



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

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

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8 Niven and Scott (2003): sixteen years of hindsight  
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15 The need for accurate perception and informed judgement in determining the appropriate  
16 use of the nursing resource: hearing the patient's voice: revisited.  
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29 Abstract  
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33 This paper revisits a 2003 publication in Nursing Philosophy: *The need for accurate*  
34 *perception and informed judgement in determining the appropriate use of the nursing*  
35 *resource: hearing the patient's voice.*  
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38 The author suggests that the basic ideas and focus of this 16 year old paper are still topical  
39 and relevant in considerations of nursing care. However it is also suggested that greater  
40 attention to the importance of the nursing-patient relationship in considerations of resource  
41 allocation, and potential rationing of nursing care, would have strengthened the original  
42 paper.  
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55 **Key words**  
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57 Patient voice, Nurse patient relationship, Resource allocation, Rationing.  
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8 The general ideas and focus of Niven & Scott (2003), published 16 years ago, in my view  
9 remain relevant. Ideas such as the need to involve patients in decision making regarding  
10 their care, sensitivity to the person who is patient, and the requirement for an in-depth  
11 investigation and exploration of the judgements and decisions that nurses make on a daily,  
12 even hourly, basis remain as relevant today as they were in 2003. Awareness, and  
13 acceptance, of the need to involve patients in decisions regarding their care may have  
14 increased, but insight into and knowledge of nursing judgement and decision making has  
15 grown little since that time.

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23 The lack of knowledge regarding basic nursing judgement and decision making is never  
24 more apparent than in recent commentaries on the Irish national radio station **RTE 1** on the  
25 2019 nurses' strike and pay claim. Commentators repeatedly suggested that nurses do not  
26 make autonomous decisions in their day to day work. As a recent recipient of care and an  
27 observer of the delivery of care, I can categorically state that such comments continue to  
28 perpetrate an inaccurate perception of nursing activity – reflecting the experience of CN;  
29 the patient at the heart of the discussion in Niven & Scott (2003).

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

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56 If I were contributing to the Niven & Scott (2003) paper today, much of the underlying  
57 arguments and the focus on the importance of hearing the patient voice would remain.  
58 However I would either drop the brief, under-developed discussion on patient autonomy, or  
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3 develop it into a more substantive argument. In doing so the notion of relational autonomy  
4 (Ells et al., 2011, Greaney, 2014), would be linked with the nurse-patient relationship, and  
5 decisions regarding allocation of the nursing resource to the provision of humane, high  
6 quality nursing care. I would also strengthen the discussion on resource allocation by  
7 introducing the notion and the evidence of active, covert rationing of nursing care – at both  
8 bedside and institutional levels.  
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15 An informed discussion with patients regarding their likely needs from nursing staff  
16 requires, in my view, a considered discussion of the nursing patient relationship. One  
17 approach to analysing differing manifestations of the nurse-patient relationship, that may  
18 help both nurses and patients identify reasonable expectations of nursing staff in a variety  
19 of contexts, is presented by Morse (1991). Her analysis may also help nurses and patients  
20 engage in a consideration of the features of a decent minimum of nursing care, particularly  
21 in situations where the nursing resource and/or availability of nursing time is under strain  
22 (For a discussion on the notion of a decent minimum of care see Savulescu, 2001.).  
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30 Morse (1991) describes 4 manifestations of the nurse patient relationship: Clinical,  
31 Therapeutic, Connected and Over-involved. The clinical relationship is appropriate when the  
32 contact is short, functional, and the needs of the patient very discreet – such as taking blood  
33 for testing, or dressing a minor wound. The therapeutic relationship, the most often  
34 encountered according to Morse, goes somewhat deeper than the clinical relationship –  
35 contact between nurse and patient is still relatively brief, the needs of the patient are  
36 relatively minor, and care is given quickly and effectively. In this type of relationship the  
37 patient expects to be treated for their presenting problem and has family and friends to  
38 meet other psychosocial support needs. Morse suggests that within the context of this type  
39 of relationship some degree of testing will occur from the patient's perspective, to see if she  
40 or he can "trust" the nurse to look after them properly until they can care for themselves  
41 again. This is likely to be the most common form of nurse-patient relationship encountered  
42 in modern acute care settings. However the needs of very dependent and/or acutely ill  
43 individual requires the nurse to be able to flex between the therapeutic and connected  
44 forms of the nurse-patient relationship.  
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3 The connected relationship either evolves over time, as patient and nurse get to know each  
4 other over an extended care period, or is stimulated by the ability of a nurse to respond to  
5 the intensity of the patient's need. Morse suggests that  
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12 *"in this relationship, the patient believes that the nurse 'has gone the extra mile',*  
13 *respects the nurse's judgement and feels grateful, the nurse believes that her care has*  
14 *made a difference to the patient."*  
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18 (Morse, 1991, p. 458)  
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21 In the over-involved relationship the nurse treats the patient as a person and friend first and  
22 as a patient second. The nurse can become territorial over the patient, may become over-  
23 extended, lose a sense of balance and suffer impaired judgement. This kind of scenario can  
24 lead to impaired patient care as well as nurse burnout.  
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29 For the purpose of this commentary, let us dispense with the over-involved relationship as it  
30 represents dysfunction and has limited usefulness in any discussion with patients regarding  
31 reasonable expectations of nursing staff.  
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35 The diary extract from CN (Niven & Scott, 2003) provides clear descriptions of both the  
36 therapeutic and the connected relationships. These are likely to be the most common  
37 manifestations of the nurse-patient relationships encountered in either acute inpatient  
38 care, or in caring for patients with chronic illnesses over the medium to long term. Each of  
39 these manifestations of the nurse-patient relationship – that is, therapeutic and connected -  
40 have different resource implications and can provide insight into the requirement of  
41 individual members of nursing staff in terms of nursing time, energy, and involvement. This  
42 analysis would have been of value in discussing the needs of patients and the importance of  
43 hearing the patient's voice as an important aspect of determining the appropriate use of the  
44 nursing resource. CN clearly indicated the importance of each of these approaches to  
45 nursing and nurse-patient interaction at the different stages of her illness and in relation to  
46 her experience of nursing care. She also pointed out the lack of professional nursing input,  
47 at least at the therapeutic level, during her first shower – and what this meant for her  
48 experience of care at that stage of her journey.  
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3 Nursing time is a limited resource. In some instances at least, there may not be sufficient  
4 nursing time to meet the needs of those requiring nursing in a given unit or context. Coming  
5 to recognise (a) that the clinical or therapeutic relationships is all that is normally required  
6 by most patients, and (b) that this knowledge may enable nurses to remain open to  
7 instances when patient need is greater (either because of the intensity of the patient's  
8 illness situation, or the intensity of the consequences of the patient's illness and diagnosis  
9 and so forth), potentially provides useful insights in relation to the distribution and effective  
10 use of the nursing resource.  
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18 Such understanding also enables the recognition of situations where an increased demand  
19 for the connected type of nurse-patient relationship is likely, and where increased nurse to  
20 patient ratios may be required as standard. This type of understanding could, for example,  
21 be used to inform concepts and definitions in tools used for calculating nursing hours per  
22 patient day (Twigg et al., 2011), and patient intensity (Rauhala & Fagerstrom, 2004), and  
23 dependency scales (Dijkstra et al., 2000). Morse's approach to nurse-patient relationships  
24 may also help mitigate a nurse's perception of being overwhelmed by patient need,  
25 particularly potential emotional and psychological support needs.  
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34 This approach helps to highlight that patients who are hospitalised or who are receiving  
35 nursing time in the community, or in their own homes, do deserve considered nursing input.  
36 Perhaps such input is of the short, sharp, clinical variety, but more likely of the therapeutic  
37 variety – competent, considered care that is not overly demanding of the nurse, in terms of  
38 psychological or emotional support, nor of an ongoing or intense nature.  
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44 This insight and understanding can inform a consideration of the nature of resource  
45 allocation in nursing. It can also inform explicit, overt discussions regarding a potential  
46 requirement to ration nursing care in particular instances or particular contexts. Such  
47 considerations should be explicitly identified, discussed, and decided by peer review; which  
48 is informed by insights from nursing practice and other relevant evidence. There is in reality  
49 a growing body of evidence suggestive of significant, covert rationing of nursing care (Jones  
50 et al, 2015, Scott et al., 2018) which, by its very nature, remains unidentified, unexamined in  
51 terms of rationale or assumptions, and unscrutinised. The result is a continual risk of  
52 inconsistent care, and of the care received (or not received) by a patient being almost  
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3 entirely at the discretion of the individual nurse looking after that particular patient at the  
4 relevant point in time.  
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10 Growing shortages of nursing staff internationally, in addition to cuts in nursing staff at front  
11 line delivery level during the recent financial crash, combined with minimalist models of  
12 care that became the norm at that time, has led to assumptions within and across many  
13 health services and nursing staff groups that it is not possible to provide safe, supportive,  
14 competent and humane nursing care with the available nursing resource (Jones et al., 2015,  
15 Harvey et al., 2016). These assumptions lead to the idea that there is no option but to ration  
16 nursing care. The often implicit argument proceeds as follows: (a) there are not enough  
17 nurses to provide the required level of care, (b) the explicit public messages from health  
18 service managers, budget holders and Ministers of Health is that all required nursing care  
19 must be provided (despite changes in patient acuity, reduced lengths of stay, turnover,  
20 increased patient expectation and increased dependency), (c) this is not possible given the  
21 nursing resource available, (d) therefore some care will be left undone (prioritization of  
22 some nursing care inputs will result in other elements of care not being done, or not being  
23 completed). Thus covert rationing of nursing care is inevitable and is being instituted.  
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36 In the absence of explicit decision making frameworks and/or public discussion of the  
37 pressures on the available nursing resource, this rationing of care is left to the discretion of  
38 individual nurses delivering care at the bedside. As such it is not open to scrutiny, review, or  
39 challenge, and until a disaster or scandal ensues over a particular instance or context of care  
40 the situation is likely to remain largely obscured.  
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46 With the value of hindsight, and the growing evidence base of the presence of covert  
47 rationing of nursing care, I would develop our analysis and discussion of the difference  
48 between resource allocation and rationing in nursing and health care, and the role of the  
49 patient's voice in this, in a clearer, more in depth and more sophisticated manner. This, I  
50 suggest, is an obvious gap in Niven and Scott (2003). If the quality of the patient experience  
51 is important to health care providers (and Ministers of Health), as current policy suggests  
52 (Byers et al., 2017), then these same service providers need to recognise the evidence that  
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3 nurses are an important factor in such quality of care experiences (Aiken et al., 2011, Aiken  
4 et al., 2012 and McHugh et al., 2013).  
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7 By highlighting more clearly the need to recognise the drivers of resource allocation  
8 decisions in health care and in particular nursing care – for example the impact of  
9 technologies such as the Diep flap mentioned by CN on the use and distribution of the  
10 nursing resource – we might be in a better position to identify when the only consideration  
11 driving resource allocation are technical, and/or medical treatment decisions, rather than  
12 the holistic nursing care needs of patients. If patients require a connected relationship with  
13 a member of nursing staff, even if over a very discreet time period, it is important that this is  
14 factored into resource allocation decisions - just as important as say the need for a  
15 technician to be in theatre for specialist surgery or the €billions spend decisions on  
16 pharmaceutical agents, often to questionable benefit (Barilan, 2015).  
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17 RTE 1 Radio: The comments were made by health journalists on separate RTE radio shows.  
18 The first is Priscilla Lynch, who is a journalist with the Irish Medical Times commenting on  
19 Morning Ireland radio programme: [https://www.rte.ie/radio1/morning-  
20 ireland/programmes/2019/0211/1028793-morning-ireland-monday-11-february-2019/](https://www.rte.ie/radio1/morning-ireland/programmes/2019/0211/1028793-morning-ireland-monday-11-february-2019/) .  
21 Accessed April 16 2019.  
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24 A second is by Susan Mitchell, who is the health correspondent of the Sunday Business Post  
25 - she is part of the panel on the Marian Finucane Show and makes the comment towards  
26 the end of the discussion on the nurses' strike: [https://www.rte.ie/radio1/marian-  
27 finucane/programmes/2019/0203/1027220-marian-finucane-sunday-3-february-  
28 2019/?clipid=103033585](https://www.rte.ie/radio1/marian-finucane/programmes/2019/0203/1027220-marian-finucane-sunday-3-february-2019/?clipid=103033585). Accessed April 16 2019  
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