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Editorial

Nurse–patient partnerships in hospital care

Commitment to nurse–patient relationships is being fostered in a number of health initiatives. However, it is questionable how far this can be achieved while financial efficiency is foremost in health care management thinking.

The rhetoric of partnership cannot be fully realized under such economic constraints. Healthcare institutions are supposed to be financially viable, but without compromising patient satisfaction. Furthermore, the demands of an informed population and society's mandate on nurses to deliver holistic care require nurses to become, as Denner (1995) stated, more than a nurse. Consequently, nurses are engaging in higher education and expanding their practice dimensions, including interpersonal skills development, thereby enhancing their competency to deliver holistic care.

Certainly role expansion, not extension, should take precedence (Wright, 1995). When there is a focus on role extension, for example to reduce junior doctors' hours and workloads, nurses' role in patient empowerment is eroded because these time-consuming, challenging responsibilities take up time which could otherwise be invested in forming therapeutic relationships with patients. Furthermore, developing therapeutic relationships require education for nurses in effective interpersonal skills.

However, I agree with McQueen (2000) that nurses and patients cannot enjoy totally equal relationships. The contractual nature of the nurse–patient encounter is one of necessity not choice, which renders it unequal. Also, the nurse's purpose is different from that of the patient (Cheahy Pilette *et al*., 1995). Both parties must acknowledge their respective inequalities, but implicitly value each other's competencies.

Some patients are engaging in self-empowerment by taking advantage of the proliferation of knowledge available via advanced information technology. Health professionals should not resent this development, but value its emerging positive consequences in terms of empowering patients to contribute actively to their healthcare. However, health professionals should remember that information obtained from, for example, the Internet, may not always be appropriate to patients' particular needs or may be misinterpreted. We should therefore assess patients' previously acquired knowledge and help them to gain the best they can from these kinds of information sources. Patient self-empowerment should be viewed as a constructive component of nurse–patient relationships, where patient autonomy is valued.

Patient autonomy is a crucial concept in contemporary debate but is perceived differently by different health professionals, as outlined by Aveyard (2000). Therefore, respecting autonomy is not always straightforward. Aveyard stresses the importance of nurses committing to a consistent, ethically defensible approach to patient autonomy, in attempting to achieve equality in the healthcare environment.

Responding to overt and covert needs of patients requires a healthcare environment that is committed to quality nurse–patient relationships. Frequently, hospital wards and the organization of nursing work do not focus attention on promoting holistic care. Such environmental barriers can frustrate nurses in their attempts to establish nurse–patient relationships and clinical nurse managers need

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more autonomy to adapt the environment and organization of nursing work in order to implement a philosophy of therapeutic care.

Additionally, ward culture – including ward philosophy and teamwork – has an impact on student nurse socialization into nursing. It is nurses' responsibility to provide an acceptable environment in which patients' diverse needs can be met (Cheahy Pilette *et al*., 1995), and also to ensure that student nurses are socialized within a positive learning environment and by role models who give individualized and holistic care.

Responding to patients' covert needs involves work that is difficult to define and evaluate and so the therapeutic value of emotional labour often remains hidden. I would argue that measuring this invisible work is possible through research studies on therapeutic relationships with patients who experience the therapeutic effects. McQueen (2000) accurately identifies that more extensive appreciation of the conceptual complexity of nurse–patient partnerships is needed, particularly because emotional involvement carries the consequence of mental exhaustion. Furthermore, professional boundary violation can undermine therapeutic relationships (Cheahy Pilette *et al*., 1995). Nurse education therefore needs to include input on maintaining appropriate professional boundaries to combat this detrimental effect.

The essence of nursing is reflected in nurse–patient interpersonal relationships and their therapeutic benefits, despite multiple organizational and financial constraints. The enormous benefits of such relationships must be valued and visible. Only then can nurse–patient relationships really be called 'therapeutic partnerships'.

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References

Aveyard J. (2000) Is there a concept of autonomy that can usefully inform nursing practice? *Journal of Advanced Nursing* **32**, 352–358.

Cheahy Pilette P., Berck C.B. & Achber L.C. (1995) Therapeutic management of helping boundaries. *Journal of Psychosocial Nursing* **33** (1), 40–47.

Denner S. (1995) Extending professional practice: benefits and pitfalls. *Nursing Times* **91** (14), 27–29.

McQueen A. (2000) Nurse-patient relationships and partnership in hospital care. *Journal of Clinical Nursing* **9**, 723–731.

Wright S.G. (1995) The role of the nurse: extended or expanded? *Nursing Standard* **9** (33), 25–2.