patient referrals and access to services. Issues of ownership were clearly articulated in a recent study of palliative care provision, and will be explored in more depth to identify its effect on the way that nurses care for palliative care patients.

## Subjects and Methods

### *Research approach*

These data are drawn from a study of referrals within community palliative care services. The methods and overall findings of this study are reported elsewhere.<sup>22-24</sup> Briefly, a qualitative case study strategy was used to explore the influences on referral decisions made by healthcare professionals providing community general and specialist palliative care services. The case was defined as 'those services providing community general and specialist palliative care to patients registered or residing within a specified Primary Care Trust'. Three Primary Care Trusts in North West England participated. Trusts were chosen against a range of criteria such as size, demography, and palliative care provision. Whilst several data sources (interviews with patients and professionals, documentary analysis, observation) were utilised to capture the complex, context dependent process of referrals,<sup>25,26</sup> this paper mainly reports interview data relating to discussions regarding concepts of ownership of patients. It does

not report non-interview data as these did not contribute to the findings in this area.

### *Participants*

Generalist and specialist community-based palliative care professionals were invited to participate. Some participants were purposefully invited because they were identified as knowledgeable informants about palliative care during early visits to sites, but most were arbitrarily selected from staff lists of relevant professionals working in the area. Participants were asked to suggest other potential informants and to identify palliative care patients who could participate. Letters of invitation were sent to selected professionals and patients, with non-responders followed up by letter and telephone by the first author (CW).

### *Data collection*

Interviews were open and conversational in style, with a topic guide prepared for each interview, iteratively generated from previous interviews. Interviews lasted between 50 and 90 minutes and were tape-recorded and fully transcribed. Data were collected over 20 months, in 2003–2005.

Research ethics approval was obtained from three local research ethics committees and the University of Manchester ethics committee. Research governance approval was also obtained from the Primary Care Trusts, and other organisations, such as hospices, employing participants. Participants gave written consent to their participation.

### *Data analysis*

Framework analysis techniques were used to analyse the data within the cases, and to facilitate cross case pattern matching.<sup>27</sup> Following familiarisation with the data, an initial thematic framework was developed, which developed iteratively during analysis. Data for each case study were then arrayed in thematic charts, and similarities and differences between and across cases examined. Multiple techniques were used to enhance the rigour of the study, including the use of multiple sources of evidence, supervision including independent analysis of data, peer debriefing using a research advisory group (consisting of the authors, a GP, district nurse, specialist palliative care nurse, and academics with subject expertise), and the use of ample data extracts to support developing themes.<sup>26</sup>

## Results

Forty-seven interviews with healthcare professionals

were conducted, including 14 with generalist community (district) nurses and 10 with specialist community palliative care nurses. Ten interviews with patients were conducted. This paper primarily draws from analysis of the 24 nurse interviews, although nursing issues are also contrasted with data from other professionals and patients. Nurses in particular discussed concepts of ownership, and demonstrated it through the use of possessive language when discussing patient care. This was linked to concepts of responsibility for and relationships with patients. Data are presented as verbatim quotations, with alphanumeric identifiers identifying the case study (A, B or C) and background (DN, district nurse; GP, general practitioner; P, patient; SN, specialist nurse; SD, specialist doctor) of the participant.

### Possessiveness

Nurses frequently used possessive pronouns in talk about patients and how this influences the way they provide care, but these were rarely used by doctors or allied health professionals (items in bold are to highlight ownership terms, not respondent's emphasis):

*We keep all **our** palliative care clients, if, if they've got a poor diagnosis. I don't, me and my team don't hand them on them on to a social service carers team, because we feel that is a nursing responsibility.* (C/DN2)

*What I tend to say to **my** patients is 'ring us first, and if we think that you need to be redirected to somebody else, then we will tell you or we will contact somebody else on your behalf, but give us a ring first.* (B/SN2)

Patients, however, never referred to nurses using possessive pronouns, although they did occasionally refer to doctors in this way:

*I don't know if they are going to liaise with **my** doctors [GP] or Macmillan [nurses], I don't know.* (B/P2)

Instead they used non-possessive pronouns when discussing their association with nurses:

*So basically that is it, I have got contact, on-going contact with **the** [district] nurse* (B/P5)

The use of these personal and possessive pronouns by nurses was often associated with a description of elements of ownership of patients – wanting to be the first point of contact, wanting to restrict access to the patient by others, and not wishing to refer to other

services. Many respondents recognised that such feelings of ownership and possession existed, and could act to restrict patient access to a wider range of services:

*Some of the nurses will say, 'my patient, my this, my that', and 'I don't like that service coming in, because I like to control', it's about control really, if you are looking at theories it's about power and control, about, you know, their piece of their patients.* (B/DN1)

There was also discussion about whether such a sense of ownership over patients was positive or negative, with mixed feelings about 'ownership':

*I suppose ownership can be a good thing. It can be a bad thing, can't it, some people might, some professionals might feel that well it's my patient and I know what I'm doing, and I don't need anybody else's advice. Whereby others, well, yes, this is my patient and I want to do the best and I'm not sure what I'm doing here, so I'm going to seek advice. So it could work either way.* (B/DN3)

*I think it's basically those that get quite attached and quite close, and I think you've got to learn to distance yourself from your professional to your personal ... if you just keep it on a one to one you've just got tunnel vision, but yeah, I still think people do, and they like that ownership, I don't, I like to share and give it away.* (A/SN2)

There is recognition of variability in the way nurses approached palliative care, with recognition of different ways of working either based on a sense of 'keeping' care to a few people, or 'sharing' care with a larger team. These issues could be viewed in either positive or negative ways. This sense of ownership and responsibility towards patients was engendered by early referral, and maintained by keeping contact with patients, and often restricting access by other professionals. Once ownership and responsibility had been established however, this then had an impact on ongoing care – with discharge of patients more unlikely because of fears that patients would be abandoned and not cared for by others:

*We as district nurses, I would just take them [palliative care patients] on and visit them, I would just keep contact with them really, I wouldn't abandon them at all.* (A/DN1)

*It's very difficult to discharge them [palliative care patients], because they have had contact with somebody, and there is nobody else apart from the GP that they have contact with.* (C/SN3)

The reluctance of professionals to 'let go' of patients may be linked to issues of trust and control, not only about patients developing trust with professionals, but also about professionals trusting others to care for 'their' patients, and not losing control of the care situation. There is a real tension here between ideas of 'ownership' of patients which promoted strong relationships between patients and professionals and promoted continuity of care, and the knowledge that some professionals were less expert and competent than others and so patients 'owned' by such staff could receive sub-optimal care.

#### *Relationship building*

Ownership of patients appeared for many to be intimately bound to the relationships which professionals form with palliative care patients. Many staff, but particularly nurses, appeared to deliberately seek to develop a relationship with patients and their families. Such relationship building appeared critical to the way they provided care, and was the focus of discussion relating to issues of timing of referrals, patterns of working and onward referrals, responsibilities towards patients, and care quality:

*If district nurses are involved from the beginning, you get to know them, so by the time the end comes you've got to know the family, you've got to know the all the little ins and outs of relationships, but when you just go in at the end stage and the families are all upset about it all, it's very difficult to form a relationship in the last few days or weeks of life. (A/DN4)*

Developing a trusting relationship was felt to be good for patient care, but also a source of job satisfaction for nurses:

*I mean it's lovely, isn't it, to go away, if you're a nurse, to deliver palliative care is what you're all about, isn't it, to make sure that that person's end of life is as comfortable and as smooth as possible, and you know the family, and you know the carers, and you, know ideally, from my point of view, I would like to deliver as much of that as our team can, and that's lovely. (B/DN2)*

It is argued that such 'knowing' and relationship building is valued by nurses, and is relevant to decision making as interventions are chosen so that the patient is treated as a unique individual.<sup>13</sup>

#### *Responsibility*

This sense of possession and ownership demonstrated by nurses is in contrast to the language used by most doctors (both general practitioners and specialist doctors) in the study. They used the language of

responsibility towards patients:

*The primary responsibility [for patients] is with the GP or consultant, in [this area] I never had somebody say I'm not doing that. (C/SD1)*

General practitioners also felt responsible for patients because of a sense of an on-going, enduring connection with families:

*It makes me feel very responsible ... so I feel I ought to be available even if I am only on the phone because I can't let people, I live continuity. It takes over my life. (A/GP2)*

However, the feeling of who can be responsible for patients, and how this affected referral and care decisions for that patient can be complex. It involved staff negotiating between those with different senses of ownership and responsibility to achieve what they felt to be best care for the patient:

*At the end of the day, we may have a bit of telephone dialogue with the GP, but at the end of the day they are taking responsibility for that patient, and it's not for me, unless the patient's life was at risk [laughs] and that's a very different banter ... we try not to get into the realm of arguing. (B/SD1)*

*If, they are at home it is usually the GP, yes as the co-ordinator, of course it goes out of our hands when they go back into hospital ... we're just part of the team, but I think that is our role, I think we've got to be very clear on that, and so our responsibility and duty to do that, you shouldn't get out of it, you can't get out of it, you wouldn't do the job if you, you wanted to do that. (C/GP6)*

*If I've looked after a patient for two years, and their care, and been very actively involved with them, I won't abandon them at that stage ... but again it's joint sharing the responsibility between the active nursing intervention, and me just hovering in the background offering psychological supportive care, but without taking away the role of the DN in that whole thing. (A/SN1)*

This highlights issues about the overlapping spheres of responsibility or territory which different professionals experienced, and concerns of overall responsibility for patients.

## **Discussion**

Nurses in this study appeared to have a sense of 'ownership' of many patients, with potential positive

and negative connotations. Nurses and other professionals felt a sense of responsibility toward patients, but it may be that this sense of ownership also occurs because to 'own' a patient confers some advantage to the nurses involved. There are two possible advantages, that the patient is intrinsically valuable (the 'object' value) or because there is ownership value.<sup>28</sup> Self evidently, nurses do not 'own' patients, so there is no 'object value'; therefore, the value to the nurses must lie in the sense of ownership engendered. Patients may be valuable because they are owned: the ownership offers privileged access, affects the owners concept of themselves, and can lead to the claiming of additional rights through ownership.<sup>28</sup> It may be that 'ownership' of a patient may give an advantage to a particular professional, for example, when decision making on behalf of patients or working with other professionals. Advantages of power and control were clearly highlighted by nurse participants, but this did not appear to be in the context of power or control over patients themselves, but of the care both they and others could give to patients.

Nurses may be working to gain power and control through patient ownership because of a commensurate lack of power and control they perceive in their work with others, primarily doctors. The classic model of the doctor–nurse relationship was first proposed by Stein in the late 1960s, and later modified as professional relationships changed and developed.<sup>29</sup> In this model, nurses exert influence by manipulating doctors, without challenging the fundamental asymmetry of the power relationship. In recent years, however, this hierarchical and structuralist model has been criticised for lacking subtlety and not being relevant to contemporary healthcare.<sup>30–32</sup> More recently, a negotiated order perspective<sup>33</sup> has been used to illuminate issues surrounding this relationship.<sup>30–32</sup> It is suggested that doctors may have technical and professional superiority, but that nurses use their superior social knowledge about patients to address the power relationships between the two professionals.<sup>32</sup> It has been argued that in home care situations formal authority belongs to the doctor, but functional authority to the nurse by virtue of their relationship with the patient.<sup>34</sup> It may be that nurses develop this sense of ownership over patients through their relationship building work in order to equalise the power imbalances they perceive in their team relationships with others.

Such a sense of ownership and responsibility for patients may have a positive impact on continuity of care. Palliative care policies frequently recommend the identification of a 'key worker' or 'lead clinician' to

co-ordinate patient care.<sup>4</sup> Whilst other research in this area has not explicitly identified the sense of ownership explored here, it does recognize that district nurses invariably identify themselves as key workers,<sup>35–38</sup> although there is rarely a single person designated to take overall responsibility for care.<sup>37,39</sup> It may be that nurses are seizing this role informally to both increase the 'functional authority' that they have within the team and to ensure care co-ordination and continuity. This may have benefits to patients as they value interpersonal continuity because it gives a sense of security, based on feelings of coherence, confidence in care, a trusting relationship and accessibility.<sup>40</sup> There may be potential for conflict though, as general practitioners also identify a sense of responsibility towards palliative care patients, citing this as one of the reasons they want to practice palliative care,<sup>41</sup> and that their role allows them to bring personal continuity to patients' care.<sup>42</sup>

## Conclusions

Ownership was acknowledged as an important concept by healthcare professionals, and appeared to have an effect on when and whether professionals referred patients onto other services. Professionals described possessive behaviour towards the patients they had a sense of ownership about, either because of their feelings of responsibility towards the patient or the relationship they felt they had with the patient. This 'territorial behaviour' had an impact on the way they conducted their work with others, but appeared motivated by desires to promote personal continuity with patients, and provide individual levels of high quality care. Such feelings of ownership could have major effects on the way professionals work with patients. Whilst positive effects are reported (such as the benefits of personal continuity), other negative effects (such as restricting access to professional care, which could benefit the patient) are also uncovered.

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