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Research Article

Relational Practice in Nursing: A Case Analysis

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Abstract

In this essay, the concept of relational practice and its relevance to nursing will be analyzed; a personal experience of nurse-patient interaction will be described; relational practice will be applied as a lens to analyze my episode of nurse-patient interaction; other concepts, including culture and cultural safety, will be integrated into the discussion; and, finally, the implications of relational practice for my future practice will be explored.

Keywords: Nursing, Relational Practice

Relational Practice in Nursing: A Case Analysis

Multifaceted contextual factors are shaping current nursing practice, and relational inquiry can enhance the capability of nurses to meet the challenges and provide health care of high quality. The concept of relational practice is based on a critique of the influence of liberal political ideology on nursing science and practice [1]. Liberal ideology underpins traditional nursing theory. For example, relationships in nursing have been understood in relevance to individualism and paternalism. In the nurse-patient relationship, the nurse is assumed to be of therapeutic intent and regarded as autonomous agent; she/he is, therefore, responsible for making decisions and achieving health outcomes as well [2]. This understanding leads to a deeper exploration of behavioral and moral concepts, such as trust and respect, rather than the discussion of multiple contextual factors shaping and determining the nurse-patient connection. The concept of relational practice, divergent from dominant liberal ideology, attempts to take multiple contexts into account and locate nursing care in a human-centered and holistic process [1].

Relational nursing practice is an understanding of patients' health care needs within complicated contexts, in which patients experience health care and nurses deliver nursing care [3]. Contextual factors include personal elements, such as gender, age and ability, and sociopolitical elements, such as economic, cultural, historical and geographical ones. Relational value is the essential core of nursing practice [3]. The concept of relational practice, however, is more than the relationships in nursing practice. It focuses on how personal, interpersonal and social structural factors shape patients' live experience. From the perspective of relational practice, nurses exam how personal capacities and socioeconomic limitations impact on live experience of patients, decision making, and management of their health care. For example, when public health nurses work with vulnerable families with infants and young children, they contextually understand risks within the capacities and complexities of families' lives, locate disadvantages in social structures and inequities, and integrally connect interpersonal factors and social justice elements [4].

Relational practice is a respectful and reflexive approach to inquire into patients' live experiences and health care needs [3]. It is the skilled action of respectful, compassionate, and authentically interested inquiry [3]. Different from the mechanistic models of human relating, which focus on behavioral communication skills, Hartrick [5] suggests five relational capacities. They are initiative, authenticity, and responsiveness; mutuality and synchrony; honoring complexity and ambiguity; intentionality in relating; and re-imagining. It means that, in order to practice relationally, nurses have to involve the active concern for patients; be able to share and acknowledge the differences; trust patients and understand uncertainty; be able

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to question and step out of the taken-for-granted values and assumptions shaping their practice; and be able to help patients transform their health experiences and evolve their relational capacity [5].

The concept of relational practice is related to nursing education. Teaching and learning in nursing education often focus on mechanical skills and technical interventions [6]. Education curricula frequently emphasize scientific, measurable technical knowledge, ignoring interpersonal aspects of nursing care. Students are taught to assess physical needs of patients, while psychosocial needs are very often ignored. Interpersonal aspects of nursing are often reduced to a set of communication behavioral skills [3,5]. Thus, in clinical practice, novice nurse students are pushed to focus on learning nursing skills. The junior status of students leads to their powerless position and impairs their ability to advocate for the needs of patients and act for their best interests. Their relational capacity, such as authenticity, responsiveness, mutuality and engagement, is not recognized; their contribution to relational nursing practice is not valued [6]. Traditional nursing pedagogy, therefore, should be questioned; interpretive inquiry, which includes a process of intense reflection on relational experience, may serve as the pedagogical foundation for the teaching of relational nursing practice [3,7].

The concept of relational practice is also related to nursing ethics. Nursing ethical codes are often inadequate to articulate ethical issues in nursing practice; relational ethics should complement these codes. The nursing ethics codes and standards, which are based on normative moral theory and abstract principles, are valid when encouraging individual principles such as beneficence, nonmaleficence, autonomy, justice, and other caring aspects of nursing practice. However, the abstract principles of ethical codes are inadequate to address relational aspects of nursing practice, such as context, historical changes, cultural concerns, character and relationship [8]. Nursing is a shared tradition of nurses and patients; nursing ethics, therefore, should be based on their consensus of values and beliefs rather than on the values of bioethics. Relational ethics, which recognize the interpersonal and relational nature of nursing practice, encourage the partnership between nurses and patients, sharing power and knowledge [9]. From the perspective of relational practice, nurses have three obligations in their professional practice: practicing reflexively, providing relational space for difficulty, and working at all levels to enhance the potential for health [2].

A Personal Experience of Nurse-Patient Interaction

Mrs. X, 81, was admitted onto a medical floor of a hospital for a month. She lived in a semi house by herself. According to her chart, she fell in her bathtub and was unable to stand up by herself. She sat in the bathtub for two days and two nights. She kept on knocking her wall for help and, finally, her neighbor called the police, who saved her and sent her to the hospital. Because of her sitting in water for a long time, she was found with dermatitis. In addition, she was surprised to be diagnosed with diabetes. Her medical doctor prescribed insulin, and a diabetes education nurse was called in to teach her how to give herself insulin injections.

Mrs. X was a quiet and pleasant lady. Occasionally, she said that she did not think she needed to live that long. She cooperated with the nurse's teaching very well. She was scheduled to be discharged one week later. As a novice nurse, my focus at that time was learning clinical skills, knowing related technology, and dealing with acute patients. I thought that she was doing fine and I could concentrate on other patients who needed me more.

One day, when I was providing morning care for her, she told me that she would go home very soon and she would not give herself insulin. I was very surprised to hear that because I thought that she was learning very well. "Mrs. X, do you have any difficulties with your insulin? I saw you learning so well," I asked. "Just to make her (the diabetes education nurse) happy. I will never give myself needle," she replied. I said, "Can you tell me the reasons that you do not like the needle?" My question initiated an inquiry of her unique live experience.

She told me that she did not see a lot of meaning in living longer. "My parents died in their sixties and my husband too. I am always fit and healthy. I can't imagine that, I, in my age, have to live with a needle every day." Through further discussion, she showed an understanding of the need for medication to control the disease, but she definitely refused injection. She agreed with my suggestion that I helped to call a doctor to furthur discuss about the possibility of giving her oral diabetes medication.

Because of our discussion of insulin injection, I realized that there might be some unknown factors influencing her health, and I needed to understand her more. During my busy scheduled days, I always spent several minutes sitting at her bedside and I knew more and more about her. She told me she was the first generation of Italian immigrants. She had been living in Toronto for sixty years, and she lived alone in her house. I knew from her chart that she had a son. She, however, said, "My son very seldom visits me or even calls me. I wish I had a daughter. Only daughters take care of parents." The most difficult thing for her at that time was that she was losing her old neighbors, who had died or moved out of her community. She very often described the happy times when her neighbors and her family gardened and partied during the summer. Without family and neighbors close to her, she felt lonely and disappointed with her life. I discussed with her the services of social workers in the hospital. She agreed to consult with a social worker.

Mrs. X stayed in hospital for one more week longer than the original schedule. She was working well with her new prescribed oral medication. A social worker was also called in to consult with her about necessary home care. She thanked me when she was discharged from the hospital.

Critical Analysis

Initially, during my first contact with Mrs. X, some personal factors shaped my interaction with her and caused me not to engage with relational practice. I am a visible minority immigrant and I tend to believe all whites as being the same and having a homogenous cultural background. I assumed that she, as a white, belonged to the main stream, was autonomous and independent,

had superior social status, and did not need any special help. In addition, as a novice nurse in a brand new environment, my personal goal was to minimize mistakes and harm to patients rather than provide best care. At that time, I concentrated on a patient's diseases, treatment and physical needs. I did not have a lot of interest to talk with her and prepare to spend extra time with her because she was not a patient in physically acute situation with high nursing care priority. Therefore, initially, my personal identity and social location hindered my willingness and capacity to be in relation with her, causing me to ignore her needs [2].

Structural factors also influenced my interaction with Mrs. X. The acute care organization, where I was working, pressures and expects nurses to treat physical injuries and diseases. Guided by dominant biomedicine perspective, the nursing assessment and the task-oriented nursing care plan, which mostly focuses on physical needs, categorized Mrs. X as an easy patient, who did not need a lot of nursing time and was waiting for discharge. Therefore, being with her was an optional rather than mandatory. Busy schedule, heavy workload, and increased patient acuity prevented me from spending adequate time with her. In addition, ideology, such as ageism, influenced my initial contact with her. Although she occasionally expressed disappointment in her life, this expression, in our society, has been assumed as normal in the aging process.

My relational practice with Mrs. X was a respectful and reflexive approach of reflecting nursing obligations. This process was initiated by my caring nature as a nurse and sense of responsibility and obligation. The obligation to be reflexive sparked my authentic interest to know about why she had rejected insulin injection. This inquiry caused me to critically examine the values, assumptions, goals shaping my interaction with my patient. My reflective practice helped me understand that my assumptions were based on my personal identity and social location; furthermore, these biased assumptions led to ignorance of her live experiences and her health care needs. I, therefore, felt the obligation to open the relational space for her to articulate her difficulties. I intentionally spent meaningful time with her and inquired into her live experiences and health care needs. Finally, I fulfilled my obligation to work on my best to advocate for her health care needs and properly organize her health care.

My relational practice demonstrated the significance of context in nursing practice and patient care outcome [2]. My inquiry helped disclose a complex picture of a patient's life experiences. Without this inquiry, she might be discharged with prescribed insulin, and her unwillingness to do self-injection might lead to deterioration of her health care status and life quality. Without this inquiry, it was no way to find out that she deadly needed social support and home care although there was her son's name in her chart. Without this inquiry, her live experiences of living in Toronto for sixty years as an Italian immigrant might not be related to her health care. My relational practice led to therapeutic nurse-patient relationships, contextual understanding of her psychosocial circumstances, better choice of her treatments, proper arrangement of her healthcare and patient satisfaction of nursing care [2]. In this contact with Mrs. X, I gained deeper understanding of culture and racism. I used to superficially understand culture as a set of behaviors, values and beliefs by a group of people. As an immigrant living in Toronto, a multicultural environment, I mostly related to the concept of culture to minority groups. I had not expected Mrs. X to describe her Italian culture to me. Her close relationship with her parents and husband, her pleasant activities and ceremonies within her neighbors, and her food preference demonstrated that everyone has a special cultural background and unique human experience which nurses should be aware of when taking care of patients. My ignorance of her care was partially due to my assumptions on her white ethnicity and social status; this situation identified that democratic racisms prevail in and bring harm to our society even though we are not aware of. As a nurse, I have responsibility to constantly reflect on our practice, articulate bias and discrimination imbedded in our daily practice and strive to provide justice care.

Cultural safety is another concept is related to my care for Mrs. X. Both the concepts of cultural safety and relational practice require nurses to look beyond the surface of people, relationships and situation to recognize psychosocial context, cultural diversity and power imbalances [10]. While cultural unsafe practice is defined as any actions that diminish, demean or disempower an individual's cultural identity and well beings, nurses can perform cultural safe practices in which they recognize negative attitudes and stereotyping of individuals, respect the unique cultural identity of patients, promote their rights, and safely meet their needs [11]. During my initial contact with Mrs. X, I did not provide cultural safety because I demeaned the significance of Italian culture in her live, diminished her autonomy and self-determination, and eventually disempowered her. My initial care did not meet her health care needs. However, in the following contact, I respected her health care choice, acknowledged her rights as a patient, an Italian immigrant, and a senior citizen, and recognized her unique life experiences and psychosocial context. My contextualized understanding of Mrs. X enabled me to provide culturally safe nursing care to her.

After learning the concept of relational practice, I thought that there was something I could have done better. First, the relational practice should be initiated at the very beginning of patient contact. Authentic, interested and intentional inquiry about a patient's experiences and needs is an obligation of nursing practice [2]. Delayed relational practice can cause unnecessary stress for patients and increase the risk of more harm. Second, I should have constantly reflected on how my personal assumptions, social location, and biased valued impact on my nursing care. Reflexivity is both a need of nursing practice and an obligation of professional nurses [2].

Conscious and intentional participation on reflective practice help nurses understand themselves and look beyond the surface of people and situations. Finally, my relational practice should not stop at nurse-patient interpersonal contact level. Nurses have obligation to act at all levels to influence health care and clinical practice [2]. I could have shared my experience of caring for Mrs. X, encouraged discussion and raised awareness of the need of relational practice in my local unit. I might take the advanced practice nurse role to advocate patients' needs and application of relational practice

in nursing care. For example, provide an education opportunity by setting up a seminar or writing a pamphlet to introduce the concepts of relational practice. In addition, assuming clinical leadership of an advanced practice nurse, I could talk with the administrative level, raise awareness about how contextual factors affect relational practice, and seek change to improve patient care in the local hospital [12].

Implications

Relational practice has important implications in nursing clinical practice. First, nurses need to understand the significance of context in nursing care. Relational practice requires nurses to look beyond the surface of people, situations and relationships to find out the contextual factors which are unseen or ignored but shaped our nurse-patient interaction. Nurses need to be aware of the socioeconomic and political issues in our society and recognize how these issues impact on people's health care [2].

Second, in Canada, a multicultural society, it is essential for nurses to understand the cultural issue and provide cultural safety in their practice [13]. Nurses' own assumptions, beliefs and values could impair or enhance relational practice [14]. Therefore, questioning the full assumptions underlying the nursing practice can help to articulate unaware biased stereotyping and how they shape nurse-patient relationship and nursing practice. Nurses need to understand difference and diversity in people's attitudes, beliefs and values, be sensitive to patients' needs related to cultural issues, and practice relationally to reach cultural safety. Nurses should take responsibility to articulate bias, discrimination, and democratic racisms, and provide justice care [15].

Third, relational practice emphasizes the significant of respect in nursing care. Relational practice requires that nurses demonstrate respect for patients' culture, age, sex, beliefs and values, health care decision and preference. Knowing patient and their family is one component of respect. Nurses should engage with patient within the specific context, and avoid assumptions, generalization and stereotyping. Authentic care, interested inquiry and attentive listening promote relational nursing practice and respectful care.

Forth, relational practice renews the content of nursing ethics. In order to practice ethically, nurses need to not only follow codes and standards, but more importantly understand patient's experiences contextually and act on their best. Relational ethics should be applied to complement nursing codes and standards. Nurses should be aware of their obligation during their relational practice. Reflexivity should be emphasized as an essential component of the process of relational practice [16].

Fifth, nursing management and leadership should be involved in relational practice. Managers should encourage nurses to pay attention to the big picture of patient care, relate socioeconomic factors to their health care practice, and connect patients' psychosocial factors to their health care needs. Advanced practice nurses and other nursing leaders should be involved in establishing related policies and providing further education about cultural safety and relational practice. Leaders should advocate for patients' needs, provide adequate resources, encourage multidisciplinary teamwork to facilitate relational nursing practice, and strive to make change in clinical practice. Advanced practice nurses and administrators should work together to increase nursing capacity to influence socioeconomic and political determinants of health [1].

Relational practice also has important implications in nursing education. Nursing schools should consider to incorporate critical social theory into nursing curricula and to educate students about cultural diversity and other psychosocial health determinants. Interpretive inquiry should be applied as a part of nursing pedagogy to encourage intense reflection and relational practice. In clinical practice, nursing educators should be aware of students' fear of deficit in terms of skills and knowledge, promote their sense of professional identity, recognize their relational capacity, value their contribution to nursing care, empower them to be members of nursing care teams, and encourage them to practice relational inquiry.

Finally, relational practice has important implications in nursing research. Critiquing the influence of liberalism on nursing science should be a focus of nursing research. For example, liberal notions of individualism, equity, diversity and their impact on nursing practice should be further explored. Qualitative research methodologies should be applied to explore the experiences of nurses, patients and their families in the process of relational practice. Barriers and facilitators of relational practice should be discussed. Research findings should be effectively translated into different clinical settings in a timely manner.

To sum up, relational nursing practice is an understanding of patients' health care needs within complicated contexts, in which patients experience health care and nurses deliver nursing care. It is a respectful and reflexive approach to inquire into patients' live experiences and health care needs. It has important implications to nursing practice, education and research.

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