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RESPONSE

The value of providing information to patients to enhance patient health outcomes and well being has been extensively documented in the literature. Our study sought to identify if specific additional information could enhance rehabilitation patients' engagement with their care. As recognized by Irving the intent of such research was to identify practice solutions to enhance patient participation in the current economic rationalist environment.

Irving (2006) seems to find patients' passivity regarding the receipt of information 'noteworthy'. She suggests the findings are pessimistic, as she perceives that they indicate that patients are disempowered. However, this could be hastily drawing conclusions. The assumption that patients are passive is derived through the comment, 'It doesn't matter that I don't know'. While patients have made this comment, it is important to contextualize what is, in fact, 'passive'. Arguably, the passivity is in relation to the information that patients desire, that is, patients believe that the information that they receive is inconsequential to them.

This passivity, though, does not directly relate to their engagement in the rehabilitation programme. While it was stated at the outset that the impetus for the study was ideally to increase engagement in rehabilitation, it was always acknowledged that the participants did 'actively' engage, albeit in their own time frame.

As patients did actively engage within a short period after admission, it could potentially be the nature of interactions with health professionals rather than the provision of information that is important in initiating engagement. Some form of empowerment may be intrinsic to the admission process to rehabilitation as the team of health professionals facilitate patients to think about their health problem and seek the ideal outcome. Patients said that their ideal outcome was discharge and so, in effect, patients had been empowered to reach the conclusion that participation in the programme was the most appropriate decision to reach their desired end point. The perception that rehabilitation is 'a ticket out', and that rehabilitation is perceived generally in a positive regard, is in essence optimistic.

Rehabilitation can only occur if the patient desires it – as they are required to instigate activity within this programme. Patients are not coerced into the programme. Discussions with the patient about the rehabilitation programme and their choice to participate in the programme may therefore represent 'an empowering' situation for the patient. Patients have the ability to problem solve and determine if they want to partake in the programme – at this point they make a choice to be involved (Ellis-Stoll & Popkess-Vawter 1998). Supporting the patient to make a decision about engagement in the programme with the assistance and encouragement of health professionals fits with alternate beliefs, namely, that of responsibility and support for the older person. Faulkner (2001) suggests the notion that 'empowering optimizes patient independence and that increasing dependence is disempowering' is opinion based and anecdotal.

Drawing on Faulkner's argument the rehabilitation programme as it is presently established enhances the control that individuals have over their activity. As suggested by Faulkner (2001) a rehabilitation programme whereby hospital staff assist people to take control of their lives, e.g. dressing for meals (all be it in a regulated environment) may encourage patients to learn mastery. Further to this Nolan et al. (2004) argue greater benefits through a relationship-centred care rather than person-centred care. Their belief

is that autonomy is incapable of underpinning any shared societal responsibility for the health of its members. This is particularly evident in a collaborative rehabilitation program where participation and progress is agreed between patient and health professionals. What is particularly emphasized with both Faulkner (2001) and Nolan et al. (2004) is that the level of negotiation and responsibility must be carefully planned and attainable. In essence it highlights the importance of the comments by patients that ‘I’ll do it in my own time’.

Essentially, passivity and disempowerment as discussed by Irving may be over emphasized. Irving quite correctly emphasizes the importance of the institution to adapt to the requirements of patients rather than patients adapting to the institution. In reality, however, these environments are not ‘all doom and gloom’, as independence is promoted in the existing structure. While we need to recognize evidence of paternalism in the structure of the clinical practice setting there is evidence that patients choices are facilitated, worked towards and considered.

While Irving (2006) makes the comment that the findings do not directly answer the question of what information nurses should give new patients, it is important to acknowledge that this question is answered indirectly. Patients are not desirous of excessive amounts of information but rather information facilitated through a process whereby they can engage at their own rate.

It has become apparent that establishing a mutual relationship through communication and engagement can be of greater effect because of the perception by the patient that their values and beliefs are, in effect, supported (McCormack 2003). This highlights the importance of the models of care as indicated by Irving because the initiation, development and sustainability of such relationships are integral to the models of care adopted by the institution. The continuity of interaction with the patient is of utmost importance while the timing of information needs to be recognized as critical to patients’ ability to interaction with information (Gambling 2003, Henderson & Chien 2004). Ultimately it may be the opportunity for a sustained relationship that provides greater benefits than the provision of specific information given the variation in patients. Such a strategy also accommodates the variation of needs during the rehabilitation trajectory as referred to by Adams. There is certainly evidence in psychology/psychotherapy that supports this assertion, i.e. people get better because of their perceptions of the quality of their relationship with their therapist rather than one particular technique.

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