The relational core of nursing practice as partnership

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Background. Consideration of the relational core of nursing has gained significance in today’s health systems, where the work of nurses is dominated by technologically-driven, prescriptive, and outcome-oriented approaches. This has led to disregard for individual experiences of living life with diverse health conditions.

Aim. The aim of this paper is to articulate the relational core of nursing practice as partnership.

Discussion. The relational core of nursing practice is explicated as a process of professional partnership, focusing on the evolving dialogue between nurse and patient. In partnership, the dialogue is open, caring, mutually responsive and non-directive. The nurse attends to that which is of concern to patients in relation to their health predicaments and the meaning in the health experience unfolds. Nurse and patient reach insight that represents more useful ways of comprehending and acting on their health predicaments.

Conclusions. Partnership represents theoretically-driven practice that invites nurses to meet patients where they are in understanding their health predicaments and what can be done about them. As such, partnership strengthens the resolve of nurses to resist the pressures of contemporary health service delivery to provide a technical form of practice and it protects the relational core of a fully professional practice.

Keywords: partnership, caring, health experience, nursing practice, nurse–patient relationship, problem-solving approach, nursing

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diminishes, even inhibits, the caring relational aspect that is essential to assist people to live life with intricate health predicaments.

The purpose of this paper is to expand further our exploration of the relational core of nursing practice expressed in terms of partnership – a process in which the nurse is present to the patient in an open caring attentiveness to whatever emerges in their dialogue (Jonsdottir et al. 2003).

Partnership has many different meanings in the nursing and health care literature; hence we distinguish our notion from the prevalent assumptions associated with the drive to effectiveness and efficiency that are characteristics of prescriptive practice (Jonsdottir et al. 2003). We recognize similarities in our intent to expose the relational core of nursing expressed in the writings of nurses such as Gallant et al. (2002). Dialogue with nurse theorist Margaret Newman (1986, 1990, 1994a, 1994b) is also integral to our work. Her theory of health as expanding consciousness gives significance to the evolving patterns of relationships in people’s lives. A set of research studies has elaborated upon this meaning of health as a relational process (Moch 1990, Connor 1998, Endo 1998, Jonsdottir 1998, Litchfield 1999, Endo et al. 2000, Picard 2000, Kiser-Larson 2002, Neill 2002a, 2002b, Pharris 2002, Jonsdottir et al. 2003, Tommet 2003). Newman et al. (1991) went further to propose that this relational process is the focus of the discipline of nursing, expressed as ‘caring in the human health experience’. This statement conveys the combination of some key concepts in nursing: health, the health experience and caring. Health reflects the overall aim of nursing and human experience is the patient’s personal component of it. Caring underscores the action component in practice, grounded in values and human relationships. Several leading nurse scholars have focused on studying the relational core of nursing as caring (Watson 1979, Leininger 1988, Benner & Wrubel 1989, Boykin & Shoenhoffer 1993, Eriksson 2002).

In this paper, we focus on partnership, with the aim of articulating a form of nursing practice that expresses ‘caring in the human health experience’. We consider how the current context of health service systems shape the work of nurses and limits full expression of the discipline. We elaborate on how nursing might be practised to uphold the relational core by drawing attention to the personhood of both nurse and patient to bring to health a meaning that is uniquely nursing.

Background

A growing concern is being expressed that Western health service systems are not meeting health needs (Smedley et al. 2002, World Health Organization 2002), despite increased expenditure. Of particular concern is that, regardless of the recognition of growing health disparities (Olafsson 1999, King 2000, National Institute of Nursing Research 2000, Flaskerud et al. 2002, Smedley et al. 2002), health systems have only taken into account this reality to a limited extent. In response to the technocratic focus underpinning the drive towards cost-effective, evidence-based practice with increasing emphasis on citizens’ responsibility for care of the sick, vulnerable and older people, nurses naively take on whatever is demanded of them (Björnsdóttir 2002, Litchfield 2002), extending their work to fit roles required for service delivery.

The emphasis on expedience for service delivery is directing nurses’ attention to the management of treatments, pulling them away from relating to patients in a caring way, and pushing them into fast-paced, fast-talking health care provision (Frank 2002). The associated standardization of health care leaves little room for responsiveness to unique patterns of patients’ and families’ personal needs. Living life with complex health circumstances is increasingly considered a private concern, with minimal involvement from service providers. Individuals and families are left to struggle when the health service is limited to instrumental treatments of pathophysiological manifestations of diseases or to comply unquestioningly with prescribed preventive measures.

The necessity of medical treatment of diseases is not in question here. What we perceive as being challenged is the limitation of health care to standardized procedures, corresponding to medical treatments of disease processes or preventative measures, which disregard people’s experiences of living life with diverse health conditions. Broyard (1990, p. 34) also recognized this when he said:

…[T]echnology deprives me of the intimacy of my illness, makes it not mine but something that belongs to science.

Medical diagnosis associated with the cure and control of diseases is given total priority, reflected by predominant discourses in the public arena of financing and research on health care services. Nursing has been framed within this. Nurses tend to see that their contribution to patients’ well being is through participation in medical regimes and imitating the processes of diagnosis and prescriptive treatment, rather than through collaborating with physicians and complementing medicine in a shared effort to provide patients with health care. Nightingale’s warning cited repeatedly throughout our history, that nursing and medicine should never be mixed because this spoils both, continues to be relevant today.

The medicalization of nursing is revealed in the rising momentum of evidence-based practice developed around
procedural approaches to the management of patients’ bodily functions, in which the body is treated as a pathophysiological object. It draws almost exclusively on the natural science roots of knowledge (Kitson 2002). Thus, the body is considered diseased, weak and vulnerable and needing intervention to overcome deficiencies and reduce risks. The unmet needs of concern to nursing that are commonly categorized as psychological, social, spiritual and existential are likely to be approached in a similar way to bodily needs, i.e. from a task-oriented notion of solving problems to achieve specified outcomes (McCloskey & Bulechek 2000). This emphasis on the rational and linear thinking approach to solving problems in a standardized, prescriptive manner has insidiously become the approach driving nursing practice.

Noting the current interest in practice as a central theme of the discipline, we believe that it is timely to elaborate upon the nature of our professional relationships with patients. To help people living life amidst health predicaments, we need to reconceptualize the scope of nursing practice. If nurses are to honour the uniqueness of the human health experience and to find out the most appropriate action, in light of all that is going on in people’s lives, we need to refocus on practice in a way that maintains the relationships between the nurse and the patient at the core. In so doing, nurses would be joining with patients in a process of collaboratively seeking meaning in their complex and often chaotic health circumstances. This participatory stance, however, calls for a radical shift in thinking about practice, a call recognized by Northrup and Purkis (2001, p. 68) who called for ‘a form of practice that requires an openness to change that transcends the familiar’. Thus, nurses’ allegiance would be returned to patients.

Dialogic form of relationship

We have articulated the relational core of nursing practice as a process of professional partnership (Jonsdottir et al. 2003). To give form to the partnership, we now focus on the evolving dialogue and consider the characteristics of relationships between nurses and patients.

In partnership, the nurse is fully present to the patient and relates to the patient with open attentiveness. The nurse holds the patient in unconditional warm regard as a fellow human being. This has its expression in a mutually responsive and non-directive dialogue between them, where the nurse’s sole intent lies in an effort to understand the patient’s experience. The nurse, having no prescriptive agenda other than attending to what is going on for the patient in their health predicaments, embraces whatever emerges and goes with this conversational flow as new meaning unfolds (Litchfield 1999, Newman 1994a, 2002a, Jonsdottir et al. 2003).

The dialogue is a natural conversation between nurse and patient as partners in addressing health matters. We use the term patient to refer to one or more individuals, a family, or a community. Nursing’s professional framework provides structure to the partnership. That is, the nurse’s understanding of partnership, its beginning and ending, is derived through scholarly endeavour in the discipline. It is philosophically founded in a paradigm of health that expresses beliefs about what it is to be human, and is articulated as the theoretical and ethical rationale for practice.

Each partnership can be described with components that give form to the dialogue. The nurse’s explanations of the reasons for the contact and expression of the purpose of partnership becomes integral to the dialogue. The focus remains on the patient’s health predicaments, told in stories of the experiences uppermost in their mind. The conversation evolves through the nurse’s questioning for clarification and elaboration and summaries made from time to time. Links amongst events and relationships are recognized by different participants and become integral to the dialogue. What were initially discrete sequences of events and relationships acquire coherence as novel patterns of life and living.

As co-participants, the patient and nurse become united in their efforts to make sense of all that is going on for the individual, family and community. The dialogue takes on a life of its own as everything that is said has relevance. Nothing said is ‘right’ or ‘wrong’, ‘good’ or ‘bad’. Rather, participants’ relived happenings, perceptions, good and bad feelings, assumptions, regrets, wishes and dreams are embraced and become interwoven. There is neither need nor purpose for a judgement of fault, problems or inadequacies because the focus is on expanding understanding.

For the nurse, being open to the flow of the dialogue, allowing the patient’s meanings of the health predicaments to surface, and embracing the uncertainty of the partnership process are of greatest importance. The situations people describe may be confusing and ambiguous, and it may occur to the nurse that the patient’s problems may be able to be fixed. What matters, is the embrace of the whole experience and circumstances relating to health, and the commitment to ‘hang in there with chaos awarely’ (Heron 1988, p. 53), trusting that the meaning of health for the patient will emerge through the dialogue.

Thus, partnership between patient and nurse emerges as a caring process with meaning unfolding through the dialogue. What makes this relational process uniquely nursing lies in the professional framework of the nurse: how they theoretically construe the key components of the partnership: the beginning and ending. The beginning takes its form from the roles the nurse plays in health services. The nurse has a
purpose for approaching the patient, defined in relation to the mission of the service with which the nurse is affiliated. The ending takes its form creatively from within the evolving dialogue. It is how the nurse ends the partnership that enables the process that leads to an outcome to be articulated and presented within the realm of the discipline of nursing.

**Insight as action**

Partnership is not merely an open-ended, on-going process of caring. We identify an endpoint to each partnership that, with the other process aspects of beginning the participation, gives it a structure. The important point is that, just as the process is not prescribed, the outcome for the patient is not predetermined. Through our research we have come to see that our recognition of the insight reached by those participating as partners provides a key to articulating the outcome of the nursing practice. It is the ending that shapes the meaning of the whole of the partnership (Litchfield et al. 1994, Litchfield 1999, Pharris 2002, Jonsdottir et al. 2003).

The Concise Oxford Dictionary (1990) derives its definition of insight as ‘the capacity of understanding, hidden truths etc., especially of character or situation’ from the Middle English meaning of ‘discernment’. This has been useful to our exploration of partnership by conveying the notion that, when attention is brought to the dialogue, insight is the clear perception and judgement that represents the new meaning emerging from it. This insight, then, is integral to the relational core of nursing practice.

Within the nursing partnership, insight tells us the meaning of health for the patient. The patient’s insight is revealed to the nurse in statements of intended actions and brings coherence to that which has happened in the patient’s life. This insight expresses how the patient has grasped in novel ways the significance of the health predicament, what has contributed to it, and what meanings these might have in the future. Patient’s insight concerns living life with disease, disability, trauma, loss, medical and nursing diagnoses and the associated treatment regimes. It might refer to accessing and use of services, preventive strategies and managing risks and dangers. The insight represents major changes in how life’s predicaments are viewed, including how to live with the circumstances surrounding death. In particular, the insight shows the patient’s new comprehension of the interdependence of significant people closely involved in health matters (Newman 1997, Litchfield 1999, Jonsdottir et al. 2003).

The actions identified could not have been predicted at the outset of partnership because the context in which it had meaning had yet to unfold within the dialogue. Although statements of intended actions surface at times during the dialogue, associated with some specific event and relationship, it is when the action brings coherence to the whole of the patient’s life that the transformative nature of the change is revealed to the nurse. The patient’s insight as action is the substance of nurse’s insight into the patient’s health circumstances. This is the wisdom of nursing partnership (Litchfield 1999).

An excerpt from the findings of a study by Litchfield involving young families with complex health circumstances provides an illustration of insight as action. The partnership with this family spread over five visits. At the penultimate visit, Litchfield recorded the following statement by the husband/father:

...When I’m home I cannot afford to really stay at my pace that I would be at work or leisure...obviously I have to slow down...the amount of activity that can be done as a family is a lot less than normal, but you’ve got to slow it down for (wife) and you’ve got to somehow work it off (son), so that’s a challenge...I need to take him away separately and do some activity...so he has less energy to spend when he’s at home, so he’s more interested and not bored...and we should let (wife) have a rest (Litchfield 1999, p. 70).

This excerpt was recognized as insight in that it made sense of all that had been talked about during previous visits, and the action represented a major change in family living. Inherent in this insight was the whole story of family health. Thus, Litchfield’s insight was a vantage point for gaining a sense of the whole of the health circumstance of the patient. The change vis-à-vis action in the patient’s life could be inferred in retrospect.

To elaborate the significance of insight for the form of the nursing partnership we now consider what meaning insight has in the respective worlds of nurse and patient.

**The world of the nurse**

Since practice is action by definition, and action assumes change, the meaning that insight as action has in the world of practitioners of nursing needs to be elaborated. We have described how nursing practice involves a process of partnership through which nurses reach an understanding of patients’ health experiences originating in the insights of patients. In the insights lies the meaning of the partnership that renders practice distinctly nursing.

The change in people’s lives represented in the insights can only be seen in retrospect. The nurse does not solicit the insights, or suggest the actions. What the nurse has already worked through at the outset, however, is their ethical stance as a practitioner. This concerns how to engage in
relationships with patients, respecting and protecting their dignity and their capability to decide and direct their own way in complex health circumstances, knowing how to access and utilize services. The nurse understands issues of privacy, confidentiality and informed consent. The world of the nurse with this ethical stance is given shape by the theoretical framework that generates professional purpose and coherence to the nurse’s practice. Within this world of the nurse, the meaning of the change in patients’ lives are given relevance for health care (Jonsdottir et al. 2003).

Insight is a key theme in Newman’s theory of health as expanding consciousness (Newman 1990, 1994a, 2002b). She has equated insight with pattern recognition, that is, an all-encompassing grasp of the changing configurations of personal relationships in a person’s life, associated with intuition. When elaborating her theory as praxis, Newman (1990) referred to the insight that people gain into their patterns of interaction with others as the ‘action potential’ through which possibilities can be illuminated, opening the way for transformation in the pattern of their life process. She saw this as the realm of nursing, and the illumination of the action possibilities as a purpose of nursing research. More recently she has referred to praxis research, in which nurses ‘reflect back to the participants the pattern of relationships described in their stories’, a process through which they ‘experience insight and, with insight, the clarity of the action to be taken’ (Newman 2002b, p. 9).

Expanding on Newman’s work, we have extended the focus of nursing partnership to the meaning of insight in the world of the nurse as well as the patient. In so doing we have come to understand insight not just as the potential for action, but as action per se, for both nurse and patient (Jonsdottir et al. 2003, Litchfield 1999). The evolving dialogue itself represents change as action in people’s lives. The patient’s insight reveals the meaning of change in their daily life. The nurse can see in the patient’s statements of actions the unique meaning of health and health care for the patient, and this information is of relevance to nursing.

In the world of the nurse the action is therefore known in retrospect. It has meaning in terms of what is possible for the patient and what is meaningful to the nurse. The nurse knows the patient’s predicament and what the patient will do about it. In their partnership they have together created the meaning of health for that patient.

To be open to what might emerge as possible in the lives of patients calls for a belief in the power of the not-yet. Upholding a belief in openness to the creativity in dialogue, and accommodating health problems in ways not conceived of before, point to a radically new approach to nursing care: beyond the focusing of health care provision on fixing or manipulating disease processes, the perspective of partnership extends it and acknowledges and respects patients as a mystery whose meanings of health and ways of becoming may evolve creatively (Skolimowski 1994).

The world of the patient

In the world of patients the significance of partnership lies in how they get on with life and living. This has been articulated as narrative and constructed in different forms. When reporting the findings of her praxis study with families who repeatedly experienced hospitalization, Litchfield (1999) presented family health as a narrative of nurse–family partnership. The change that occurred in family life was described as movements ‘from being trapped in the present without vision’ as family members struggled to manage the health-related problems that had thrown life into chaos, to knowing what they would do here and now, that had meaning in the context of how their predicaments had come about and future prospects: ‘the presence of past and future’ (p. 66). Essential to this change was a reconfiguration of interpersonal relating that enabled them to accommodate chronic disease and disability into everyday living in a radically new way. The central theme of the narratives was increasing connectedness in the sense of belonging as family and citizen. This showed as a growing inclusiveness and interdependence in managing health predicaments. It was so significant that it was construed as a transformative shift in family life.

Newman’s (1986, 1990, 1994a) theory has provided researchers with the narrative form that gives coherence to their study. She presents the narrative as a developmental sequence in patterns of personal relationships over a lifetime. Insight into pattern is represented as a turning point in the life process as people move to higher levels of consciousness: ‘The client comes to a point in life where the way is not clear. The old rules don’t work anymore...When the choice is made, the client’s life takes an unanticipated direction characterized by greater freedom and connectedness, and more caring relationships, all of which are manifestations of expanding consciousness’ (Newman 2002a, p. 9).

From this perspective, Endo et al. (2000) described pattern recognition with families of women with cancer as a sequence of phases of a transformative process. The families were considered to be in a far-from-equilibrium condition. Through participating in a caring partnership with a nurse who focused on the meaning of the family relationships, families ‘shifted from separated individuals within the family to trustful caring relationships’ (p. 604). The transformation allowed women with cancer to move beyond the present
disorder to a new order in their lives, and it thus illustrated the theory of health as expanding consciousness.

When Tommet (2003) visited with parents of children who were medically fragile, she revealed the evolving patterns in their lives living with continual uncertainty. The families had changed from struggling to gain control of their chaotic situations to learning to live with relative order. This was manifested in new ways of relating to others, growth, increasing family strengths and confidence in handling future challenges.

Ruka (2004) focused on the process through which nurses and caregivers reach insight into their relationships with people with dementia living in a nursing home. She identified patterns in people’s behaviours and information from their families. Promoting comfort and moving in synchrony with the rhythm and pattern of residents, nurses and caregivers recognized transformations in the residents. They became more peaceful, relaxed and loving. Unconditional acceptance of the person, along with maximizing strengths and minimizing limitations, were cornerstones of nursing care for these people.

The meaning of nursing practice

In the discussion above, we have begun to explore the meaning of partnership from the perspectives of nurses and patients. In reality, these worlds are not separate, but dimensions of the same praxis process through which the meaning of health for each patient and nurse evolves and is articulated in narrative form. In the following exemplar we illustrate the partnership process as experienced in a practice research setting.

Partnership with a couple in which the wife has breathing difficulties

When I (HJ) met the couple at a crossroad in their lives: ‘Everything is in a mess’, the woman said. Three main concerns surfaced. Firstly, the woman had to quit smoking. Secondly, there was the imminent threat of having to leave home and move closer to specialized health care. The third concern was problems within the family, particularly between mother and children, but also between the couple, who appeared angry and apprehensive towards each other.

The conversations about smoking took a dramatic turn during the partnership: first the woman said that she was ashamed of her smoking, she experienced stigma and preferred to die rather than use oxygen daily: ‘Why should I stop smoking? What kind of life am I going to have, anyway?’ Continuing smoking would soon make her a resident in a nursing home, a decade before reaching retirement age. The woman resisted assistance to quit smoking from health professionals. She felt ‘too much pressure to quit’ from them and the family. Later the couple started asking questions about ways to cease smoking. In the end they talked about steps they had taken to reduce smoking in preparation for stopping when the right time came.

The woman’s main concern was that her family did not comprehend the troubles the disease had brought to her life: ‘They have no idea about it’. She felt that they controlled her and were inconsiderate. The husband expressed uneasiness about not knowing how to meet her needs and that she became irritated and critical in response to actions taken by him and the children when their intention was to make life easier for her. The woman wanted to be in command, but they did not obey. The family hardly talked together; but threw messages at each other, like throwing daggers. The woman said: ‘They are immature’ and the children maintained that she was ‘mad’. The situation only worsened and on one occasion the woman demanded that the children leave her alone and the husband leave home, which they did.

At this point in the partnership process a thought came to my mind that the couple’s problems were so extensive that this form of practice would not suffice. I, however, decided to continue staying with my goal and continue the visits. My main intent was to understand more fully, so I attempted to stay with the flow of the conversations; to ask questions to clarify and expand on issues being talked about and to summarize what was discussed. I had no idea where the dialogue would take us but trusted that insights would evolve.

During the fourth visit I sensed a major change. Insights had evolved for all of us and as actions for change. The couple looked more relaxed, smiled, made jokes, moved around more easily and the wife’s breathing problems were less. There were still extensive problems. But the major change that had taken place was that the couple were now talking together and the relationship with the children had changed: ‘It couldn’t be better’. The couple had taken a long tour together and enjoyed the challenge of making it a successful event. They had a better sense of what they needed and wanted. Now they would consult health professionals, not strictly obeying them. The wife was ‘seeking friendship with the lung disease’ rather than seeing it as an enemy to fight against. Together the couple were making serious efforts to stop smoking.

In this narrative the actions that surfaced were mainly related to new ways of being together as a couple and as a family, changed ways of interacting with health professionals, reducing smoking and taking action to getting the most
issues and innovations in nursing practice

What is already known about this topic

• A technologically driven, outcomes-oriented problem-solving approach is dominant in Western health care services.
• The relational core of nursing has predominantly been studied in terms of caring.

What this paper adds

• Challenges to the technologically driven, outcomes-oriented problem-solving approach of nursing by articulating the relational core of nursing practice through partnership.
• A professional practice approach that centres on dialogue representing the relationship between the nurse and the patient and underpinning action.

Conclusion

The essence, purpose and social mandate of the discipline of nursing is the development and use of knowledge for people’s health, articulated by Newman et al. (1991) as ‘caring in the human health experience’. This inevitably places the nurse–patient relationship at the core. We have articulated this relationship process as partnership. In it, nurses are fully present to patients and relate to them with open attentiveness as they engage in dialogue about whatever is of concern in the patients’ health circumstances. As insight into these circumstances is gained, new comprehension of living life not envisaged before is formed and revealed in subsequent actions.

Focusing on nursing practice in terms of its relational core is different from centring on the roles that nurses take to provide care when constrained by organizational requests for cost-effective service delivery. Practice, referring to theoretically driven, coherent actions by nurses in addressing health, differs from the notion of a role, indicating how practitioners contribute to the provision of health care within the network of health services. Engaging in partnership with patients requires that nurses are free to practise without constraints to achieve outcomes predetermined in relation to the service delivery. It necessitates a role that allows nurses to meet patients where they are in terms of understanding their health predicaments, engaging in dialogue with them until a new meaning has unfolded and patients have found a more useful way of living life. This being said, we acknowledge that more work needs to be done to address the interrelationship of service and nursing practice in contemporary health systems.

Partnership is a moment in the life of the patient through which change happens. It is in the world of the nurse that the change is given meaning as health, with relevance for the provision of health care. As narrative, partnerships are information for the nursing community, evoking professional dialogue around the nature of nursing practice and its advancement in whatever roles might be necessary. That is, evolving dialogue within partnership informs patients, nurses, and the profession about health care provision. As such, our conceptualization of partnership contributes to the meaning of health as expanding consciousness, as theorized by Newman.

Knowledge of partnership constitutes wisdom about core elements of a practice that is uniquely nursing. It has immediate relevance and makes a difference to nurses by revealing new ways of seeing and being with patients. Practising partnership refocuses nursing to its relational core to enable nurses to ‘know the people with whom they are working’. Thus, knowledge of partnership has the potential to strengthen the commitment of professional practice so that it will better address health needs of patients in the face of pressures to conform to the demands of medically-delegated tasks.

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Commentary

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The current dilemmas in health care and nursing are often located within a framework that emphasizes the outer forces of economics, staffing shortages, and technological–medical issues, or system/institutional needs. This limited orientation toward problems in the health care delivery system is in stark contrast with the deeply human, ethical–professional dimensions that affect the whole.

Contrasting points of view, which invite creative, constructive, professional-disciplinary discourse, as a path for solving external system dilemmas, are rare. Yet, only an inner-directed, professional perspective can ultimately address the heart of the outer-directed problems and the core issues underlying the outer manifestations.

Any authentic nursing or institutional solutions have to be located within a more deeply human discourse that underpins the professional-disciplinary practice world and the lived world of those being served. This paper by Jonsdottir et al. on ‘The relational core of nursing practice as partnership’ offers such a discourse. As such, this paper is directed toward both current and lasting solutions to wider healthcare system problems, as well as nursing problems in particular.

In addressing the relational core of nursing practice as ‘partnership’, the authors help to clarify not only practice dilemmas, but also larger disciplinary foundational dilemmas that can be called upon to guide professional practice, and ultimately serve as a guide for larger system problems.

The authors make a strong case for a professional practice model, referred to as ‘partnership’, as a solution to current (and future) system problems. This proposed solution is framed within the disciplinary-theoretical context of Newman’s theory of ‘Health as evolving consciousness’, as well as the focus on nursing as ‘caring in the human health experience’ (Newman 1991, Newman et al. 1986/1994). Partnership, so defined, is thus located within both Newman’s theory and caring theory and philosophy. However, the secondary focus of caring as a theoretical and philosophical framework to guide the concept of ‘partnership’ is not made as explicit as it might be, especially given the nature of the paper as ‘the relational core of nursing practice’.

However, the authors bring a deep understanding to the nature of the ‘partnership and relational core’ of the professional–practice dialogue. That is, the partnership-relationship is informed by an ethical and theoretical disciplinary context explicated by Newman’s theory. Further, development of the dialogical nature of the relational partnership is enhanced with exemplars from the literature, helping to ground and substantiate this more in-depth position for professional practice.

The dialogical relationship is developed as a natural conversation between nurse and patient as partners/co-participants in addressing health matters. It is philosophically founded in the human caring aspects of the professional relationship, revealed through stories and conversations evolving through discrete events as patterns unfold. Both nurse and patient are united in a common effort in search for meaning and insight that allows for a constructive beginning, process and closure to the partnership. The goal for the partnership is ‘health as expanding consciousness’, revealed through insights, meaning, and patterns of living and dying, which emerge through the relational dialogue.

The ultimate partnership emerges as a caring process as the meaning unfolds through co-participation of nurse and patient, informed by a professional caring ethic. This process resides uniquely within a professional/disciplinary-nursing framework. The patterns and insights that emerge become a form of ‘insight as action’, in that the new horizons of meanings result in new understandings that shape the whole partnership and help to articulate the outcomes of nursing practice. Thus, new comprehensions emerge through the dialogical caring process, resulting in fresh understandings of how to live with individual life circumstances of health, illness, death, dying, and so on. This disciplinary-professional practice model is positioned as an approach to bring new meaning to nurses and nursing in the midst of current health-nursing system crises; thus, it offers a refreshing relational human-to-human orientation to transform nursing practice. This direction is in stark contrast to conventional externally-oriented approaches.

While the authors have developed an important focus for professional practice – that is, a practice model informed by distinct nursing theory and a relational ethical context – there is room for additional explication of the position that builds more fully upon their starting point of Newman’s theory and definition of nursing (Newman et al. 1991). For example, ‘Nursing is caring and the human health experience’ is the basis for explicating dialogue partnership as the relational...
core of nursing and co-participation as process. However, the caring process aspect of relationship and dialogue, as well as the caring ethic and definitional aspects of nursing, are underdeveloped. Therefore, this work introduces a starting point for a deeper level of discourse for transforming professional practice through disciplinary underpinnings. It invites additional discourse from caring science scholars to extend the ideas and position posited here. Such a trans-theoretical discourse allows for an evolving consciousness at the disciplinary and professional level. As the caring nature of dialogue and relationship is made more explicit, this perhaps will uncover even more the deeply human nature of the caring process, as the relational dialogical core. Such a view acknowledges caring as ethic and a relational human-to-human process that is more fully woven into extant theory.

In summary, while there may be inconsistencies and gaps in explicating the caring foundation for this model, this paper helps to elucidate an evolving consciousness for both the profession and discipline of nursing, opening new insights for nurses and nursing as well as for the public. It elevates the discourse from professional confusion to informed disciplinary convergence as a constructive model of ‘insight as action’. The paper invites creative, constructive, professional-disciplinary discourse, as an evolving path for solving external system dilemmas as well as internal professional dilemmas.

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