Advantages of the Nurse-Patient Contract

JANET HARRIS*

Various authors have reported advantages of establishing a nursing contract with the patient and/or the family (Blair, 1971; Forrest, 1975; Sloan and Schommer, 1975). Practical, professional and philosophical considerations account for the increasing attention on contracts in recent studies.

PRACTICAL CONSIDERATIONS

A contract is defined as "an agreement between two parties for the doing or not doing of some definite thing" (Parsons, 1972). Since both nurse and patient are involved in establishing the terms of the contract, the goals and expectations of both parties become apparent. Patients often have ideas that differ markedly from those held by professionals (Friedson, 1960). The nursing contract can help clarify these differences and clear up incorrect assumptions on both sides (Maluccio and Marlow, 1974; Parsons, 1972; Pincus and Minahan, 1973: 178). During interactions between nurse and patient, each party can refer back to the original terms of the contract for clarification and direction.

Rosenstock's studies of health behaviour draw attention to the futility of considering the patient a passive recipient of care. "It is worth remembering that the patient is an active participant in dealing with his illness and will take what he regards as appropriate steps within his own life framework" (Rosenstock, 1975).

Once the goal or goals of the contract have been mutually established, the nurse and patient share a sense of purpose. Ultimate achievement of the goal(s) enhances the morale of both parties (Blair, 1972).

Finally, there is evidence that the patient who is involved in planning, goal-setting, and decision-making is more likely to internalize the new health behaviour (Kalisch, 1975). Internalization, as opposed to compliance, results in the most permanent change (Dyer, 1973; Green, 1976).

PROFESSIONAL CONSIDERATIONS

Once the terms and goals of the contract have been established they can be summarized on the patient's record, thus enhancing continuity of nursing care and communication with other members of the health team (Davis and Woodcock, 1971).

* The author recently completed studies towards the M.Sc.N. at the University of Toronto.

Blair (1971) believes the contract has potential for making better use of the nurse's time and energy. By involving the patient in discussion and clarification of mutual goals, the nurse can more quickly and validly determine what needs the patient perceives and what services she can provide. Furthermore, the requisite time limits for each contract encourage mutual evaluation when the contract expires. At this time the contract can be renegotiated or terminated and this process aids the nurse in evaluating her performance.

Finally, professional accountability is an issue of high priority in nursing. To be truly accountable, we must first define nursing's competencies, establish nursing's domain and "demonstrate to ourselves and others nursing's unique contribution to patient care" (Mass and colleagues, 1975). Gortner (1974) urges nurses to make explicit the outcomes for which we will be held accountable. The use of the nurse-patient contract may well advance the fulfilment of these aims. Certainly, the contract can facilitate the identification and measurement of nursing activities.

PHILOSOPHICAL CONSIDERATIONS

The philosophy of nursing embraces two basic tenets: a professional commitment to optimal health care for the patient and/or family, and an ethical commitment to the personal integrity and autonomy of each individual and family.

These two tenets are not always compatible; indeed, they may be mutually exclusive. For example, a public health nurse working without an established contract may assess unresolved or potential problems requiring care which the patient and/or family decline. Should the nurse pursue health care goals or respect the individual's right to self-determination? This philosophical dilemma could be alleviated, if not avoided, within the framework of a nurse-patient contract. In the author's experience, goals of mutual concern can usually be identified. Once these are agreed upon, a relationship which facilitates further intervention can evolve.

> If we really believe in (patient) autonomy, if we believe we are assisting the patient to cope with the problems and not solving them for him, then it follows that he should have a collaborative role when it is possible (Little and Carnevali, 1969: 187).

In support of this belief the nursing contract promotes patients' autonomy, involvement and responsibility in their own health care. More important from a philosophical standpoint, the contract permits patients to exercise their right to self-determination (Forrest, 1975)

and affirms patients' ability to solve their own problems (Sloan and Schommer, 1975) while allowing nurses to fulfil their professional responsibilities.

TYPES OF NURSE-PATIENT CONTRACTS

The following four-part classification by Blake and Mouton (1976: 450-55) echoes various modes of intervention commonly used by health professionals.

Acceptant Contract: In an atmosphere free of judgments, the patient is helped to sort out problems in a self-reliant manner. The intention of the acceptant contract is to establish a helping relationship. (The author has found techniques of active and passive listening and supportive counselling effective in this mode).

Catalytic Contract: The patient is assisted in collecting further data with which to test and reinterpret his perceptions. The patient is not told what to do, but may arrive at a better awareness of the problem and how to handle it through exposure to new information or new techniques of problem-solving.

> . . . . . the nurse can fulfil her responsibility to the patient by providing him with the necessary information which will enable him to make a sound decision on his own. He should be informed of the consequences of each alternative open to him (Lewis, 1976).

Confrontation Contract: The patient is challenged to re-examine his thinking and assumptions and to select new more effective actions. This contract may lead to threatened reactions.

Prescriptive Contract: The prescriptive contract is frequently seen in medical practice and may occasionally be used by nurses in crisis or emergency situations. In this mode the patient is told what to do to rectify the situation. The prescriptive contract involves issuing prescriptions and recommendations.

Contracts will vary according to the nature of the problem and the terms acceptable to both nurse and patient. The type of contract and the mode of intervention may change as circumstances change.

CONCLUSIONS

When viewed in the light of practical, professional and philosophical considerations, the advantages of the nurse-patient contract become apparent. These theoretical advantages and the various types of contracts need to be investigated further through empirical research. If the value of the contract is confirmed by research, the implications for nursing practice and nursing education are far-reaching.

REFERENCES

Blair, K. K., It's the patient's problem — and decision. *Nursing Outlook* 19:9:587-89., September, 1971.

Blake, R. R., and Mouton, J. S. *Consultation.* Massachusetts: Addison- Wesley Publishing Company, 1976.

Davis, R. C., and Woodcock, E. The nursing contract: An alternate in care. *Journal of Psychiatric Nursing and Mental Health Services* 9:3:26-27. May-June 1971.

Dyer, W. G. Planning change in the family, in *Family-Centred Community Nursing,* ed. by A. M. Rinehart and M. D. Quinn. St. Louis: C. V. Mosby, 1973.

Forrest, J. W. The contract and nursing practice. *Nursing Papers* 7:2:14-21. Summer 1975.

Friedson, E. Client control and medical practice. *American Journal of Sociology:* 374-82 January 1960.

Gortner, S. R. Scientific accountability in nursing. *Nursing Outlook* 22:12: 764-68. December 1974.

Green, L. W. Change process models in health education. *Public Health Reviews* 5:1:7-29. 1976.

Kalisch, B. J. Of half gods and mortals: Aesculapian authority. *Nursing Outlook* 23:1:22-28. January 1975.

Lewis, L. *Planning Patient Care.* Iowa: William C. Brown Company, 1976.

Little, D. E., and Carnevali, D. L. *Nursing Care Planning.* Philadelphia: J. B. Lippincott, 1969.

Maluccio, A. N., and Marlow, W. D. The case for the contract. *Social Work:* 28-36. January 1974.

Mass, M.; Specht, J.; and Jacox, A. Nurse autonomy: Reality not rhetoric. *American Journal of Nursing* 75:12:2201-08. December 1975.

Parsons, V. Contract vs contact: The process of taming. *Journal of Psychiatric Nursing and Mental Health Services* 10:3:18-20. May-June 1972.

Pincus, A., and Minahan, A. *Social Work Practice: Model and Method.* Illinois: F. E. Peacock, 1973.

Rosenstock, I. M. Patients' compliance with health regimens. *Journal of the American Medical Association* 234:4:402-03. October 27, 1975.

Sloan, M. R. and Schommer, B. T. The process of contracting in community nursing, in *Contemporary Community Nursing,* ed. by B. N. Spradley. pp. 427-42. Boston: Little, Brown, 1975.

Avantage du contrat infirmière-client

Plusieurs des avantages théoriques du contrat infirmière-client sont décrits ici. Ce genre de contrat facilite la pratique de l'infirmière car il fait ressortir les buts et les attentes des deux parties; ceci permet de découvrir des objectifs communs. Les contrats contribuent à la réalisation des buts professionnels de l'infirmière, tels que la responsabilité des soins infirmiers et leur évaluation; en effet, les contrats favorisent l'identification et la mesure des interventions de l'infirmière. Parmi les considérations philosophiques, citons l'accent placé sur la participation des clients à leurs propres soins et leur responsabilité à cet égard. En fait, le contrat représente une affirmation de l'autonomie du client. On peut classer les contrats comme des modes d'intervention acceptants, catalytiques, de confrontation, ou de prescription. L'auteur recommande que des recherches soient conduites pour confirmer la valeur du contrat infirmière-client.