Research Report

Nurses' Challenges to Developing Interpersonal Relationships During Integrated Care for Complex Patients

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Abstract

Background: Individuals with multimorbidity and complexity have multifaceted care needs requiring integrated and collaborative care from nurses, families, and health care teams. Nurses, as the frontline care professionals, should develop therapeutic relationships with patients and their families and professional relationships with health care team members to ensure the delivery of effective integrated care. Failure to develop effective interpersonal and professional relationships can negatively affect patient care.

Objective: The purpose of this study was to explore nurses' challenges with developing interpersonal and professional relationships during integrated care for individuals with multimorbidity and complexity.

Methods: A descriptive qualitative design was used. We interviewed a purposive sample of 19 nurses with experience of caring for individuals with multimorbidity and complexity across two hospitals in Pakistan. Semi-structured interviews were used for data collection, and data were analyzed using reflexive thematic analysis.

Results: Two challenges were identified affecting the relationships between patients' families and nurses, and two challenges influencing the professional relationships within the team. Families withheld information, controlled care access of their relatives, posed unrealistic demands, and abused nurses, affecting nurse-family relationships. Power struggles to demonstrate authority in decision-making were common within health care teams, affecting nurses' professional capacity to provide effective care.

Conclusions: Health care team, patient, and family collaboration is instrumental in improved care for individuals with multimorbidity and complexity. Nurse leaders and health care organizations should take initiatives to address nurses' interpersonal confrontations to support them in the provision of quality care.

Keywords

interpersonal relationship, complex patients, multimorbidity, integrated care, person-centered care

Individuals with multimorbidity and complexity (i.e., complex patients) have multifaceted and emerging complex care needs requiring integrated patient care.[1-3] These individuals often live with multimorbidity (ie, two or more chronic conditions) and/or mental health issues, limited education, low socioeconomic status, and/or polypharmacy.[4] Integrated patient care is defined as "patient care that is coordinated across professionals, facilities, and support systems; continuous over time and between visits; tailored to the patients' needs and preferences; and based on shared responsibility between patient and caregivers for optimizing health."[5(p113)] Person-centeredness is the core dimension of integrated care,[6] and nurses, patients and their families, and health care teams are the key partners in integrated patient care, among others.[5,7] Previous research focused on family involvement in primary care and health care professionals' views about interdisciplinary team work for the provision of care.[8-11] However, no studies focused on understanding nurses' challenges encountered in building interpersonal and professional challenges when individuals with multimorbidity or complexity are readmitted to acute care with deteriorating symptoms and health conditions. Therefore, this study addressed this research gap.

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Importance of Therapeutic Relationships in Integrated Care of Complex Patients

Nurses need to develop therapeutic interpersonal relationships with their patients and patients' families, as well as professional relationships within the health care team to ensure the delivery of integrated patient care.[12] Failure to develop effective interpersonal and professional team relationships can negatively affect the delivery of integrated patient care to this marginalized patient population.[13] A recent qualitative review of 11 studies highlighted the need for nurses to develop therapeutic interpersonal relationships with individuals with multimorbidity and complexity and their families, as well as to develop improved collaboration within interprofessional teams.[14] Recent qualitative and mixed-methods studies of individuals with multimorbidity and complexity also reported that these patients expect nurses to be more cognizant of their living situations and social care needs and develop therapeutic interpersonal relationships to enhance the delivery of integrated and compassionate care.[2,15,16] Families of individuals with multimorbidity and complexity and health care teams are important partners in the delivery of person-centered integrated care.[17,18] Scoping reviews have highlighted that enhanced collaboration among health care professionals and families of patients is crucial for the delivery of integrated care.[19,20]

Research Gap in Nurse Challenges to the Delivery of Integrated Care

While the importance of interpersonal relationships with patients and families and professional relationships with the health care team is emphasized, no study has explored nurses' challenges of developing therapeutic interpersonal relationships with families of individuals with multimorbidity and complexity and maintaining professional relationships within health care teams. Previous studies explored the challenges of family involvement in primary care for older adults[8,9] and nurses' and physicians' views on interdisciplinary work in integrated care in primary and community care settings.[10,11] However, these studies do not provide any insights into challenges encountered in building interpersonal and professional relationships when individuals with multimorbidity or complexity are readmitted to acute care with deteriorating symptoms and health conditions. There is also a dearth of literature about South Asian nurses and their challenges of caring for individuals with multimorbidity and complexity. Understanding nurses' challenges in developing such relationships is a precursor to designing and establishing approaches for better collaboration between nurses with patients, their families, and the rest of the health care team to deliver effective integrated care.

Objective

The purpose of this study was to explore nurses' challenges about developing interpersonal and professional relationships during integrated care for individuals with multimorbidity and complexity.

Methods

Design

A qualitative descriptive design was used to explore the phenomenon in a naturalistic setting,[21,22] with a greater emphasis on understanding the subjective views of participants in actual practice and offering a rich account of a particular phenomenon.[23] The study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research checklist (Supplementary Material).

Study Context

The Pakistani health care system includes public and private hospitals. The health care system is progressing, with hospitals and community health care centers striving to meet the increasing demands of individuals with chronic illnesses working within limitations. There are inadequate health care resources in public hospitals compared to private hospitals. Patients desiring high-quality care choose private hospitals but require health insurance.[24] Therefore, lower- and middle-income families mostly visit public hospitals and pay their health expenses from their own pockets.[25,26] Families, particularly men in the family, are more involved in the decision-making process pertaining to familial, sociocultural, and health care issues and in care of individuals with chronic illnesses.[26,27]

Setting and Sample

The population consisted of nurses working in the inpatient and outpatient units of 2 public hospitals in Islamabad, Pakistan. An estimated 25 to 30 complex patients visit outpatient units daily, and about 5 to 10 are readmitted for care and symptom management. Using purposive sampling, 19 nurses were recruited based on the inclusion criteria: Nurses older than 18 years, nurses with a degree or diploma, and nurses with at least 6 months of clinical experience working with complex patients.

Data Collection

Participants were recruited through advertisement and flyers posted at designated places in the hospitals. Data were collected using virtual semi-structured interviews via Zoom from October 2020 until January 2021. Two male researchers, one doctorally prepared (A.Y.) and one doctoral nursing

student (S.I.), with prior experience with qualitative research conducted the interviews. Virtual interviews were conducted because of the severe acute respiratory syndrome coronavirus 2 pandemic. The interview questions explored nurses' definitions of complex patients, their experiences of working with complex patients, approaches to care for them, and perspectives on challenges to provide patient-centered as well as integrated care. The interviews were conducted in English and Urdu to capture the experiences of participants in their native language.[28] The interviews lasted for 22 to 61 minutes. Data saturation was reached after 17 interviews as no new topics emerged. However, 2 additional interviews were conducted before ending data collection to corroborate findings.

Data Analysis

The interviews were transcribed verbatim and entered into MAXQDA Plus 2020 for analysis. Six-step reflective thematic analysis using the constructionist lens (ie, assuming that data can allow for understanding social discourses and meanings) was used for analysis.[29] First, two researchers (A.Y. and S.I.) read the transcripts several times to develop a broad understanding of nurses' experiences, and then the data were broken down into segments within and across transcripts before undertaking coding. Second, inductive codes that are data-driven were developed and compared across cases (ie, code comparison feature in MAXQDA) to examine the number, frequency, volume, and essence in relation to the study purpose. Third, various codes similar in meanings and essence were collated, clustered, and refined into sub-themes. Fourth, the sub-themes were refined and collated into final themes based on their significance, content, and meanings. At this step, thematic maps were developed to identify linkages among sub-themes and theme. Fifth, the final themes were named to capture the abstract meaning. At the final step, the theme description was developed, and themes were written with supporting quotes.[30]

Rigor and Trustworthiness

The methodological bricolage metaphor was used to establish rigor.[31] The bricolage approach involves applying analytical moves to understand the phenomenon through a flexible use of relevant data collection, analysis, and interpretation methods. This approach enhances trustworthiness by cobbling together multiple methodological decisions and choosing a combination of analytical moves. Our analytical moves included (1) collaborative data analysis by 2 researchers, (2) keeping reflexive journals during data analysis and interpretation, (3) developing themes that are data-driven and grounded in participants' responses, (4) use of MAXQDA for keeping an audit trail, (5) member checking with 11 participants for verification of verbatim transcripts, and (6) using a framework for the thick description of findings and methods.[32] These strategies contributed to the credibility, transferability, confirmability, and dependability of study findings.[33]

Ethical Considerations

Ethical approval was obtained from the Ethics Committee of Al Nafees Medical College, Isra University (approval number: F, 2/IUIC-ANMC/EC-233/2020). Written informed consent was obtained from all the nurses. Participants were assured of the confidentiality of information and non-disclosure of identity. The data were encrypted and kept in password-protected encrypted computers.

Results

We interviewed 19 nurses of whom 11 were men, with an age range of 25 to 38 years. The clinical experience of working with complex patients ranged from 2 to 14 years. These nurses worked in a range of inpatient and outpatient settings such as general medical and surgical units, cardiac, critical care, emergency, higher dependency, and transplant units. Sixteen nurses had a bachelor's degree in nursing. Two nurses had a master's degree, and one nurse had a 3-year nursing diploma. All the nurses also had experience collaborating on interdisciplinary teams working with complex patients. Demographic information is presented in Table 1.

Themes

We identified 4 themes. The first 2 themes captured the challenges of nurses developing therapeutic relationships with the patients' families during the delivery of person-centered integrated care. The remaining 2 themes pertained to the professional challenges of working within integrated care teams. The themes are described as follows and illustrated with subthemes in Figure 1.

Families' Deliberate Withholding of Information and Controlling Care Access

Nurses discussed that most complex patients presented are readmitted to acute care settings with deteriorating symptoms. Therefore, being aware of the factors that led to the deterioration of the patient's condition or worsening symptoms is critical for initial assessment and ongoing integrated care planning. However, most family members consciously withhold critical information that could help nurses develop a comprehensive understanding of the patients' presenting symptoms in relation to multiple chronic conditions. In addition, some family members control their relatives' access to health services. Based on their clinical experiences, nurses outlined several reasons for such behaviors of family members. The commonly reported

Table 1. Demographic Information.

Patient	Age	Gender	Education level	Clinical setting	Clinical experience
1	29	Male	Post RN	Critical care/medical intensive care	5 years
2	33	Male	MSN	Higher dependency care unit	9 years
3	27	Female	Post RN	Intensive care	4 years
4	28	Female	Post RN, MSN	General medical unit	5.5 years
5	30	Male	BSN	Emergency and general medical unit	6 years
6	31	Male	BSN	Transplant unit	5 years
7	25	Female	Post RN	Cardiology	5 years
8	37	Female	Post RN	Cardiology	14 years
9	25	Female	Post RN	Cardiology	5 years
10	25	Male	Post RN	Intensive care unit	4 years
11	30	Female	Post RN	Medical intensive care	7 years
12	30	Male	Post RN	General surgical unit	3 years
13	38	Female	Post RN	Higher dependency care unit	12 years
14	25	Female	Diploma	Adult care unit	3 years
15	26	Male	Post RN	Transplant unit/adult care unit	4.5 years
16	30	Male	BSN	Medical/cardiology	6 years
17	31	Male	BSN	General medical unit	5 years
18	28	Male	BSN	General medical unit	2 years
19	30	Male	Post RN	General medical/surgical unit	10 years

BSN are nurses who completed a 4-year bachelor of science in nursing degree. Post RN refers to 3-year-diploma nurses who completed an additional 2 years to get equivalence to a bachelor of science in nursing degree.
Abbreviations: BSN: bachelor of science in nursing; MSN: Masters of Science in Nursing; RN: Registered Nurse.

reasons were limited knowledge about the severity of condition, protecting their negligence, social sense of insecurity, lack of trust in health care professionals, use of complementary and traditional medicines, interpersonal familial conflicts, and logistics, transportation, and financial problems. Nurses stated that when they discuss these issues with the family members, it creates conflicts and further delays the delivery of care.

> The greatest challenge that I have faced is that getting accurate information about the needs and cases of complex patients from their family members is sometimes very difficult. Often the family members withhold information for the health care providers to protect their social dignity or negligent care of their sick relative. So, in these situations, an appropriate medical and nursing care plan cannot be developed and implemented because the health care history is not accurate. If health care providers are able to get the needed information in a timely manner, they can prevent the patient from complications. (Female, age 25)

Nurses discussed that many patients with multimorbidity and complex needs are of older age. Therefore, the patients are reliant on their family members to bring them to hospitals and care centers. However, the family caregivers and children often ignore the patients' genuine symptoms and worsening conditions. Therefore, they delay their access to care and control the treatment that they provide within health care settings. Nurses raised concerns that such delays hamper their ability to develop an integrated care plan in a timely manner through involvement of the health care team. Nurses also noted when these issues are brought to the attention of family members, the family members deny any wrongdoing and show aggression toward health care professionals, affecting the development of interpersonal relationships.

> Usually, a patient develops complicated health issues at an older age when most of these complex patients would be married with adult children. Many of the children of these patients are not interested in taking care of their elder parents with multiple health issues. The children are busy in their own life, so the patients are not taking their medications on time, neglect their self-care, they are unable to make it to their appointments, and delay treatments. The children neglect their care and do not bring them to the hospital. Sometimes, it also happens that the children completely dismiss the complaints of their parents. For example, a child may say that cough is a normal part of old age or diabetes is normal for your age so there is no need to go to the hospital. I think this has become a common norm in our culture. The complaints of elderly complex patients are not taken seriously because people just consider the complex issues a part of their ageing. So, because of these reasons delays in seeking health care services deteriorate their condition and make it challenging for us to manage. (Male, age 25)

Difficult to Fulfill Family Demands and Abuse

Nurses discussed that developing a therapeutic interpersonal relationship with patients' families was particularly challenging because of their aggressive and abusive behaviors toward health care professionals in general and nurses in particular. Participants described that negative behaviors of

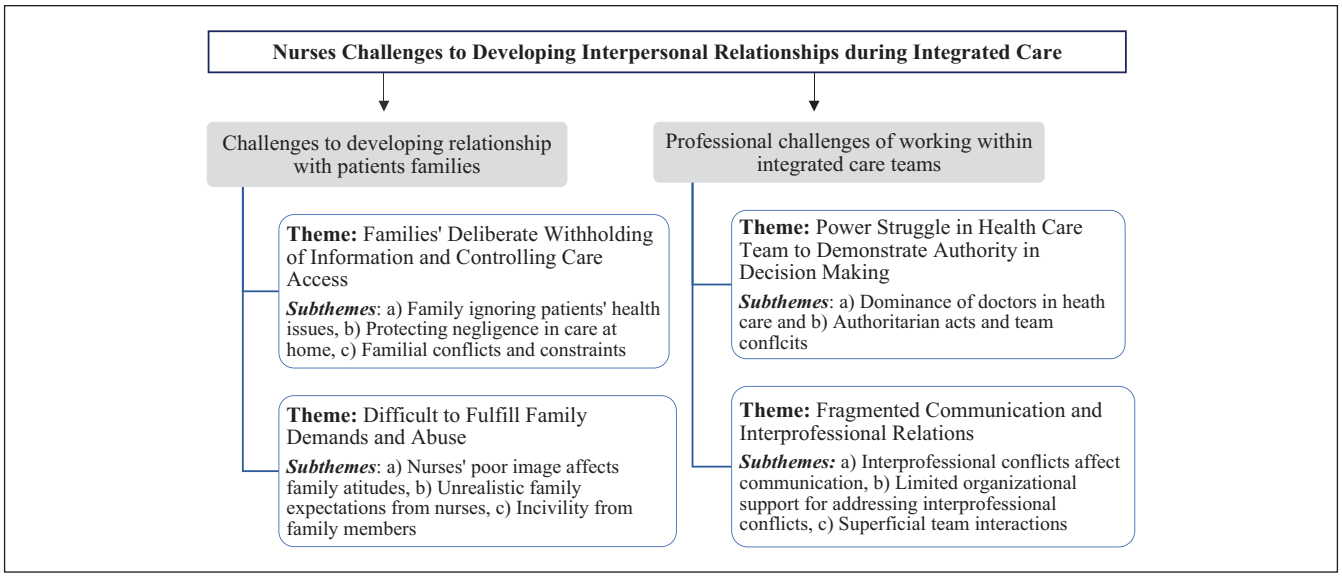

Figure 1. Themes and sub-themes.

families could be attributed to lack of respect for nurses in the country compared to physicians, low education levels, limited knowledge about the complexity of their relatives' illnesses, and distress due to their relatives' illnesses. In addition, nurses noted that some family members neglect the care of their relatives at home, resulting in complications. When they are asked about the reasons for the worsening condition of their relative with a chronic illness, they often become defensive and try to compensate for their negligence by blaming the nurses, physicians, and health care team.

> Some of the complex patients could get very aggressive. In spite of using compassionate language, sometimes patients become abusive. They even try to attack you. Even there are some patients whose family members are aggressive. If their patient gets critical or dies due to delays in reaching hospital, these family members break hospital doors and attack staff. Such behaviors are very challenging to handle. These abusive patients and families' behaviors negatively affect health care providers as well as other patients in the unit. Things get even worse if health care providers are not aware of the ways to handle such aggressive and abusive behaviors. (Female, age 25)

Nurses also discussed that many family members have unrealistic expectations of nurses and health care teams. The families expect health care professionals to be able to manage every complication in a very limited time. Sometimes they have unreasonable demands, such as seeking all the information about the patient's health in one brief interaction, asking for female nurses to care for their female patients even when no one is available, and asking physicians and nurses to spend most of their time with their relatives. Nurses noted that family members asked a lot of questions about the patient's care and affirmed that it is their right to ask questions. However, they also raised concerns that asking unnecessary questions that have already been clearly answered leads to time constraints for nurses and the health care team. Nurses noted that often they would answer one family member and then another family member would come back to seek answers to the same question. Despite explaining to them that they should ask their family, they get angry. This affects the building of effective relationships needed to provide timely and quality care to their relatives. Nurses elaborated that when family members are requested to cooperate with the health care team and wait for their questions to be answered, they often harass nurses and team members.

> One quite strange behavior is that some people use the patient as an excuse to mistreat you [nurses]. The patient may be completely satisfied with your care, but the family members harass you as if they hold some sort of grudge against you. Like, they do not like you and they do not like your care. They might try to harass you in front of your seniors or may verbally abuse you. Some of the family members use various means to abuse the health care providers verbally or physically, which is quite a painful process and not comprehendible. Health care providers are unable to focus on patient care. Instead, they are expected or usually spent more time answering somewhat unnecessary questions of patients' family members or uncles and aunts. (Male, age 30)

Power Struggle in Health Care Team to Demonstrate Authority in Decision-Making

Nurses emphasized the collaboration of nurses and physicians to deliver integrated care to individuals with multimorbidity and complex health needs. However, they discussed

that there is a consistent power struggle with physicians who want to demonstrate that they are the most respected health care professionals and therefore have the authority to make all decisions regarding patient care. Nurses elaborated that there appears to be grandiosity in physicians as they do not value the contribution of nurses in integrated care teams. They noted that often physicians are wrong in their decisions, but they fail to accept their mistakes and jeopardize professional relationships and patient care. Nurses also discussed that the management also supports physicians and fails to recognize nurses' value.

> Well, even though everyone talks about teamwork and its importance in providing quality care, I think not all health care providers follow the general principles of teamwork. I mean doctors are quite authoritative in our health care settings, they often degrade nurses and do not value their opinions. Such behaviors could take a toll on the mental well-being of nurses, which ultimately affects the development of a professional relationship with nurses and the delivery of quality of patient care. (Female, age 37)

Nurses also talked about the unethical and rude behavior of physicians. They noted that some of them are authoritarian and use rude language to delegate tasks to nurses, which affect nurses' motivation to work together in integrated care teams. Nurses also noted that when we need urgent consultation for patients' complex issues, physicians often refuse to discuss them. They completely block all requests or ignore nurses, and therefore, nurses continue to work alone to ensure the delivery of care. Nurses also could not bring these issues to the management because they are supportive of physicians and refuse to listen to nurses' concerns.

> Unfortunately, sometimes we [nurses] are given a "Shut up call" there and then, and we cannot share our issues and concerns with the top management. Or sometimes it happens that one of the unit nurses was treated in such an inhumane manner, that it automatically shuts off other nurses to bring forward their issues and work in collaboration with the doctors and the management. (Female, age 27)

Fragmented Communication and Interprofessional Relations

Nurses described that communication within the health care team is broken and that interactions are superficial due to power struggles between physicians and nurses, lack of support from management, authoritarian attitudes, and lack of respect and value for nurses' and other health care team members' viewpoints. They noted that these issues hinder the transmission of critical case information needed to manage individual patients. Participants were concerned that the fragmented relationship between physicians and other team members makes it challenging for the smooth flow of case information from one professional to another.

> We would like to establish a good working relationship, but when doctors are authoritarian, rude, and disrespectful it is not easy to maintain a good relationship. It is sad because ultimately patient care is affected. Doctors do not value our opinions or the opinions of other allied health care professionals who are important team players in the delivery of integrated care. Sometimes, I feel doctors have grandiose views about themselves, and they believe that they are the showrunners. (Female, age 30)

Nurses elaborated that sometimes one health professional self-selects themselves as the team leader and makes authoritarian decisions, which affects the morale of nurses and other team members to maintain a unique and necessary professional relationship. The absence of professional relationships ultimately affects care delivery. Nurses recognize that physicians have an essential role to play in integrated care teams, but often they create a power-driven working culture. Some team members support physicians merely due to fear of losing their job because the management supports physicians. Nurses further elaborated that many allied professionals such as pharmacists, physiotherapists, respiratory therapists, and nursing assistants are important team players too, but their role and contribution are often undervalued. This breaks communication channels because not everyone is comfortable sharing their views during the development of integrated care plans.

> I have experienced that doctors by force or default are considered the team leaders and they do not recognize the role of other team members nor do they respect their opinions during care planning. Sometimes, the physiotherapist may have better information to share because the complex patient has deteriorating mobility as the presenting symptom. At other times, nurses may have critical information about patient condition, but the leader does not want to take those views into account. When this happens, the communication channels break, and team members do not want to share any information. Just because they know that their opinions will not matter. (Male, age 31)

Discussion

This study explored the challenges that nurses face in developing interpersonal and professional relationships with the families of complex patients and the health care team involved in the delivery of integrated care. Nurses discussed that families withheld information and controlled care access of their relatives, posed unrealistic demands, and abused nurses affecting nurse-family relationships necessary to deliver integrated care. Previous studies on integrated care in primary care settings also identified that health care professionals experience obtrusive demands from family members, hindering their ability to deliver care.[8,9] Controlling health care access of their relatives and how nurses' confrontation of this issue impacted the development of interpersonal relationship was a unique finding in this context. This finding can be explained from a sociocultural perspective; in Pakistani culture, the family role

is very intertwined with personal preferences of patients. Many patients live in joint families, and hence, close and distant relatives are involved in decision-making pertaining to access to care, self-care, and chronic disease management.[13,26] Previous studies also highlighted that this issue could be observed in South Asian populations residing in high-income countries.[26,34-37] Future research to explore if family control of care access evolves across settings and contexts can provide useful insights for nurses caring for South Asian immigrant populations in high-income countries.

Nurses noted that patients' family purposely withheld information and engaged in abusive behaviors toward nurses, thereby affecting the quality of interpersonal relationships and integrated care. These issues could be attributed to families' lack of knowledge about the severity of their relatives' illnesses, their stress and anxiety about the well-being of their loved ones, and cultural issues of dominant roles within the family. Because there is no evidence to support these reasons, additional studies to further explore this phenomenon within South Asian culture can provide valuable insights for improving nurse-patient dynamics and their collaborative work within integrated care teams. The practice implications of these findings are that counseling and education services could be provided to family members, and forums can be developed for nurses and patients' families to discuss their issues and develop workable solutions that ultimately benefit the interpersonal relationships and person-centered integrated care provided to individuals with multimorbidity and complexity.

In terms of nurses' challenges in developing professional relationships within health care teams, power struggles, professional role hierarchies, fragmented communication, and problematic interpersonal relationships have been reported in previous studies.[10,11,13,37] These findings bring to attention the role of management and administration in resolving interprofessional conflicts when working in integrated care teams. The nurses in this study also noted that management and administration are biased toward physicians and value their viewpoints more so than nurses and other health care professionals. This issue calls for initiatives to address these epistemic boundaries impacting the importance of valuing the viewpoints of all members of the health care team and the delivery of quality care. To achieve this, unit-level meetings and forums can be organized to discuss the challenges of each health care professional group and generate solutions to address these challenges impacting integrated care delivery. Further research is warranted to explore the perspectives of administrators and managers on this issue and how they ensure that favoritism and biased attitudes are minimized or eradicated. Studies should also be conducted to design and evaluate unit- and organization-based interventions to improve the delivery of integrated care by overcoming the obstacles nurses outlined in this study. Training can be conducted to improve nurses' competencies in conflict management and therapeutic relationships for effectively working within health care teams.

Our sample comprised South Asian nurses working in low- and middle-income clinical contexts and settings. Therefore, further research in other contexts may provide different insights into nurses' challenges in diverse contexts. We conducted interviews in both Urdu and English languages and then translated them completely into English; thus, there is a possibility of losing the meaning of nurses' experiences. Nevertheless, bilingual researchers worked together to ensure that the translation was accurate. The data were also collected during the COVID-19 pandemic; hence, face-to-face interviews could not be conducted.

Delivery of integrated person-centered care to individuals with multimorbidity and complexity requires health care team and patient and family collaboration. Nurses need to be cognizant of challenges that may impede their ability to develop interpersonal and interprofessional relationships within integrated teams to ensure the utilization of individual-level strategies for overcoming these challenges. Nurse leaders and health care organizations should take the initiatives to address nurses' interpersonal confrontations and conflicts to support them in playing their part in delivering integrated care.

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Supplemental Material

Supplemental material for this article is available online.

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