



Kindness, Listening, and Connection: Patient and Clinician Key Requirements for Emotional Support in Chronic and Complex Care

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Jane Bradshaw^{1,2} , Nazlee Siddiqui, PhD¹,
David Greenfield, PhD^{3,4}, and Anita Sharma, PhD^{5,6}

Abstract

Emotional support for patients is critical for achieving person-centered care. However, the literature evidences an ongoing challenge in embedding emotional support within current health services. This study aimed to investigate the strategies to embed emotional support from the perspectives of patients and clinicians. This is an exploratory qualitative study that collected data through focus group discussions (FGDs) and interviews from 11 patients, 2 carers, and 7 clinicians in the multi-disciplinary care teams in an outpatient complex and chronic care setting in New South Wales, Australia. The FGDs and interviews were recorded, transcribed, and thematically analyzed. Three main themes emerged from the experience of both the patients and clinicians: (1) warmth and kindness, (2) deep listening, and (3) social connection in the process of treatment. Clinicians' and patients' shared experience of these themes was key to embed emotional support in care. Practical strategies including promoting shared understanding of emotional support, enhancing provider's capability to deliver emotional support, and building patient's networking opportunities in treatment processes were discussed to facilitate emotional support in patient care and health services.

Keywords

clinician–patient relationship, communication, organizational culture, patient/relationship centered skills, patient perspectives/narratives, patient satisfaction, trust

Introduction

Emotional support is recognized as an essential element in safe, high-quality patient and family centered care (1,2). Patient experience is positively enhanced when care encompasses both clinical and emotional aspects (3–6). Emotional support composes 3 components, including: a cognitive understanding of patient needs; an affective imagination of what the patient values; and an altruistic action to alleviate the patient's pain (7,8). A further inherent aspect of emotional support is narrative knowing (9). That is, shared understanding between the clinician and patient, regarding experience of the chronic disease and feelings such as helplessness and suffering (9). Additionally, there are other practices to facilitate emotional support such as active listening, empathetic communication, applying relevant therapeutic resources (7,10,11), and a trusting relationship (8).

Health organizations need to provide appropriate structures and processes for staff to deliver emotional support (12,13).

To achieve this outcome requires integrating patient centric workplace culture and leadership (13,14), efficient use of resources (15), provision of staff education (16), and services knowledge and use of right model of care (11,17). While the requirement for effective emotional support is well established (7,18), the embedding of emotional support in treatment

¹ University of Tasmania, Health Service Management School of Business & Economics, Sydney, Australia

² Be Pain Smart Service, Royal Rehab, Ryde, Australia

³ UNSW Simpson Centre for Health Services Research, Sydney, Australia

⁴ University of New South Wales Southwestern Sydney Clinical School, Liverpool, Australia

⁵ Nepean Blue Mountains Local Health District, Western Sydney, Australia

⁶ Nepean Clinical School, University of Sydney, Sydney, Australia

Corresponding Author:

Jane Bradshaw, Royal Rehab, 235, Morrison Road, Ryde. NSW 1680, Australia.

Email:janebradshaw454@gmail.com



processes is an ongoing challenge for many services. Healthcare organizations should implement the suggestions to embed emotional support as this strategy would improve the patient experience, enhance the effectiveness of services, improve health professional working culture, and prevent the burnout of clinicians (5–7,12,13).

Emotional care is present in settings, such as psychiatry (19) and physiotherapy (20), but there are gaps in other services. Clinicians' propensity to provide patients with emotional support is influenced by their experience of compassion in the organization (21) and availability of clinical supervision, which can be variable across service settings and professional groups. A further organizational constraining factor has been the focus on the task of treatment *to* patients rather than the quality of the therapeutic relationship *with* patients and ensuring emotional support is embedded in treatment delivery (22,23). Nevertheless, many clinicians value emotional care as it is a professional virtue (24) that contributes to their psychological vitality and wellbeing (21). Some experienced medical clinicians provide emotional support, whereas others assess that it is not their role to provide such care, or lack appropriate training to do so (25). Allied health team members, such as physiotherapists or social workers, are known to have acceptance and capacity to provide emotional support to patients with chronic disease (7,26,27). Overall, clinicians report diverse opinions and experience about how emotional support should be provided in clinical settings (25,28), including chronic and complex care (1,25,29,30).

The patient element of emotional support is best understood through the patient voice, as the perception of the care provided can be different between patients and clinicians (31). Patients, across chronic care settings, including COPD treatment programs (32), stroke (5), mental health (22), and cancer care (33), report emotional support as warm, personal, safe and being treated as a human being. Patients highly value clinicians who demonstrate emotional concern for them, including in rehabilitation and recovery phases (3,7,21).

How to effectively deliver emotional support deserves greater attention, particularly for patients with chronic and complex diseases. Patients with such conditions present with multi-morbidities, suffering from deteriorating quality of life and emotional wellbeing, and require individualized care plans (16,33–35). Understanding the challenges to providing emotional support in the patient journey is crucial for chronic and complex services to be able to: deliver person centered care (3,5–7); ensure the well-being of service providers (7,8); prevent staff burnout (12); and the ethical and value proposition of the health system (18). Hence, to address this important need and gap, the study aim is to investigate the strategies to embed emotional support in chronic and complex care settings.

Design and Methods

This research was conducted in outpatient services in a tertiary teaching hospital in Western Sydney, NSW, Australia, from

May to August 2018. These services, conduct over one million outpatients and community visits each year, incorporating chronic and complex care, including geriatrics, rehabilitation, and chronic pain. Multidisciplinary teams, providing healthcare, include medical and rehabilitation specialists, physiotherapists, and social workers. The study used an exploratory-descriptive research design (36) with an inductive approach (37), using focus group discussions (FGD) and interviews (36,38). The team of researchers are experienced clinicians in the chronic and complex care services and academics in the discipline of health services management.

Participants, recruited across the 3 clinical areas comprised 2 cohorts: clinicians and patients with carers or relatives. Potential participants were made aware of the research by email, posters in the clinical area, or verbal invitation by staff. Patients were carefully selected by independent clinician colleagues. Qualitative research literature has drawn meaningful insights from the range of 5 to 25 research participants and the more experienced are the respondents, the lesser number of respondents would suffice (39,40). All the participants had substantial experience with patient care to answer the research question, hence, the recruited number of participants was deemed adequate for this study (41).

All those invited for the FGD, and interviews agreed to participate in person, in the setting of the outpatient services. All volunteered their time with no remuneration and provided written and verbal consent to participate in the study. Ethics approval was gained from a Human Research Ethics Committee in NSW. The clinicians participated in one group, and patients, families, or carers participated in either a group discussion or an interview. The inclusion criteria for patients were that they were currently attending the chronic and complex outpatient setting during the study period and were English speaking. The exclusion criteria were if the patients had an acute or chronic illness that would limit participation in the study and were a current patient of the first author. The inclusion criteria for carers and families were that they could speak English. The exclusion criteria for family and carers were that if they were a carer for a patient of the primary researcher. The inclusion criteria for clinicians were that if they were currently working at the chronic and complex outpatient service in the study.

The overarching research investigated the 6 patient centered-care domains (1), including: respect for patient preferences and values; emotional support; information; communication and education about treatment planning; involvement of family and friends throughout the care process; and, coordination of and access to care. This study focused on the domain of emotional support.

A study guide, used to direct interview and group discussions, comprised open ended questions; for example, "Could you tell me about the emotional care you received during treatment?." Each activity which lasted between 30 and 60 minutes was recorded using an audio recorder and transcribed verbatim, with unique codes used to maintain anonymity, for example: R=patient in rehabilitation, P=

patient from other setting, PT = physiotherapist, and D = doctor. Transcription was completed by the first author. Member checking was used with all transcripts offered to participants for review; but no amendments were suggested and made (42). Data analysis was conducted using thematic analysis (37). This step-by-step approach of thematic analysis includes 6 non-linear processes which included reading of the manuscripts using a reflective diary followed by coding, then the process of creating themes. The themes in this study related to the domain of emotional support in line with the research question that this paper is addressing. The themes represented the strongest ideas that consistently emerged across the data. The next process was reviewing the themes for authenticity, followed by defining themes. The last process was the drafting and revising the results. Members of the research team (first and second author) discussed the emerging codes and themes. The interim analysis was presented to and reviewed by the whole research team. Points and final phrasing were determined through collaborative discussion and agreement (43).

Results

There were 20 study participants, comprising approximately 60% patients, 10% carers, and 30% clinicians (Table 1). There were 3 overarching themes: warmth and kindness; deep listening; and social connection in the process of treatment. However, the associated subthemes for the patients and carers differed from those of the clinicians (Table 2).

Warmth and Kindness

The first key theme was warmth and kindness. Patients explained this experience in three interrelated ways. Firstly, patients commented how the personal attributes of clinicians such as a friendly manner facilitated the therapeutic relationship. They described clinicians in friendly,

engaging ways, including that the psychologist was “approachable” (P1) and the physiotherapy staff in the rehabilitation gym were “warm and personal” (P2). Secondly, it was the “sense of being known.” One patient stated that she developed, over a 2-year period, a close interpersonal connection with the treating physiotherapist who now “knew and cared for her” and that “they (the clinicians) sense when I am not ok” (R2). Another patient also stated that they too had become friends with their therapists during treatment (R1). Thirdly, patients witnessed staff extending acts of kindness to patients. Physiotherapy staff were observed in the hydrotherapy pool providing careful, attentive, intensive support to patients who had severe disabilities. This was illustrated by the comments: “Staff concentrated on the ones that needed the help” and “made sure we were all right” (P4).

Clinicians described warmth and kindness, as essential for recovery in care, and encompassed 2 elements. First, the necessity to build trust, and second, the intention to build a positive therapeutic relationship. Together they were considered key to emotional support and the foundation in the patient journey. A clinician stated the point “you need to build that trust and rapport first and then it [the therapy] is easy” (PT4). Kindness was a motivating factor for clinicians in supporting patients and building a therapeutic relationship, as reflected by: “I want to make a positive influence in their life” (PT1) and “I want the therapeutic relationship to be positive” (PT4). Another clinician talked about the need to persevere with patients whose mood was grumpy when they initially attended treatment. They explained how to use a warm and engaging manner to address barriers to therapeutic relationship, that is:

Table 1. Participant Details.

Participant group	Participant details	Number
Clinicians	Physiotherapists: 11 years' experience average	4
	Geriatric Medical Specialist: 31 years' experience	1
	Rehabilitation Medical Specialist: 30 years' experience	1
	Social Worker: 10 years' experience	1
Patients, family and carers	Patients: geriatric service (falls prevention program)	4
	Patients: rehabilitation service	5
	Patients: chronic pain service	2
	Family members or carers	2
Total		20

Table 2. Overview of the 3 Themes and Associated Subthemes.

Themes	Subthemes patients and carers	Subthemes clinicians
Warmth and kindness	<ul style="list-style-type: none"> Personal attributes of staff Sense of being known Witnessing acts of kindness 	<ul style="list-style-type: none"> Building trust Intention to create a positive therapeutic relationship
Deep listening	<ul style="list-style-type: none"> Importance of being listening to Listening facilitates engagement 	<ul style="list-style-type: none"> Listening facilitates engagement Listen to the main complaint of the patient
Social connection in the process of treatment	<ul style="list-style-type: none"> Sharing lived experience of illness Making friendships 	<ul style="list-style-type: none"> Strong social supports are important with chronic disease management

They're the patients I really like to work with because it's a challenge for me and that where I get the positive kind of feedback or that feeling when you finally crack that really grumpy 94-year-old man that just doesn't want a bar of you. When you find something, you just see the change straight away, that's what I enjoy (PT2).

Deep Listening

The second key theme was deep listening. Patients explained this experience as follows: firstly, patients reported the importance of experiencing being listened to in the interaction with the clinicians. One patient summarized the positive experience as “(the) doctor really sat and *listened*” (PF1). Being heard assisted them to engage and participate in treatment. Patients reported that in most consultations, the clinicians were able to mindfully listen to them. Secondly, they explained that listening was important to develop trust within the therapeutic relationship motivating them to engage and adhere to the treatment plan, even when struggling physically or emotionally. One example of this was demonstrated when a patient said “they all listened. I was really impressed so I thought-yep-right well go with it” (PF1). Following this experience the patient enrolled in and completed a falls prevention program. Conversely, patients reported when, on occasion, the clinician was distracted and did not listen they felt distressed, irritated and there was a sense of emotional disconnection with the clinician.

Clinicians spoke about the necessity of listening to patients as the first step to engaging them in therapy and healing. They explained “listening is the basis of everything” (PT3) and “we listen to the patient ... (because) ...the patient wants to express how they feel” (PT1). There was consensus that an emotional connection must commence at the initial consultation. One doctor, reflecting the view of her colleagues, said her treatment methodology was to use “respectful engagement” involving the family, reporting: “... (I) talk to them (the patients), be respectful, and also then include the relatives into the conversations” (D1). Clinicians suggested practical ways to improve connection with patients and families, including asking about the patient's pets (PT2) or using humor to improve patient engagement, particularly when the patient seemed depressed (PT1). Additionally, the focus for clinicians was to discover what mattered to the patients by listening intently. Clinicians reported that successful treatment was achieved when they focused first on the patients concerns—be that social, pain or sleep issues—and then they undertook their assessments for cognition or functional ability. As one clinician explained: “(I) listened to the main complaint. They (the patients) may be coming to my clinic for cognitive impairment, but they say I've got a sore arm” (D1).

Social Connection in the Process of Treatment

Patients spoke about 2 elements facilitating the social connection in the treatment process. They first discussed how

they valued the opportunity of sharing the lived experience of having a chronic illness with others. This social opportunity created by the treatment program—either at the physiotherapy gym, chronic pain service or the hydrotherapy pool—enabled conversations concerning the major challenges of having a chronic illness, thus, gaining and giving emotional support to each other. One patient from the chronic pain service explained this experience: “I'm surprised, because I haven't experienced that in the past, just talking to other people who have similar problems. I think that's really important” (P4). He suggested that there should be more group programs to manage chronic pain conditions to facilitate this peer support. The second element was that patients who attended the weekly physiotherapy program or the hydrotherapy pool reported that they formed new friendships. This was important to patients, because they were experiencing social isolation. A patient reflected on the physiotherapy rehabilitation gym at the hospital which she attended weekly stating “it's a supportive environment, I became friends with other patients here” and “it's a community environment” (R1). A confirmation of this theme of the social, emotional connection was noted at another rehabilitation venue as a patient reported “I met so many nice people at the hydrotherapy pool” and “once a month we go out and have coffee after we have been to the (hydrotherapy) pool” (P5).

The clinicians' view confirmed that social supports were important for the patients, particularly with the geriatric population who live alone with chronic and complex illnesses. A clinician affirmed this idea explaining that “strong social supports and social networks were essential, so the patient is in a much better position to deal with ageing” (PT2). There was general agreement with this premise by the clinician FGD: they stated a positive dynamic became established; that is, patients who managed the chronic and complex disease in positive ways, had strong social connections, which led to better emotional wellbeing, enabling them to manage their health better.

Discussion

This study has established that in the setting of chronic and complex outpatient care, emotional support encompasses 3 elements: (1) warmth and kindness; (2) deep listening; and (3) social connection in the process of treatment. Additionally, the study makes a unique contribution in evidencing that a shared understanding of the experience of these 3 elements between the clinicians and patients is the key to embed emotional support in care. Hence, emotional support is simultaneously a simple, complex, and essential domain of person-centered care to support high quality patient health outcomes (7). “Warmth and kindness,” a key component of emotional care, is the clinician engaging the patient with warm interested personal interactions (11). Deep listening, which aligns with narrative knowing, is how the clinician develops an understanding of the individual's experience of their health issues and resultant physical,

emotional, and psychological distresses (9). Together these actions facilitate a strong therapeutic relationship, a collaborative communication style between clinician and patient (44), and enhance adherence to treatment plans, and improved outcomes (9,45,46). A further, significant dimension to enhance the care process and outcomes was identified: social connection in the process of treatment. Patients sharing the lived experience of having a chronic illness, formed new friendships, gaining and providing emotional support. This activity is a highly effective strategy to drive improvements and aligns with the current practice of shared medical appointments (47). Patient networking is a psychosocial activity for managing chronic illness that can reduce isolation, promote shared understanding, and build resilience despite their health challenges (48). The flow on impact of social connection in treatment is increase in positive health outcomes for patients (49).

Implications

The findings of this study imply the need for 3 strategies to effectively embed emotional support in chronic and complex care. The first strategy is for the organization to promote shared understanding of emotional support between clinicians and patients. There is a lack of understanding of the necessity of emotional support by clinicians and education is required to ensure a common understanding exists (50). The education is a precondition for the practice of effective emotional support in an organization. This would include processes, for example, using patient feedback to develop shared understanding between patients and clinicians (50) and ensuring that an appointment has a consultation time of extended length to allow for in-depth communication between the clinician and the patient. The second strategy is for the health service to enhance the provider's capability for emotional support. This would include emotional support champions who are necessary to advocate, encourage, support, and guide colleagues to master this skill in practice (47). In addition, managers who encourage staff to bring the best of themselves to patient care are vital to join the team of champions to embed practice of emotional support as an organizational value (51,52). A final recommendation to support this strategy is clinician education for deep listening via organizational programs such as narrative supervision groups and Schwartz rounds, making uncaring behavior from staff burnout less likely (53,54). The third strategy is that networking opportunities during treatment, provided by not only clinicians but also via peer support, should be a norm for patients as it improves care outcomes and the patient experience. Health services, when possible, can combine the compassionate care provided by staff and facilitate connection between patients enabling a sharing of the lived experience of chronic illnesses (47).

Limitations

The study limitation is that it was based at one site, involving a modest number of participants. There was possibly unintended

selection bias in the study due to the inclusion and exclusion criteria. If the study is replicated, then the inclusion of a randomized design would overcome this issue. Nevertheless, the research has provided a window into a challenging but important dimension of clinical practice. Further research is recommended in other locations, service types and different professions to continue emotional support knowledge and practice evidence development.

Conclusion

Emotional support, in chronic and complex settings, comprises warmth and kindness, deep listening and social connection during treatment. Emotional support is a challenging but essential component of the way healthcare services should, and can, be delivered. But, in practice, emotional support is recognized as a challenge for organizations and clinicians to implement and maintain. Systemic, multifocal, and comprehensive strategies that address the patient needs can embed emotional support and achieve enhanced clinical outcomes for patients and satisfying work for clinicians.

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Ethical Approval

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ORCID iD

Jane Bradshaw  <https://orcid.org/0000-0001-9657-0101>

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