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**Niven and Scott (2003): Sixteen years of hindsight**

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Niven and Scott (2003): sixteen years of hindsight

or

The need for accurate perception and informed judgement in determining the appropriate use of the nursing resource: hearing the patient’s voice: revisited.

Abstract

This paper revisits a 2003 publication in Nursing Philosophy: The need for accurate perception and informed judgement in determining the appropriate use of the nursing resource: hearing the patient’s voice.

The author suggests that the basic ideas and focus of this 16 year old paper are still topical and relevant in considerations of nursing care. However it is also suggested that greater attention to the importance of the nursing-patient relationship in considerations of resource allocation, and potential rationing of nursing care, would have strengthened the original paper.

Key words

Patient voice, Nurse patient relationship, Resource allocation, Rationing.
The general ideas and focus of Niven & Scott (2003), published 16 years ago, in my view remain relevant. Ideas such as the need to involve patients in decision making regarding their care, sensitivity to the person who is patient, and the requirement for an in-depth investigation and exploration of the judgements and decisions that nurses make on a daily, even hourly, basis remain as relevant today as they were in 2003. Awareness, and acceptance, of the need to involve patients in decisions regarding their care may have increased, but insight into and knowledge of nursing judgement and decision making has grown little since that time.

The lack of knowledge regarding basic nursing judgement and decision making is never more apparent than in recent commentaries on the Irish national radio station **RTE 1** on the 2019 nurses’ strike and pay claim. Commentators repeatedly suggested that nurses do not make autonomous decisions in their day to day work. As a recent recipient of care and an observer of the delivery of care, I can categorically state that such comments continue to perpetrate an inaccurate perception of nursing activity – reflecting the experience of CN; the patient at the heart of the discussion in Niven & Scott (2003).

Of course, the decision making and work of some professions in healthcare is more visible than others: physiotherapy and medicine are examples of the former; nursing an example of the latter. Invisibility however does not necessarily equate with non-existence. As CN had pointed out in 2003, inviting the patient to decide if they want reconstruction, and if so what type, is a visible, high-cost decision that will direct elements of future patient care and requirements. This decision was made in active consultation with CN as a patient. Deciding which nurse or care worker would look after CN, at which point in time and for which care requirements, is not nearly so visible a decision. As CN also pointed out, this was not something about which she, as a patient, was consulted. These decisions were made by nurses – decisions with significant impact on the patient experience.

If I were contributing to the Niven & Scott (2003) paper today, much of the underlying arguments and the focus on the importance of hearing the patient voice would remain. However I would either drop the brief, under-developed discussion on patient autonomy, or
develop it into a more substantive argument. In doing so the notion of relational autonomy (Ells et al., 2011, Greaney, 2014), would be linked with the nurse-patient relationship, and decisions regarding allocation of the nursing resource to the provision of humane, high quality nursing care. I would also strengthen the discussion on resource allocation by introducing the notion and the evidence of active, covert rationing of nursing care – at both bedside and institutional levels.

An informed discussion with patients regarding their likely needs from nursing staff requires, in my view, a considered discussion of the nursing patient relationship. One approach to analysing differing manifestations of the nurse-patient relationship, that may help both nurses and patients identify reasonable expectations of nursing staff in a variety of contexts, is presented by Morse (1991). Her analysis may also help nurses and patients engage in a consideration of the features of a decent minimum of nursing care, particularly in situations where the nursing resource and/or availability of nursing time is under strain (For a discussion on the notion of a decent minimum of care see Savulescu, 2001.).

Morse (1991) describes 4 manifestations of the nurse patient relationship: Clinical, Therapeutic, Connected and Over-involved. The clinical relationship is appropriate when the contact is short, functional, and the needs of the patient very discreet – such as taking blood for testing, or dressing a minor wound. The therapeutic relationship, the most often encountered according to Morse, goes somewhat deeper than the clinical relationship – contact between nurse and patient is still relatively brief, the needs of the patient are relatively minor, and care is given quickly and effectively. In this type of relationship the patient expects to be treated for their presenting problem and has family and friends to meet other psychosocial support needs. Morse suggests that within the context of this type of relationship some degree of testing will occur from the patient’s perspective, to see if she or he can “trust” the nurse to look after them properly until they can care for themselves again. This is likely to be the most common form of nurse-patient relationship encountered in modern acute care settings. However the needs of very dependent and/or acutely ill individual requires the nurse to be able to flex between the therapeutic and connected forms of the nurse–patient relationship.
The connected relationship either evolves over time, as patient and nurse get to know each other over an extended care period, or is stimulated by the ability of a nurse to respond to the intensity of the patient’s need. Morse suggests that

“In this relationship, the patient believes that the nurse ‘has gone the extra mile’, respects the nurse’s judgement and feels grateful, the nurse believes that her care has made a difference to the patient.”

(Morse, 1991, p. 458)

In the over-involved relationship the nurse treats the patient as a person and friend first and as a patient second. The nurse can become territorial over the patient, may become over-extended, lose a sense of balance and suffer impaired judgement. This kind of scenario can lead to impaired patient care as well as nurse burnout.

For the purpose of this commentary, let us dispense with the over-involved relationship as it represents dysfunction and has limited usefulness in any discussion with patients regarding reasonable expectations of nursing staff.

The diary extract from CN (Niven & Scott, 2003) provides clear descriptions of both the therapeutic and the connected relationships. These are likely to be the most common manifestations of the nurse-patient relationships encountered in either acute inpatient care, or in caring for patients with chronic illnesses over the medium to long term. Each of these manifestations of the nurse-patient relationship – that is, therapeutic and connected - have different resource implications and can provide insight into the requirement of individual members of nursing staff in terms of nursing time, energy, and involvement. This analysis would have been of value in discussing the needs of patients and the importance of hearing the patient’s voice as an important aspect of determining the appropriate use of the nursing resource. CN clearly indicated the importance of each of these approaches to nursing and nurse-patient interaction at the different stages of her illness and in relation to her experience of nursing care. She also pointed out the lack of professional nursing input, at least at the therapeutic level, during her first shower – and what this meant for her experience of care at that stage of her journey.
Nursing time is a limited resource. In some instances at least, there may not be sufficient nursing time to meet the needs of those requiring nursing in a given unit or context. Coming to recognise (a) that the clinical or therapeutic relationships is all that is normally required by most patients, and (b) that this knowledge may enable nurses to remain open to instances when patient need is greater (either because of the intensity of the patient’s illness situation, or the intensity of the consequences of the patient’s illness and diagnosis and so forth), potentially provides useful insights in relation to the distribution and effective use of the nursing resource.

Such understanding also enables the recognition of situations where an increased demand for the connected type of nurse-patient relationship is likely, and where increased nurse to patient ratios may be required as standard. This type of understanding could, for example, be used to inform concepts and definitions in tools used for calculating nursing hours per patient day (Twigg et al., 2011), and patient intensity (Rauhala & Fagerstrom, 2004), and dependency scales (Dijkstra et al., 2000). Morse’s approach to nurse-patient relationships may also help mitigate a nurse’s perception of being overwhelmed by patient need, particularly potential emotional and psychological support needs.

This approach helps to highlight that patients who are hospitalised or who are receiving nursing time in the community, or in their own homes, do deserve considered nursing input. Perhaps such input is of the short, sharp, clinical variety, but more likely of the therapeutic variety – competent, considered care that is not overly demanding of the nurse, in terms of psychological or emotional support, nor of an ongoing or intense nature.

This insight and understanding can inform a consideration of the nature of resource allocation in nursing. It can also inform explicit, overt discussions regarding a potential requirement to ration nursing care in particular instances or particular contexts. Such considerations should be explicitly identified, discussed, and decided by peer review; which is informed by insights from nursing practice and other relevant evidence. There is in reality a growing body of evidence suggestive of significant, covert rationing of nursing care (Jones et al, 2015, Scott et al., 2018) which, by its very nature, remains unidentified, unexamined in terms of rationale or assumptions, and unscrutinised. The result is a continual risk of inconsistent care, and of the care received (or not received) by a patient being almost
entirely at the discretion of the individual nurse looking after that particular patient at the
relevant point in time.

Growing shortages of nursing staff internationally, in addition to cuts in nursing staff at front
delivery level during the recent financial crash, combined with minimalist models of
care that became the norm at that time, has led to assumptions within and across many
health services and nursing staff groups that it is not possible to provide safe, supportive,
competent and humane nursing care with the available nursing resource (Jones et al., 2015,
Harvey et al., 2016). These assumptions lead to the idea that there is no option but to ration
nursing care. The often implicit argument proceeds as follows: (a) there are not enough
nurses to provide the required level of care, (b) the explicit public messages from health
service managers, budget holders and Ministers of Health is that all required nursing care
must be provided (despite changes in patient acuity, reduced lengths of stay, turnover,
increased patient expectation and increased dependency), (c) this is not possible given the
nursing resource available, (d) therefore some care will be left undone (prioritization of
some nursing care inputs will result in other elements of care not being done, or not being
completed). Thus covert rationing of nursing care is inevitable and is being instituted.

In the absence of explicit decision making frameworks and/or public discussion of the
pressures on the available nursing resource, this rationing of care is left to the discretion of
individual nurses delivering care at the bedside. As such it is not open to scrutiny, review, or
challenge, and until a disaster or scandal ensues over a particular instance or context of care
the situation is likely to remain largely obscured.

With the value of hindsight, and the growing evidence base of the presence of covert
rationing of nursing care, I would develop our analysis and discussion of the difference
between resource allocation and rationing in nursing and health care, and the role of the
patient’s voice in this, in a clearer, more in depth and more sophisticated manner. This, I
suggest, is an obvious gap in Niven and Scott (2003). If the quality of the patient experience
is important to health care providers (and Ministers of Health), as current policy suggests
(Byers et al., 2017), then these same service providers need to recognise the evidence that
nurses are an important factor in such quality of care experiences (Aiken et al., 2011, Aiken et al., 2012 and McHugh et al., 2013).

By highlighting more clearly the need to recognise the drivers of resource allocation decisions in health care and in particular nursing care – for example the impact of technologies such as the Diep flap mentioned by CN on the use and distribution of the nursing resource – we might be in a better position to identify when the only consideration driving resource allocation are technical, and/or medical treatment decisions, rather than the holistic nursing care needs of patients. If patients require a connected relationship with a member of nursing staff, even if over a very discreet time period, it is important that this is factored into resource allocation decisions - just as important as say the need for a technician to be in theatre for specialist surgery or the €billions spend decisions on pharmaceutical agents, often to questionable benefit (Barilan, 2015).
References


