

Nurse–patient relationships in palliative care

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Aim. The aim of this paper is to report a study exploring aspects of nurse–patient relationships in the context of palliative care.

Background. Although there are numerous studies addressing nurse–patient relationships, little research has focused on these in the context of palliative care. Furthermore, no previous study has examined the relationship in the Chinese context.

Methods. Qualitative data were collected from 10 hospice nurses and 10 terminally ill patients by means of open ended unstructured interviews. Respondents were asked to reflect on practices and incidents that would allow an understanding of the meaning of nurse–patient relationships in palliative care.

Results. Four major categories emerged from the perspectives of patients and nurses: (1) forming a relationship of trust; (2) being part of the family; (3) refilling with fuel along the journey of living and dying; and (4) enriched experiences. Responses revealed that a relationship of trust is formed, and that nurses are not only regarded as health professionals, but also become part of the family or a good friend. Nurses who develop trusting relationships demonstrate a holistic approach to caring, show their understanding of patients' suffering, are aware of their unvoiced needs, provide comfort without actually being asked, and are reliable, proficient, competent and dedicated in their care.

Conclusion. Trust, the achievement of the goals of patients and nurses, caring and reciprocity are important elements of nurse–patient relationships in palliative care. Such relationships not only improve patients' physical and emotional state, but also facilitate their adjustment to their illness, ease pain and can ultimately lead to a good death experience. It is nurses' personal qualities and skills, which are embedded in these relationships, that constitute excellence in nursing care. Nurses also derive satisfaction and are enriched through the relationships.

Keywords: nurse–patient relationship, palliative care, nurses' qualities, trust

Introduction

The nurse–patient relationship is viewed as central or foundational to the practice of nursing (Benner & Wrubel 1989, Ramos 1992, Tanner *et al.* 1993, Weissman & Appleton 1995, Taylor 1998). Theoretical work on the

nurse–patient relationship by Peplau (1952) was critical to the development of the notion that nursing practice encompassed more than physical care. She described four phases of the nurse–patient relationship: orientation, identification, exploitation and resolution, and developing nursing knowledge apart from the 'disease model'. This conceptualization

was subsequently expanded in the works of interactional nurse theorists such as King (1981) and Paterson and Zderad (1976). Recent writers continue to cite the importance of relationship development to balance the emphasis on technical skills (McQueen 2000, Chant *et al.* 2002). They have emphasized that a capacity for forming relationships with others is a key attribute of individuals.

Hartrick (1997) has argued that the emphasis and reliance on mechanistic models of relating often results in failure by nurses to realize the importance of relational capacities. Hartrick has described five relational capacities: initiative, authenticity and responsibility; mutuality and synchrony; honouring complexity and ambiguity; intentionality in relating; and re-imagining. Relational capacity embraces the caring values of nursing and the primacy of relationships in caring nursing practice. Hagerty and Patusky (2003) have provided an alternative framework for nurse–patient interactions based on the theory of human-relatedness, which consists of four states: relatedness-connection, disconnection, enmeshment and parallelism. The four states are based on levels of involvement and comfort.

Some studies have explored the nature and types of nurse–patient relationships (May 1991, Morse 1991, Ramos 1992, Morse *et al.* 1997). Morse (1991) has commented that the relationship between nurse and patient is the result of interplay or covert negotiations until a mutually satisfying relationship is reached. She has also identified four types of mutual relationship according to the duration of contact between nurse and patient, the needs of the patient, the commitment of the nurse and the patient's willingness to trust the nurse. They are: clinical relationship, therapeutic relationship, connected relationship and over-involved relationship. It is argued that the intensity of the negotiations depends upon the patient's perception of the seriousness of the situation and the patient's feeling of vulnerability and dependence.

Palliative care aims to promote the physical and psychosocial well-being of patients whose disease is no longer responding to curative treatment. In nurse–patient relationships, nursing work is directed at maintenance of the body rather than its restoration. Emotional and psychosocial distress are common as individuals confront the terminal phase of an illness and their impending death. One of the core elements of good palliative care is good nurse–patient relationships. The change of focus has the effect of reconfiguring interactions between nurse and patient.

During the process of dying, time is limited and the patient is vulnerable, making the patient–nurse relationship in palliative settings an interesting area for exploration. May (1995) highlighted the important role of nurses in helping terminally ill patients to come to terms with the imminence of

death. Such work is highly demanding and often stressful. The nurse–patient relationship goes beyond 'sitting and listening' and 'talking', in which the patient is the object of clinical attention or a subject manifesting psychosocial problems. Here, the patient not only wishes to speak, but is also known to the nurse in an intimate and private way. Because of the underlying structural inequality of relations between nurse and patient, May has described the relationship as in some way pastoral. The nurse expresses sympathetic concern, while at the same time the patient reveals the most private aspects of their life; the relationship is not reciprocal. However, some patients prefer to detach themselves from the situation. In such cases, they do not allow nurses to become involved, which makes care more difficult as nurses are then unable to perceive how patients are feeling. In addition, when nurses take time to talk to patients and meet their needs, they must then contend with other, competing, work demands. In order to take time to talk, nurses may have to re-arrange other work or re-allocate staff. May has described how the nurse–patient relationship is imbued with a moral value, which is an investment that undercuts its status as paid labour.

Spross (1996) has emphasized that in palliative care, primary interventions are interpersonal and that patients' subjective status is given ever greater priority. Spross has described the nurse–patient relationship as 'one-sided intimacy'. The nurse would always know more about the patient than the patient would know about the nurse. She acknowledges that the depth or intensity of this nurse–patient relationship makes it like friendship. However, unlike friendship, the relationship demands conscious use and interpretation of complex cognitive, affective, and behavioural knowledge to enable nurses to communicate deliberately to achieve therapeutic goals. Spross further described the central interpersonal process of nurse–patient relationships as coaching. At the initial encounter, nurse and patient have entirely separate goals and interests. They have their own preconceptions of the meaning of the situation and the roles of each in the encounter. The initial encounter between them is that of strangers, and it is important for each to accept the other person as they are and to treat them as an emotionally able stranger. As they work together, they begin to arrive at a mutual understanding of the situation and establish common goals that focus on the patient.

Jones (1999) applied the concept of containment to analyse the nurse–patient relationship in palliative care. Containment was described as a process of projective identification. An example of containment is an infant feeling assaulted by strong feelings: because of being unable to 'think', the child empties its feelings into the mother or a substitute (container).

A mother who is able to ‘contain’ the feelings can refine and moderate them and so return them to the child in a more comforting form. As a result, the child is calmed and feels a sense of order. In palliative care, nurses allow dying patients to assign their anxiety, appropriately to nurses, who in turn help the person to tolerate distress through the containing process.

The study

Aim

This aim of the study was to explore the nurse–patient relationship in the context of palliative care. The paper specifically focuses on several dimensions of this relationship, including its context, relational qualities and patients’ and nurses’ interpretations and meanings of the relationship.

Design

Phenomenology offers an approach to researching the complex world of human experiences and accommodates non-empirical data such as values, beliefs and feelings. Van Manen’s phenomenological approach was used to guide the hermeneutic investigating process in this study because his methodology is interpretative, open to innovation and emphasizes dialogue through self-reflection. It consists of a dynamic interplay among the following research activities: stop and think, dwell on the phenomenon through dialogue, reflection and dialogue (Van Manen 1990).

Participants

The following criteria guided the identification of nurse participants:

- working in a palliative care setting as a direct caregiver;
- working in a palliative care setting for at least 2 years.

The following criteria guided the identification of patient participants:

- diagnosed with incurable cancer and referred for palliative care (either inpatient or home care);
- clearly aware of the incurable nature of the illness;
- able to verbally express themselves;
- inpatients were required to have a length of stay of at least 1 week;
- patients having the home care service were required to have been receiving this for at least 4 weeks;
- able to identify one or two particular nurse/s who have been caring for him/her.

Over the course of 9 months (May 2001 to February 2002), purposive sampling resulted in data being gathered

from tape-recorded interviews with 10 hospice nurses and 10 people with incurable cancer. There were 15 nurses working in the palliative unit; therefore, the participants represented 66% of these nurses. The patient participants were those receiving palliative care services in the hospital or at home. There were a total of 110 such patients; hence, the participants represented around 9%. Each interview lasted from 1 to 2 hours. Observational notes were written immediately after each interview, and then added to the transcript data. Interviews with nurse informants lasted around 1.5–2 hours and were conducted in the interview room of the palliative care unit. Nine interviews with patient informants were conducted in their homes and one was conducted in the ward.

Interviews

Open-ended, unstructured interviews were conducted. The interviews with patients started with the question, ‘Can you tell me about how you have experienced your illness and about your relationship with your nurse?’ Those with nurses started with the question, ‘Can you tell me about how you experience caring for patients with incurable cancer and about your relationships with your patients? I am particularly concerned with what this relationship is like for you’. Van Manen (1990) noted that the art of a hermeneutic interview is to keep the meaning of the phenomenon open and to go on asking questions. During the interviews, the researcher tries to strike a balance between allowing the story to emerge and directing the interview.

Ethical considerations

Approval for the study was granted by The Hong Kong Polytechnic University’s Human Subjects Ethics Subcommittee and the Hospital’s Ethics Committee. Permission to access patients’ medical records for demographic data was obtained from the palliative care unit involved. It was clearly explained to participants that they had the right to withdraw from the study, and that participation was voluntary and would not affect the treatment they received. The confidentiality and anonymity of the data were assured, and informants signed a consent form. No reference to participants’ names or any other detail that might identify them was made in the text of the study.

Data analysis

The interviews were conducted in Cantonese and transcribed verbatim into Chinese. The accuracy of transcription was verified by comparing the text with the tape and rectifying

any errors or omissions. All 20 interviews were examined for the essence of the nurse–patient relationship. According to Van Manen (1990), a hermeneutic interpreter is in a reflective position. From the transcribed data, a selective reading approach was adopted, meaning that we read the text several times and asked: ‘What statements or phrases seem particularly essential or revealing about the phenomenon or experience described?’ These statements were underlined and highlighted. The findings were formulated based on reflections on the essential themes that characterized the phenomenon. The hermeneutic process entailed a systematic analysis of the whole text, systematic analysis of parts of the text, and comparison of the two interpretations for conflicts and an understanding of the whole in relationship to its parts. Shifting back and forth between cases revealed new themes, patterns and a global picture of the phenomenon. The goal was to seek commonalities in meanings, situations and lived experiences. Categories, themes and exemplars that vividly depicted the themes were identified. The goal of thematic analysis was to discover meaning and to achieve understanding. The categories, themes and exemplars were then translated into English.

Findings

Characteristics of participants

The ages of nurse participants ranged from 24 to 40 years, giving a mean of 33.4 years. Two were Enrolled Nurses, seven were Registered Nurses and one was a nurse manager. Their mean length of nursing experience was 11 years and mean hospice experience 6.2 years. All had completed a hospice nursing course.

Patient participants ranged in age from 40 to 78 years, giving a mean age of 62.9. Four were female and the other six were male. Four of 10 were widows, and the other six were

married. Three had received tertiary education, three had received a secondary education and the other four had had primary education. All had been diagnosed with cancer in different sites, with or without secondary occurrences. Table 1 presents the demographic characteristics and descriptions of the patient participants.

Interpretation of the data

Phenomenological model of the nurse–patient relationship

The model of nurse–patient relationship that emerged from the analysis is shown in Figure 1. The thoughts, emotions, and questions are deeply embedded in the context of the participant’s life-world. Munhall (1994) has described four existential life-worlds and their interconnectedness in a person’s life: space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality). The patient and the nurse had a complex, lived reality that shaped and was shaped by the context of their experiences. According to nurse participants, their encounters with patients in the hospice had special meaning, which meaning derived from the context of patients’ limited remaining time and from their suffering. The patients received palliative care and all lived with the awareness that they were going to die. They were living with incurable cancer, and making the transition to a life awaiting premature death. They also experienced suffering and loneliness. The nurse–patient relationship consisted of four main processes: encountering in the caring process, forming a trusting and connected relationship, refilling fuel and being enriched.

In the encounter of palliative care, nurses aimed to reduce suffering and to provide maximum comfort to patients. They took the initiative in approaching patients. In such encounters, some patients revealed their needs and fears to nurses, while others preferred to keep their thoughts private. All nurse participants chose to continue to work in hospice care

Numbering of patient	Age (years)	Sex	Cancer site	Time confirmed incurable	Education level
P1	63	M	Liver + lung	2 years	Tertiary
P2	65	M	Lung + brain	8 months	Primary
P3	54	M	Lung + bone	4 years	Tertiary
P4	83	M	Lung	4 years	Tertiary
P5	40	M	Liver + bone	1 year + 2 months	Secondary
P6	78	F	Pancreas	8 months	Primary
P7	52	F	Lung + bone	1 year + 4 months	Secondary
P8	78	F	Lung	6 months	Primary
P9	57	F	Breast + bone	2 years	Secondary
P10	59	M	Abdomen	4 months	Primary
Mean	62.9				

Table 1 Demographic characteristics and descriptions of patient participants

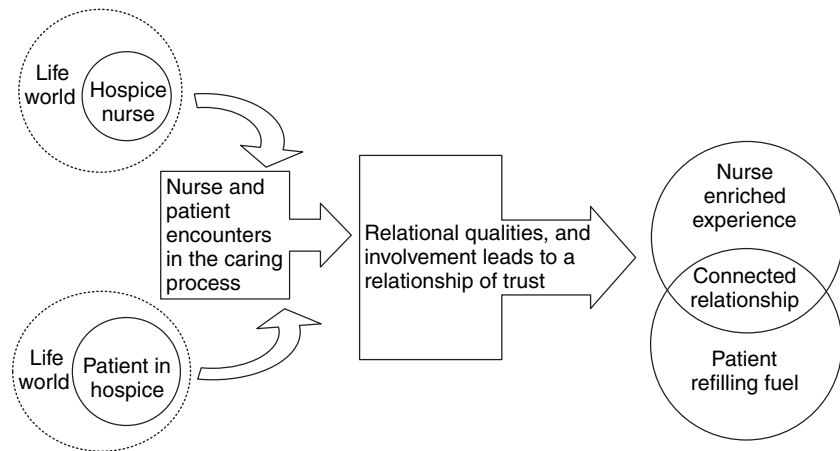


Figure 1 Nurse–patient relationship.

because of the job satisfaction they obtained and because they felt enriched in their encounters with patients.

Their relationships with nurses gave patients someone to rely on, someone they could trust, and someone to whom they could express their deeper feelings. Of utmost importance was that, through their relationships with nurses, they experienced themselves as people who mattered. The relationship was like being refilled with fuel, giving them energy. It enabled them to find meaning in life and eased their suffering. Although the categories are presented and discussed separately, they are clearly not mutually exclusive.

Encountering in a caring relationship

The relationship between nurse and patient developed on a continuum. There were three themes related to this category: (1) expectations of the nurse’s role, (2) involvement, and (3) reciprocity. At the initial encounter, nurse and patient had their own preconceptions of the meaning of the situation and the roles of each in the encounter. Nurses were faced with certain responsibilities. These involved meeting expectations, whether assigned by themselves or by society, and knowing what to take on. Nurse participants stated that their goal was to relieve the suffering of patients:

I knew the patient would die soon. I felt the urgency to relieve the suffering, as time was short. If I could do that, I felt I could achieve something and my heart would be at ease. Patients usually suffer along the trajectory of dying. When a patient dies in an agitated way rather than in peace, I feel sorrow and so do the families. (N1)

As for the patients, they were aware of their limited time and often had feelings of fear and helplessness. The relationships they had with their nurses might be either mutual or unilateral, according to the outcome of covert interactive negotiations or implicit interplay. Whether a mutual relationship developed was dependent on whether both nurse and patient were willing to enter into the encounter. The

involvement of nurses and patients determined the depth of the relationship:

When patients only talked to you in a superficial way and did not express their emotions, this indicated they did not want to disclose their intimate feelings. It did not mean that they rejected the nurse. They were not ready to disclose their feelings and sufferings.

You would find the patient was suffering and struggling in pain and anger. However, he would choose to control himself and didn’t allow you to enter into his inner world. One had to respect him even though one knew that ventilating his emotion was good for him, but we had to accept his pace rather than push him or force him to say how he felt. Often the patients did not want to talk at that particular time; maybe later they would talk. (N6)

In the process of entering into the relationship, the nurse took the role of initiator and was sensitive in ‘palpating’ the relating process. Taking the initiative meant not being pushy, and giving time and space to patients when they were not ready to disclose their deeper feelings. As the nurse–patient relationship evolved, it went beyond the superficial.

On the other hand, the nurse took the initiative to respond to the patient’s needs quickly, in a timely and appropriate manner, and to show that they really cared.

Development of a trusting and connected relationship

When a nurse responded to a patient’s needs in a trustworthy way, a relationship of trust developed. Nurse participants found that their relationships with patients evolved into friendships and that they became part of patients’ families. There were four themes in the development of a trusting and connected relationship: (1) understanding the patient’s needs; (2) displaying caring actions and caring attitudes; (3) providing holistic care; and (4) acting as the patient’s advocate. According to participants, nurses who developed a trusting

relationship with patients demonstrated understanding of their needs and suffering. One nurse said:

In establishing the relationship, the nurse needs to be approachable, you need to know your patients, understands their needs. The patient welcomes the nurse because he/she knows you, they know you care. Even though you might not be able to help him/her to get better, they still trust you; and because the relationship has evolved into a friendship, the nurse becomes part of the family. Also, they feel secure because you are a medical professional. (N8)

The nurse–patient relationship evolved into a trusting and connected relationship as patients found that nurses were caring in both action and attitude:

The nurse took the initiative to come to visit me, asked how I was, and examined my body. She checked not only my hands, but also touched my feet to see whether they were oedematous. When I was in the hospital ward, she came to visit me, although it was not her responsibility as she was the Hospice home nurse rather than a nurse in the wards. She expressed her care in action. (P2)

I found that the nurses were cheerful, didn't wear a long face all time and were patient. Their attitudes were very important. Their love was visible through their soft voices. They took the time to listen to what I said. (P2)

Nurses in the study took a holistic approach in caring for patients, tending to their physical, psychosocial and spiritual needs, showing awareness of their expressed and unvoiced needs, providing comfort without actually being asked; they were reliable, available and present, and listened to patients' deeper feelings. The personal qualities of nurses were perceived as integral to establishing a trusting relationship, and patients felt that the nurses were genuinely interested in them:

I visited (the patient) at his home. He was weak, lying in bed. He was really tired and reluctant to talk. I read scripture for him. I said to him, 'You don't need to say anything, just listen to what Jesus said to you.' I felt that he listened to the message and found peace and let go. On another day, when I stepped into his room, at the first glance, I found that his eyes looked pitiful, helpless and sad. I stayed with him, gave him support by telling him I would be around if he needed help. I saw him become more relaxed. Whenever he was in fear and sorrow, I took the initiative to be with him, listened to his feelings, or was just there, and encouraged him, and I found he was changed. (N5)

Nurses' understanding of the desires and choices of patients formed the basis for the strong advocacy role that they assumed. The nurses interceded on behalf of patients with family members or medical staff, and provided specific care

according to patients' unique needs. Nurses took the initiative in relationships and believed that their care made a difference to patients. As a result, patients considered nurses as part of their families and believed that nurses had gone 'the extra mile':

With a trusting relationship, as patient I could tell her everything I need. She would bring my issues to the meeting at the hospital, so my concerns would be heard. It wouldn't be that way if our relationship were a distant one. The nurse was not only a healthcare professional, she was also a good friend, part of the family. (P2)

A fuel station for revitalizing energy

For the dying patients in the study, their relationships with nurses gave them the incentive to continue to live, helped them to find a sense of peace and security, and eased their suffering. They expressed the view that their relationships with nurses were like going to a refueling station and being refilled with fuel in order to keep on going. The fuel triggered their inner strength; hence the relationships had the capacity to sustain them. In their experience of struggling with incurable illness, the intensely traumatic process required that they have energy to continue. They chose to disclose their deepest pains to nurses because they trusted them and felt that they knew them in an intimate way. As a result of 'refueling', patients were able to go on, as illustrated by the following examples:

I have had the illness for too long. It's really a traumatizing process that is repeated and repeated as I've gone through all the losses. Inner strength is the fuel that allows me to go on. When I was caught in the toughest emotional struggle, I chose to disclose my deepest pain to my nurse, although it was not easy for me to tell someone else. I needed help...It was a tough situation and the strong trust in her drove me to ease this pain through dialogue with her. (P3)

Since we developed a good relationship, my days with the illness have changed for the better. I have peace at heart and I've found security in the relationship. I could share my feelings with my nurse. Before I worried a lot, but now I am much more at ease with myself. I know that whatever is going to happen, I can approach the nurse, who is a reliable person. (P1)

Enriching experiences

For nurses, the relationships, although focused on the goals and needs of patients, were enriching. Their understanding of patients' worlds enhanced their personal growth. The three themes here were: (1) personal growth; (2) letting go; and (3) satisfaction with one's life. When nurse participants

encountered patients who were so close to death, this provided them with an opportunity to reflect and develop meanings that were largely free from the stressful and meaningless aspects of their own lives and embraced aspects that defined personal meaning. One nurse mentioned that learning to search for joy and beauty in life, and to let go and be more open. Nurses' encounters with patients gave them satisfaction through the process of caring, and they also found tremendous worth in patients, and were inspired by their integrity and motivated by the way they transcended their suffering:

An elderly man, Mr X, and I have the same religion. I wondered how he could be so different from other patients. I learned from him that one could choose a different attitude when facing an adverse situation like death. I have learned from (his) attitude towards the difficulties of life. His whole perspective has influenced me personally. (N5)

This satisfaction is not from gifts received from clients. It is something coming from the patient...like a patient taking care of a small plant in front of the window, or a patient who recently brought his little goldfish into the ward. I was happy, for I found beauty in life and in the hospice. People might think of a hospice only as a place of hurry, death and tension. Actually it is a place of living, and you can find a patient who is dying and still enjoys life. That's life. (N6, p. 4, line 20–25)

Through the relationship with the patients, I learned to let go. I won't insist on a lot of things. I find myself being more open. (N8)

Discussion

The study findings show that nurse–patient relationships have evolved from a professional relationship that emphasizes their functions to a focus on mutual understanding, and that there is feeling and affection in these relationships. The former type of relationship involves fulfilling obligatory functions and expectations, while the latter is one of trust and connectedness. A trusting and connected relationship is one that involves concern and dedication, and has a high emotional component. The relationship capacities found in this study are consistent with those described in the nursing literature, which show that relating with other human beings is a caring process that involves values, intent, knowledge, commitment and actions (Gadow 1985, Watson 1988, May 1995, Jones 1999).

Involvement of both nurse and patient

As May (1991) has pointed out, involvement does not necessarily refer to a specific attachment to a particular

patient. In our study that involvement was getting to know the patient, and taking initiative to respond to their needs quickly. Involvement represents encounters that emphasize the importance of being concerned, interested and giving. In the context of palliative care, some patients refuse to talk about their problems and difficulties. This refusal might reflect emotions of depression, anger, pain and helplessness. Nurses in the study nurtured the relationship by giving patients space in the encounter, allowing them to be angry, and waiting until they were ready to disclose their personal needs and feelings. This respects patient choice and wishes.

Getting to know the patient

The findings further support the view of May (1995), Luker *et al.* (2000) that it is only through knowing a patient that nurses can provide care that fulfils the specific needs of that patient. Knowing a patient allows nurses to more truly understand a patient and their world as if they were inside it. One must be able to understand the other person's needs and respond properly to them. Our respondents viewed their work as involving more than responding to patients' physical condition. They emphasized the importance of knowing patients and being involved with them, and developed their relationships with patients, which included satisfying the needs of individualized patients and being exposed to and resolving psychological problems. Both patients' and nurses' accounts clearly described the investment of effort by nurses into knowing patients. This knowing enabled nurses to obtain an objective view of patients' total needs. Radwin (1995) identified factors consistently related to knowing the patient. These include the continuity of contact and a sense of closeness between patient and nurse.

Affection

In Chinese, an emotional relationship (*gan qing*) is an important relational concept that symbolizes mutual good feelings, empathy, friendship and support between two people. The emotional relationship is mediated through caring for a patient. Attending and responding to a patient's needs and wishes through attitudes and actions appear to provide the foundation for a viable relationship. Yu and Gu (1990) have commented that the Chinese view of love is an internal feeling that need not be expressed by words because actions have replaced words. Patients appreciated that nurses were cheerful and patient and that they demonstrated their care by taking time to listen. Relationships that demonstrated warmth and acceptance restored patients' faith in themselves and

What is already known about this topic

- The nurse–patient relationship is considered the foundation of palliative nursing care.
- The literature usually discusses the structure, elements and phases of the relationship.
- Conditions that form the essential basis for a therapeutic relationship are trust; empathy; genuineness; initiative; authenticity and responsibility; mutuality and synchrony; honouring complexity and ambiguity; intentionality in relating; and re-imagining.

What this paper adds

- Trust, achievement of the goals of nurses and patients, and reciprocity are important elements of nurse–patient relationships in palliative care.
- The existential component in nurse–patient relationships in palliative care for patients is related to having inner strength, a sense of security, experiencing ease of suffering and developing a broader perspective.
- For nurses, the relationship is one of personal growth and satisfaction in caring.

made it possible for them to reach their goals. When patients had been enabled to feel that they did not have to struggle alone, and that help was forthcoming when needed, they felt secure. When they found that they could be themselves within relationships with nurses, that they could have and express their own feelings, knowing that nurses would not make judgements and would not disapprove, then they felt satisfied.

Many of the patients' accounts revealed that the caring actions, attitudes and trustworthiness of nurses built connected and trusting relationships. These not only improved patients' physical and emotional state, but also facilitated their adjustment to illness, eased pain and could ultimately lead to a good death experience. It is a nurse's personal qualities and skills, which are embedded in the nurse–patient relationship, that constitute excellence in nursing care.

Creating positive meaning for both nurses and patients

Nurses in the study found meaning in palliative care. This meaning was necessary both to sustain them throughout their involvement in the situation, and also to sustain hope for patients and families. Nurse participants found relationships with patients an enriching experience, which involved both giving and receiving processes. Being invited into some of the most vulnerable moments of people's lives, as well as the

personal meaning gained from the encounters, had enriched their life experiences. Creating meaning during patients' dying was an integral part of healing for patients. Meaning was used in a more existential way to provide significance to a person's life. When a patient's dignity was maintained, the individual felt secure and had a sense of peace. Our findings echo the Spross's (1996) description of the nurse–patient relationship as one of coaching, arriving at a mutual understanding of the situation and establishing common goals that focus on the patient. It can also be described as a process of containing, in which patients can empty their fears and anxieties into the nurses. Through this process, patients were able to hear themselves saying the unthinkable aloud and then receive feedback, which also allowed them to develop different insights and options (Jones 1999). Personal meanings develop and change through talking with another person about matters closest to one's heart and mind. Regardless of individual circumstances, dying patients have a basic need to be valued, even when they know they do not have very much time left. Nurses in the study were able to show that the patient was an important person and that nurses really cared about them.

Limitations of the study

The participants interviewed in this study were primarily cancer patients in palliative care. An opportunity to study the interactions of nurses with clients suffering from other illnesses in palliative settings might uncover different aspects of the phenomena explored here.

Conclusion

In this study, both patients and nurses clearly articulated the pivotal role of knowing patients through their involvement and the formation of trusting relationships in providing optimum palliative care. In the absence of a positive relationship, shared goals were difficult to achieve. Further verification of the findings is recommended by replication in different clinical settings with larger Chinese populations, such as in Mainland China. More importantly, however, the study helps to show the complexity of the interactional processes that comprise nurse–patient relationships. We hope that future studies across different clinical settings and time will develop a richer picture of these processes.

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