Empathetic Partnership: An Interdisciplinary Framework for Primary Care Practice

Nicole Flemmer, MN, FNP-C, Lida Dekker, EdD, PHCNS-BC, and Dawn Doutrich, PhD, CNS

ABSTRACT

This article introduces Empathetic Partnership, an interdisciplinary framework for primary care practice in the United States. The framework provides a practice framework for primary care nurse practitioners to create effective and therapeutic partnerships with patients. Empathetic Partnership uses women who have sex with women as an exemplar of a marginalized population. Empathetic Partnership is influenced by the lead author's previous work; the cultural safety work of Dr Irihapeti Ramsden, a nurse; and sociologist Dr Brené Brown. The framework consists of 6 key elements: reflection, environment, language, knowledge, partnership, and empathy.

Keywords: Brené Brown, cultural safety, empathetic partnership, interdisciplinary, Irihapeti Ramsden, women who have sex with women

Most patients experience some sense of vulnerability and uncertainty when interacting with nurse practitioners (NPs), other providers, and the health care system in general. Patients are often asked to discuss the most intimate parts of their lives with NPs and other clinicians. Patients are asked to discuss personal health status, daily practices, relationships, sexuality, and much more. Because of the vulnerability of those seeking health care, it is important for NPs to focus on creating safe environments and effective and meaningful partnerships with patients in order to elicit information and to build trust for collaboration on both client-centered and mutual goals.

The purpose of this article is to introduce an interdisciplinary framework, Empathetic Partnership, which adds new concepts to the primary author's previous work "Creating a Safe and Caring Health Care Context for Women Who Have Sex With Women."[1] The Empathetic Partnership framework will be used to show key components for practice as a way for NPs to establish safe, effective, and meaningful partnerships with patients.

Empathetic Partnership is influenced by the concepts of New Zealand nursing's cultural safety, the teachings of the architect of cultural safety Dr Irihapeti Ramsden, and the work of Dr Brené Brown, a sociologist in the United States. Because of the influences of cultural safety concepts and the work of Ramsden and Brown, these interdisciplinary factors are discussed in this article. Because they inform and validate Empathetic Partnership, they will be referenced commonly and used to illustrate the key elements of the framework. To further illustrate the framework, women of sexual minority are used as the example of a marginalized population.

The Empathetic Partnership is a needed addition to the nursing profession because "nursing has lagged behind medicine, social work, and other professions in the publication of research studies, theoretical frameworks, and practice guidelines about LGBT [lesbian, gay, bisexual and transgender] health."[2] This framework can be used with all patients but is specifically useful when providing care for individuals or families from marginalized populations.

Empathetic Partnership comprises 6 elements: reflection, environment, language, knowledge, partnership, and empathy. Empathetic Partnership expands the primary author's previous unnamed framework of 4 elements (reflection, environment, language, and knowledge) to 6. The previous 4-element framework was informed by concepts of New Zealand's cultural safety and is a synthesis of the primary tenets of cultural safety and the primary author's own ideas and concepts. After extensively researching Dr Brené Brown's work as a US sociologist, 2 more concepts were added to the original unnamed framework. Brown's Acompañar theory,[3] as well as her more recent research on shame resilience, vulnerability, authenticity, and empathy are synthesized in this article.[4] The 2 added key components are partnership and empathy, and the framework was subsequently named Empathetic Partnership. Brown influences the addition of the partnership component because, while this concept has roots in cultural safety, it is also emphasized and researched in her Acompañar theory and subsequent research.[3] Although Brown's work as a US sociologist enhances all the key components of the Empathetic Partnership framework, her work specifically brings in the empathy component, a concept that is well described in her research.

A frequently marginalized and stigmatized group within contemporary society is women of sexual minority or women who have sex with women (WSW). Sometimes referred to as *lesbian* or *bisexual*, many WSW do not self-identify in those terms.[1] Therefore, using WSW is more inclusive because of the varying self-identifications of women and the inherent fluidity of sexuality. As stated in the author's previous work, WSW have faced historical invisibility, mistrust, and abuse and have suffered marginalization and stigma not only in society as a whole but also within the health care system.[1] It is acknowledged that many WSW have also had positive experiences of being cared for in safe, effective, and therapeutic ways within health care and that many NPs are well established in creating safe partnerships with WSW patients. However, the lack of safe, effective working partnerships with patients is all too common and pervasive in our health care system. Having a history of minority status, stigma, abuse, and marginalization, the WSW populations provide an excellent opportunity to illustrate the prevailing need for NPs in clinical practice to use the Empathetic Partnership framework.[5-9]

DEVELOPMENTAL INFLUENCES ON EMPATHETIC PARTNERSHIP: CULTURAL SAFETY, RAMSDEN, AND BROWN

Introduced in the 1980s in New Zealand, cultural safety began as a concept and developed into a conceptual guide informing nursing education and practice with influences from critical social and feminist theory in the nursing profession. Cultural safety is defined as "the effective nursing practice of a person or family from another culture, and is determined by that person or family."[10] Cultural safety encourages the NP (and all nurses) to recognize and understand the inherent patient-provider power imbalance and to recognize and honor the patient's culture(s).

Cultural safety also requires that the NP identify his or her own culture(s), including values and biases, and reflect on how these may affect the relationship with the patient. It calls the NP to establish a health care relationship that respects, nourishes, celebrates, and encourages the individual or family. *Culture* is defined broadly and refers to "the beliefs and practices common to any particular group of people."[10,11] Two important tenets of cultural safety are the need for the NP to exercise self-reflection and establish a trusting partnership between provider and patient. Cultural safety asserts that within the health care context, the patient and his or her culture(s) are the norm, whereas the health care environment is the exotic or other.[11,12]

There is no doubt that the US is emphasizing the need to address cultural care issues.[13,14] However, although there are many commonalities between the US ideas around cultural awareness, cultural competency, and cultural sensitivity and New Zealand's cultural safety, there are also some fundamental differences. Perhaps the biggest difference is that cultural safety specifically addresses the inherent power differentials between patient and provider and emphasizes the importance