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Relationships between Nurses and Family Caregivers: Partners in Care?

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▾ Abstract

Increasing reliance on family care of elderly people at home calls for a critical analysis of the relationship between formal and informal caregivers. Although much has been written about how health professionals and family caregivers should relate to one another, we know very little about the relationships that develop between them. Using data from a qualitative study, this article illustrates that relationships between community nurses and family members caring for frail elders are complex, dynamic, and multifaceted. Shifting boundaries in caring work leads to changes in nurse-family caregiver relationships, which can be categorized as four distinct, yet interconnected, types: (1) nurse-helper, (2) worker-worker, (3) manager-worker, and (4) nurse-patient. Each type is described, and implications for nursing practice and research are discussed.

Caring for rising numbers of frail or ill elderly people is a fundamental challenge facing Western societies. [1] In Canada, the provision of such care is occurring increasingly in private homes. [2] Admittedly, health care has always been carried out in the home, but the nature of family caregiving in the home has changed rapidly due to several converging trends. First, a financial "health care crisis" has resulted in strong pressure to locate services outside expensive institutions. [2,3] A steady decline in the number of acute and chronic hospital beds in every province has occurred, and this decline has accelerated in the past few years. [4] Long-term care patients are now cared for in the community, which shifts responsibility from paid caregivers to unpaid family members and allows the closure of long-term facilities. [5,6] Second, the growing proportion of older people with disabilities and chronic illnesses has increased the need and changed the nature of home care dramatically. [7-9] Finally, technological advances have made it possible to provide medical treatments at home that were previously performed

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Outline

only in hospital settings. [8,10]

The manner in which nursing and family caregiving are conceptualized has major consequences for the ways in which health care of elders is organized. With an increasing emphasis on collaboration over the past decade, nurses have been urged to develop "partnerships" with family caregivers in hospitals, nursing homes, and the community. [11-13] It has been estimated that 85% of all care received by elderly people comes from the family or informal systems-most commonly wives, daughters, and daughter-in-laws. [6,7] The remaining 15% is supplied by formal health care services, most no-tably nurses. In times of economic constraints,when public expenditures on formal services for the elderly are either reduced or frozen, women are usually the ones who shoulder the physical, social, emotional, and financial costs of caregiving. [3-6] Although the idea of "sharing" caregiving responsibilities is appealing to many, one underlying rationale for this approach to long-term care is that it is provided at less cost to governments or insurance companies. [14]

Controlling public expenditures by shifting more nursing work to the family may alter relationships in important ways. The examination of the relationship between nursing and family caregiving is of particular significance because health care administrators and policy makers are seeking to regulate the definitions of home care work. [15] Although much has been written about how health professionals and family should relate to one another, little empirical analysis has been undertaken of the relationship that develops between nurses and family caregivers, despite the fact that nurses constitute the largest group of health professionals. In this article, selected findings from a study about home care to frail elders [16] are used to illustrate that the nurse-family caregiver relationships that evolve through caring for an elder at home are complex, dynamic, and multifaceted. (Other aspects of this study, including a full account of the methodology and findings, will be reported in future publications.)

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LITERATURE REVIEW

The empirical literature about caregiving for older persons tends to be fractured along the lines of formal and informal care. [16,17] As a result, little attention has been given to the relationships between formal (professional) and informal (family) caregivers. A few researchers have gathered data from both family caregivers and health professionals about how they work together in providing care, [17-20] or how that relationship changes over time. [21] Others [18,22-24] have concluded that negotiation of partnerships is a dynamic process that involves considerable conflict. However, very little is known about relationships when elderly people with ongoing needs are cared for at home by nurses and family caregivers.

When health professional-family caregiver relationships have been studied, most researchers have focused on the perceptions of the family caregiver [11,25,26] or the perceptions of health care workers. [27] Most findings suggest that conflicts arise when health professionals fail to recognize family caregivers' expertise, [11,28] when roles overlap, [29,30] when roles are defined rigidly, [11,31] or when professional expectations of family caregivers are contradictory. [22] It appears that family caregivers occupy an ambiguous position in relation to health care professionals, who tend to view them as both the problem and the solution to the care of the ill family member. [20,33]

Failing to value family caregiving expertise and affective work in institutional care settings has been put forward as one source of conflict in formal-informal caregiver relationships in many studies. [11,23,31,32] Bowers [31] found that family members of relatives in nursing homes actively monitored staff and sought to work collaboratively and cooperatively by learning technical care themselves and by teaching individualized preservative (affective) care to nurses. However, they felt that both the importance of individualized affective care and the need for

partnerships to ensure high-quality care were unrecognized or ignored by staff.

Similarly, Ong [26] found that family carers valued being treated as equals and with respect by community nurses. When asked about their caring work in relationship to that of the nurse, family caregivers claimed to have unique knowledge about the care recipient and specific expertise needed to personalize care. They expected these to be acknowledged as an indication of preferred role as full partner in care. [19,26] These findings point to the importance of experiential, particularized knowledge of the family caregivers and to their desire to act as full partners in the care of their relative.

The absence of a shared perspective between family caregivers and health care professionals also has been suggested as the basis of conflict. Rosenthal and colleagues [30] described how hospital nurses cast families of patients of all ages into three roles: visitor, worker, and patient. In this study, a relative who either spent considerable time at the hospital or who was perceived to interfere with the nurses' preferred work style or the control of their work environment was considered to be a "problem" by the nursing staff. When family members were seen to be slipping out of the visitor role, they were cast into either the role of worker or patient. These roles did not reflect a true working partnership, but were rather a nursing strategy to contain interference, carrying an inherent subordination to the authority of the nurse. The current view about professional-family caregiver relationships, however, is away from this hierarchical view of health professional dominance toward a collaborative interaction in the provision of care to ill family members. [28,34]

The location of the health care interaction between family and professional caregivers is an important but understudied dimension, including its effect on the relative power of the participants. [35,36] Fischer and Eustis [17] studied 39 home care workers, 54 elderly clients with chronic disabilities, and 15 family caregivers. They found that both cooperation and conflict exist between family caregivers and home care workers. Caregiving alliances between family caregivers and workers were created in order to manage the care and support each other in problematic caregiving situations. Conflictual relationships were found when the worker's authority was challenged by family caregivers.

Researchers repeatedly have found that many family caregivers attempt to avoid or decrease conflicts by building collaborative relationships with health professionals. [11,21-24,29,31] In secondary qualitative analyses of data from two Canadian studies [32,37] about the relationships between health professionals and family caregivers of chronically ill and terminally ill relatives, negotiations in three distinct stages were identified in evolving relationships: naive trusting, disenchantment, and guarded alliance. Naive trusting was the label used to describe the early stage of the professional-family caregiver relationship. In this stage, family members initially believed and trusted that professionals had their best interests in mind. The second stage, disenchantment, was characterized by mistrust and occurred when the health professionals did not behave as expected, such as withholding information or providing insensitive care. The final stage, guarded alliance, was conceptualized as a relationship between professionals and family caregivers based on four different styles of trust in providers. These styles were hero worship (trust of one individual professional), resignation (feelings of hopelessness), consumerism (focus on services needed rather than relationships), and team playing (both perspectives are equally valued).

Frankfather's [18] investigation of staff (case workers and homemakers) and family relationships in home care revealed significant disagreements that tended to occur when families were not informed of home care options, when family members and staff could not agree on the nature or the amount of a specific service, or when family caregivers and care recipients did not agree on service options. As a result, staff would sometimes side with either the elder or the family. Similarly, Hasselkus [19] found an apparent three-way pattern of tension among family caregivers, elder care recipients, and professionals in the naming, framing, action, and judgments that took place in the caregiving situation. For

instance, while family caregivers were most concerned with maintaining an orderly routine of care and ensuring that no harm was brought to the care recipient, professionals were seen as being more concerned with enhancing the care recipient's independence.

Clark and colleagues [21] found that occupational therapists used four primary types of interactions with family caregivers of elderly receiving home care services: caring, partnering, informing, and directing. The strategies they employed were mostly of a directive nature, which failed to recognize the family caregivers' expertise and knowledge. Similar to other analysts of health care relationships, [38] the investigators of this study assumed that the expectations, values, and goals of family caregivers and professional caregivers were the same, and therefore that the roles are or should be collaborative. These researchers call for more active negotiation and mutually "reflective practice." In other words, if family and professional caregivers would engage in more reflection on the practice of the other and listen more to the other, then collaboration would result. However, the discrepancies in role expectations and treatment goals and values, as described earlier, often lead to conflict. [39,40] Few researchers specifically question why family caregivers and health professionals tend to operate from different assumptions and value systems, have conflicting role expectations, or hold differences in power.

In summary, although much has been written about how professional and family caregivers should relate to each other, little systematic analysis has been undertaken of the relationships that develop between them. Most researchers have focused either on health care professionals or family caregivers, neglecting the relational aspects of caring work. With a few exceptions, [22,41] researchers have failed to analyze professionals' and family caregivers' underlying assumptions, role expectations and responsibilities, and how negotiation between the two types of caregivers takes place. The relationship between nurses and family caregivers appears to be complex and dynamic and merits closer empirical examination if we are to better understand the "private" and "public" provision of home care of the elderly. In the next section, data from a study [16] of community nurses and family members providing home care to older persons are used to illustrate that both nurses and family caregivers cross the public and private boundaries and that complex negotiations are carried out between these two providers.

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SHIFTING BOUNDARIES OF CARE

A critical ethnographic approach was used to examine the relationship between community nurses and family members providing home care to older persons in urban Canada. Critical ethnography was chosen as the research method because this approach is meant to make explicit those assumptions that are implicit in a culture. [42] It not only illuminates the taken-for-granted Western assumption of "family care," but also focuses on how family caregivers and nurses are positioned and participate in specific power relations. Although most ethnographies begin with the premise that the structure and content of culture disadvantage some groups more than others, critical ethnography strives to promote the movement of oppressive situations toward emancipation. [43] As previously mentioned, there is increasing evidence that women already bear a disproportionate share of the costs associated with elder caregiving; therefore, the social justice that underlies critical ethnography is consistent with the activist stance of socialist feminism.

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Theoretical framework

The study was guided by a socialist-feminist perspective of caring, which is articulated in the writings of Fisher and Tronto [44] and Ungerson. [45] One of the most significant achievements of this scholarship is the way it challenges and de-constructs women's roles. Female caregiving is viewed as highly skilled emotional,

mental, and physical work that crosses "public" and "private" boundaries. Although a socialist-feminist perspective helps to explain the interconnections between public and private caring work, it does not specifically address the interpersonal relations between family and professional caregivers. Therefore, another perspective used is derived from Twigg and Atkin's [20] four models or conceptualizations of response of health and social workers to family caregivers: carers as resources, as coworkers, as co-clients, and as superseded carers. One of the limitations of their conceptual model is that it is based on the perspectives of social and health professionals and not those of family caregivers. However, the four prototypes of carers help provide a frame of reference to examine the different types of relationships between family caregivers and nurses and to understand the varying roles that may develop between them.

Sample and method

A purposive sample of 23 family caregiver-nurse dyads was drawn from three nonprofit, publicly funded community nursing agencies in southwestern Ontario. The dyads had known one another from 3 months to 14 years, with a mean of just under 3 years. While the frequency of contact between each dyad ranged from daily to less than twice a month, most saw each other weekly. The average age of the nurses was 47 years. With one exception, all the nurses were female. The majority were born in Canada (67%), spoke English as their first language (93%), held a diploma in nursing (53%), and had been practising community nursing 11 or more years (53%). All the family caregivers were female and ranged in age from 33 to 82 years, while most were over 60 years old. None were employed full time; however, three participants worked part time. The majority had been born in Canada (65%) and provided care to their husbands (70%) who had a chronic illness (87%). The elder care recipients ranged in age from 65 to 99 years, with a mean age of 78.9 years.

The approach used to recruit and interview participants, as well as the ways in which data were analyzed and disseminated, was informed, in part, by the work of feminist researchers. [3,42] Participants were assured that anonymity and confidentiality would be maintained, and building rapport and providing support and information were some of the strategies used throughout the study. Using an in-depth focused interviewing approach, [46] both types of caregivers were asked to talk in private about their experiences of working together. This type of approach encouraged accounts of negotiations about caregiving responsibilities and the relationships that develop, as well as the conditions, constraints, and consequences of these negotiations. A total of 38 interviews were audiotaped, each averaging 75 minutes in length. Interviews with the family caregivers were conducted in their homes; all but one of the caregivers lived with the elderly relative who needed care. Approximately half of the interviews with the nurse participants were held in an office or conference room; the remainder occurred in the nurses' homes. The interview data, along with field note data, were transcribed and analyzed. Analysis was facilitated through the use of computer software, NUD*IST (Thousand Oaks, Sage), which helped with the location of patterns within and across nurse-family caregiver dyads.

The making and breaking of relationships between nurses and family caregivers

The findings suggest nurse-family caregiver relationships that evolve through caring for an elder at home are complex and dynamic. Relationships involved four distinct, yet interconnected, types: (1) nurse-helper, (2) worker-worker, (3) manager-worker, and (4) nurse-patient. Each type conceptualizes the roles of the nurse (left) and family caregiver (right) differently, and each has different goals and outcomes. While these relationships appear to evolve over time, they are not linear or unidirectional. Some nurse-family caregiver dyads tend to oscillate between the four types of relationships. However, the overall aim is eventual termination of the nurse-family caregiver relationship.

The types of relationships between nurses and family caregivers are shaped, in part, by the fiscal climate in Canada's mixed economy and in response to home care management's need to cut costs of nursing care. Although home care has always had a mix of for-profit and not-for-profit service delivery, it is essentially funded publicly by the provincial governments. To keep public costs down, nurses used three major strategies in negotiating care with family caregivers: delegating as much care as possible to the family caregiver, gradually decreasing the frequency and range of care, and accessing other less expensive community services. However, in a few situations, nurses either resisted giving up their caregiving activities or occasionally increased their responsibilities to include those tasks previously carried out by family caregivers, such as bathing. Although family caregivers acted in both a cooperative (eg, agreeing to take on more care) and resistant (eg, expressing disappointment and complaining) manner, caregiving tasks, in terms of degree and complexity, were transferred from nurses to family members. This illustrates the ways in which nurse-family caregiver relationships involve power exchanges, and how negotiations are embedded in a broader political and economic environment.

Nurse-helper relationship

In nurse-helper relationships, nurses provide and coordinate the majority of care, while family caregivers assume supportive roles to nurses. Although most nurses and family caregivers reported that this was the type of relationship they had at the beginning of the elders' illness, this was the least common relationship found in this study. Only two of the three dyads caring for terminally ill elders described their relationship as being of this type.

For nurses, the goal in this relationship is "taking time to care." In palliative care, nurses tended to provide care 7 days a week for approximately 2 hours each day, which increased gradually as the care recipient's needs increased. Elders appeared to receive optimal nursing care because, as one nurse claimed, the number of nursing visits allowed by the case manager is greater for palliative care than for chronic care:

Palliative care is kind of a special instance because they're dealing with a life-threatening situation and there's going to be coping problems that will affect the caregiver as well as the patient. So they do take that into account and they give us a little more leniency when we're asking for extra visits.

Most of the negotiating strategies involved nurses assuming more care than previously stipulated by the case manager and resisting agency policies and directives to give up this care. As one nurse commented, palliative care requires nurses "to be the nurse" in the home. Nurses rarely shifted or transferred their care to family caregivers. Although family caregivers tended to trust the nurses' judgment in relation to the care required, they actively sought out opportunities for involvement citing the need to feel useful or to have some control of the situation. In turn, nurses supported the family caregivers, acknowledging their need to participate in the elders' care. In the words of one family caregiver:

I think the nurses knew that I needed to be involved. I'm sure that was part of it, because if you're involved you feel as if you have some control over what's happening even if it's in a limited way.

The boundaries in this nurse-family caregiver relationship were relatively unambiguous. Both types of caregivers recognized and valued the separate contributions of each other's caring work. This finding supports other studies [11,23] in which family caregivers and health professionals engaged in a supportive, cooperative relationship as they shared the process of caring. With the exception of palliative care situations, this type of relationship did not last for any length of

time. Due to the cost of providing formal care to chronically ill individuals, nurses were expected to shift quickly into the second type of relationship.

Worker-worker

Only a few dyads operated within the second relationship, as coworkers, but most had experienced it in the past. Based on the notion of "teamwork," nurses aimed to work with family caregivers in a way that recognized their expertise, but in an essentially co-opting and controlling way. Many talked about the importance of forming relationships as colleagues with family caregivers and sharing information so that mutual decisions could be carried out in the nurses' absence. However, the following quote illustrates that compliance of the family caregiver rather than mutual decision making between the nurse and family caregiver is clearly what is expected:

If you don't have the family on side, then they do what they want to do…. I just work with them in order to achieve the desired goals…. It's almost like coworkers, both of us working on the patient's problems.

Many nurses expected family caregivers to learn how to care for the elder and proceeded to teach them a variety of technical skills. They sought to gain the family caregivers' trust and cooperation in order to be successful in delegating their nursing work. As a result, a one-way flow of instrumental tasks from the nursing domain to the family caregivers' realm of responsibility occurred gradually over time. In the words of one woman who cared for her husband:

I do everything for my husband with no training or proper papers. The nurses taught me how to do it and that was it…. She said "this is how you do it" and I took it from there.

Within this type of relationship, ongoing negotiations between nurses and family caregivers centered on family caregivers' growing competence and skill in assuming more caring tasks usually associated with nursing. Almost 75% of the family caregivers cooperated fully with the nurses in learning these new skills. This work-transfer process took time and trust on the part of the family caregiver and patience and persuasion on the part of the nurse. Those family caregivers who did not go along with the premise that they should assume those technical tasks complained of feeling frightened, overwhelmed, or angry that the task appeared too difficult or technical. One woman spoke about being harassed to learn a new skill that clearly fell outside of her expertise:

I am NOT a qualified nurse! I was expected to give him his injections of medications, which I absolutely refused to do…. The nurse was going to teach me how to stick a needle in my husband come hell or high water. But I was just as determined that I was NOT going to put a needle in my husband. I have seen some of the damage that can be done with a needle not put in properly, and I was not going to take that responsibility.

One of the consequences of this type of nurse-family caregiver relationship is that family caregivers had a great deal of responsibility with little authority. On the one hand, nurses taught them a number of procedures and skills so they could be informal members of the health care team. On the other hand, they were asked to defer to, and comply with, the advice and expectations of professionals. One particular woman caring for her terminally ill husband recalls feeling anger and helplessness when she sought assistance in the early hours of the morning:

The needle site of the morphine pump kept shutting down … so finally [I] ended up calling this number and they said, "We can't talk to you, you're not a

doctor or nurse." I said, "I beg your pardon?" I just about hit the roof because I called the nursing agency and they gave me the nurse on call and she told me to call this number…. I was livid. My husband is laying here in pain and you're telling me you're not going to talk to me.

In contrast to the first nurse-family caregiver relationship, the coworker relationship was full of tension, conflicts, and ambiguities. As others have found, [22,32] family caregivers were faced with contradictory expectations; they were caught in a web of messages that often were in opposition. Ambiguity about the family caregivers' responsibilities and authority created a moderate to high amount of tension. In the end, co-optation of the family caregivers' "free" labor depended largely on the creation of a trusting relationship with the nurse. Eventually, family caregivers assumed responsibility for virtually all the elders' care, moving into a third type of nurse-family caregiver relationship.

Manager-worker

The majority of the dyads (n = 16) operated within the relationship "nurse as manager/family caregiver as worker." As nurses gradually transferred their actual caregiving over time, the importance of monitoring the family caregivers' "coping skills" and "competence" increased. Although many family caregivers had accepted increases in their actual caring work in terms of complexity and time, not all family caregivers were convinced that this arrangement was satisfactory to them. Most family caregivers were confused and sad that the nurses had reduced their time and emotional involvement. A few actively confronted the nurses' attempts to set limits on their roles, but with minimal success.

One elderly woman who had been caring for her chronically ill spouse for 2 years had experienced a gradual reduction in nursing services. Since the care of her husband had not changed over the years, she was providing complicated technical and personal care, mostly on her own. In frustration she reacted to a further reduction in nursing visits:

At first she was coming three times, and then they cut it back to twice a week. And now they are cutting it down to once, just once a week. Again this is the case worker's suggestion that she only comes once a week. They feel that I am able to look after him and give him the care that's needed…. It makes me uncomfortable, to feel that, again I've been given more responsibility because no matter how you dress it up, that's what it is! It's the responsibility of my husband's care, it's going to be solely in my hands and sometimes it comes to a point where you just lose it.

Overt concern for the family caregivers' well-being by nurses was minimal, and, if present, this concern was usually directed at keeping the family caregiver well for the sake of the elder. One particular nurse explains:

I think if you keep the caregiver together it keeps the client together…. If the caregiver falls apart, forget it, you know. What's going to happen? A crisis. And we found that because a lot of them burn out.

Concern for the well-being of the family caregiver also was overridden by the belief that family care should stay within the "family." Many nurses spoke of their role as a "resource person," providing information and emotional reassurances to the wives, daughters, and granddaughters so they could continue in their primary caregiving role. Nurses only rarely considered increasing their own responsibilities or enlisting other less expensive caregiving services in order to decrease the family caregivers' workload. Instead they usually advised family caregivers to access alternative resources such as caregiver support groups. While these suggestions were seen as somewhat helpful to some, many family caregivers complained that

the assistance being offered did not meet their specific needs for help with nursing care. In the words of one family caregiver:

All I'm saying is I don't need a support group. That isn't what I need. All I need is physical [help]. I need physical help.

Discrepancies in values and norms prevailed in these negotiations and tension between family and professional caregivers was relatively high. Although family caregivers accepted that the nurse had technical and experiential knowledge of the elders' illness, they resisted the nurses' efforts to tell them how to cope with caring for their relative. Family caregivers asserted their right to decide on what types of services to accept into their home and to control their lives as much as possible.

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Nurse-patient

The final type of relationship, "nurse as nurse/family caregiver as patient," surfaced almost as frequently as the manger-worker relationship. Family caregivers were seen as people in need of care in their own right, especially those women who were elderly or who had chronic health conditions. As a result of their demanding caregiving schedules, coupled with preexisting health conditions in some cases, many family caregivers became the nurses' patient.

Family caregivers reported that the amount of caring work they were expected to do caused physical and emotional exhaustion, social isolation, and strained family relationships. Some spoke of health conditions such as angina, arthritis, and hypertension that resulted from and impacted on their hectic caregiving schedules. Many characterized themselves as "chronically tired" and "extremely tense." They felt that they had no choice but to ignore their own health in order to look after their relative.

In this type of relationship the source of conflict between nurses and family caregivers is the fact nurses were faced with contradictory expectations. They were expected to care for the elder at the same time they were expected to make sure the family caregiver remained well. Nursing interventions were aimed at relieving the family caregiver of her ongoing caregiving demands temporarily by arranging short-term respite services and preventing any crises from occurring. Although some nurses acknowledged that they felt "pulled" between the needs of the family caregiver and the needs of the patient, the family caregivers' status as "patient" was rarely a fully equal one, since they were not officially "on service." One of them explained:

It's just that I think the main goal in this is keeping them both out of hospital. It's keeping mom at home, cared for, and keeping the family caregiver at home, not falling apart, not having a breakdown. And it's a balancing act every time you go there.

Generally speaking nurses expressed concern for the family caregivers' health. However, they either tended to minimize the problems or rationalize that they were doing their best within the current fiscal "reality" of the home care system.

In summary, among the four nurse-family caregiver relationships, the most predominant ones were those of manager-worker and nurse-patient. Although there are some overlapping elements in both types of relationships, the nurse in the manager-worker relationship visits less often, assumes a primary supervisory role, and is less concerned about the family caregiver's well-being compared to the nurse in the final nurse-family caregiver relationship. Most nurses and family caregivers, however, did not fall exclusively into any one type of relationship. They

tended to oscillate between the four different types of relationships as the caregiving situation evolved.

Contradictory expectations on the part of both family caregivers and nurses created tension. Family caregivers experienced tension when nurses leaned toward a relationship that demanded more of them than they felt that they could give, when nurses left them on their own to provide the bulk of care, and when their expertise and skill in providing care were not recognized beyond the nurse-family caregiver relationship. Nurses experienced tension when they were caught between the needs of the elder and the needs of the family caregiver, when they related to the family caregiver both as the "worker" and the "patient," and when family caregivers did not comply in learning new skills or accepting suggested services. Moreover, tension was apparent if nurses and family caregivers held vastly different role expectations of one another. For instance, if the nurse treated the family caregiver as the "patient," while the family caregiver saw herself as the primary caregiver, the goals and roles within these two types of nurse-family caregiver relationship conflicted. Thus, relationships between family caregivers and nurses tend to be ambiguous and characterized by tension.

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DISCUSSION

Despite study limitations, such as a cross-sectional design and a small convenience sample of highly educated nurses and preselected family caregivers (ie, nurses were asked to approach eligible family caregivers), the results point to a number of important implications for nursing practice and future research.

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Implications for nursing practice

Study findings point to an exploitative relationship between family and professional caregivers, not one that reflects a true "partnership." A partnership implies that both types of caregivers contribute equally to client care. In this study, family caregivers were making greater contributions than nurses in terms of physical, emotional, and intellectual labor. Study findings support other research [11,23-25] that found family caregivers who are managing get praise from practitioners but little practical assistance to support the continuance of that care. Furthermore, although nurses in this study truly understood the tremendous demands placed on family caregivers, for the most part they did very little in terms of advocating on the family caregivers' behalf. Most family caregivers were left socially isolated without adequate resources to provide care, and this situation raises ethical concerns. Intentionally or not, holding family caregivers accountable for the provision of care without adequate resources is completely unacceptable. [47] Failure to provide resources to help family members provide care could risk even further increases in health care costs, as injuries or illnesses of the elder and/or family caregiver ensue.

Applying the notion of partnership to professional-patient relationships also ignores the tension that exists between the two caregivers, especially when family caregivers are given primary responsibility for the elders' well-being. Health professionals need to understand that the tension and frustration that they experience as caregivers are indicators of an adversarial relationship. Moreover, until the physical, emotional, and intellectual components of nursing work are formally acknowledged and valued, programs in long-term care will continue to be geared toward instrumental task maintenance. In this study, both nurses and family caregivers operating within the nurse-helper relationship did not vocalize feelings of powerlessness and stress as often as those nurses and family caregivers in other types of relationships. When nurses were permitted to spend more time in palliative care situations, family caregivers felt more supported than their counterparts caring for a chronically ill family member.

Study findings also challenge the nature of the relationship between formal and informal care providers. It is important that health professionals take a serious look at what they do and what outcomes they want their caring work to serve. [48] Although this may place the health professional in a double bind (personal interests versus social responsibility), a change in professional practice is essential to improve the situation for family caregivers. It is important that nurses and other health care providers evaluate not only the negative impact that work transfer has on the family caregiver, but also how this "exploitative" labor process to save money disadvantages them as well. Thus, health professionals must move beyond the rhetoric of shared care in order to "reconceptualize home care and recognize the price it is exacting in its present form." [22(p19)]

With one exception, feminist thinking did not seem to influence nurses' professional interactions with family caregivers in this study. For the most part, they witnessed and understood the tremendous demands placed on family caregivers, especially those who cared for chronically ill elders requiring 24-hour care. And yet, they did very little in terms of advocating on the family caregiver's behalf. Although the needs of professionals are different from family caregivers, it is important to highlight that both types of caregivers depend on one another to provide care. If nurses and family caregivers discuss their mutual concern about the lack of resources to provide adequate care, perhaps, as McKeever suggests, "their mutual plight would become obvious," [49(p18)] leading to an awarenes that could eventually lead to coalition building and lobbying for their collective well-being.

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Implications for research

More needs to be known about the development and nature of relationships between formal and informal caregivers of the elderly and other dependent populations. Future research is needed to validate the four evolving interconnected types of nurse-family caregiver relationships found in this study. Replication of this study, using nurse-family caregiver dyads in a variety of long-term care settings, would permit comparisons between types of settings and care situations in relation to the most common nurse-family caregivers relationships.

Since study findings illustrate the importance of time in the development of these relationships, longitudinal research would increase our understanding. In particular, it is important to understand the exact mechanisms that promote inequitable exploitative relationships between family caregivers and health professionals and the specific consequences for each type. It also is important to examine how care recipients, family caregivers, and health care providers are interconnected by the work-transfer process; who is disadvantaged by this labor process; and to what extent. Data on the direct and indirect effects of work transfer could be used to design equitable long-term care practices and policies.

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CONCLUSION

Calls for forging "partnerships" between professionals and family caregivers [11,13,39] must be met with caution since they appear to be based on economic rather than humanitarian grounds. [50] Using data from a study of community nurses and family members providing care to an older person illustrated how relationships between nurses and family caregivers are negotiated. Furthermore, they showed that boundaries between formal and informal caregivers shift over time, in terms of both the work allocated and the resulting four types of relationships. Constantly shifting boundaries also made alliances between nurses and family caregivers quite complex and challenging at times. Ultimately, transformation of the broader political and economic conditions of home care is necessary if a more equitable sharing of responsibility between family and professional caregivers is to occur.

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Key words: caregiving; eldercare; feminism; home care; relationships