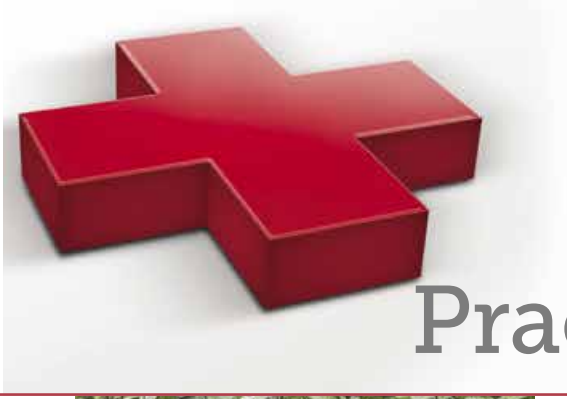

ARTICLES, PROFILES AND OPINION PIECES FROM ACROSS THE NURSING SPECTRUM

Practice, People & Policy

Sallie Greenwood & Katrina Fryers

Cultural safety and relational practice: ways of being with ourselves and others

How nurses relate to patients is integral to nursing. In their first article, KATRINA FYERS and SALLIE GREENWOOD looked at developing reflective skills to support self-knowledge and culturally safe practice. They now consider how self-knowledge enhances the concept of relational practice and draw examples from their research.

Nursing has always been more than providing competent clinical care. Nursing is also very much about relating to the people being cared for with respect, trust and compassion and in ways that are culturally safe.

The art of authentically being with people is part of relational practice, a concept that has been widely discussed and considered in depth by nurse scholars, educationalists and writers interested in leadership. But what it actually means to be 'relational' in nursing is a question that is often still asked. So this article begins by sharing our understanding of what it means to be relational as a nurse and as a nurse educator.

As with reflective practice, being relational requires a conscious awareness of both one's own experience in the moment and the experiences of those with whom we work, be they students, patients or clients. Relational practice is a way of being that includes collaboration, trust, compassion and empowerment. True compassion is based on empathy, respect and recognition of the unique individual and a willingness to engage in a relationship with them that acknowledges the limitations, strengths and emotions of all parties. It requires that practitioners engage in a 'real' dialogue with patients based on honesty and courage.

Imagine what it feels like to receive a diagnosis of a chronic illness: heart failure, for example. You may have had some symptoms, followed by a few tests and then are told that, although the symptoms can be managed, you cannot be cured. This is devastating. You are no longer the person you were before the diagnosis; you are now someone who has a life-limiting and possibly life-changing illness.

As the nurse who is with the patient when they are given the diagnosis, how are you going to be? What will guide your decisions about how to be with this person who is struggling to find meaning? Hopefully you will consider the context within which this catastrophe is happening; an alien context full of machines, medical jargon and uniforms. Perhaps there is no privacy, perhaps there is no close friend or family there. Will you take the time in a busy environment just to be still with this person; to be whatever it is they need? Perhaps they need to be alone.

Understanding the patient in their context, what they need and how you can best respond to that need are part of relational practice and also important aspects of cultural safety. The decisions that nurses make in every patient encounter make an immense difference to the patient's experience. It is clear therefore that relational practice is an ethical issue.

Joan Lischenko has argued this in her research around nurses' efforts to search for a bridge with patients that they did not like. Therefore a relational ethic builds upon a justice and care ethic to include "a concept of personhood that values autonomy through connection, a recognition that sensitivity to ethical questions is as important as the ability to secure answers, and an awareness that our practice environments shape our moral responses".

SKILLS THAT CONTRIBUTE TO A RELATIONAL WAY OF BEING

Communication in nursing is often taught in a behavioural way, as a set of skills to be mastered; this can be useful for beginning practitioners. However, relational practice requires much more of us in terms of knowing how and when to use the skills. As Hartrick, Doane and Varcoe remind us, relational practice is at the heart of nursing practice, which is complex work carried out in rapidly changing situations with diverse individuals and groups of people.

Because one size or one way of responding does not fit all, whether we decide to be with someone in silence or to provide them with reassuring knowledge will depend on the patient and the situation. Similarly in the learning environment, as educators, we have to judge whether to offer a gentle challenge to the views being expressed by a student, or whether to hold the challenge because it would be too destabilising to that student or to others in the class at that particular moment. To support this stance, we endeavour to model relational practice in our interactions with students and believe that this supports the development of a safe space for students to explore difficult issues.

It is often through reflection that we become aware of our previously unquestioned beliefs. This can in turn challenge our values and so be a very uncomfortable experience. This is when students need to feel supported and not judged.

One of the biggest things I have learned from this course and from reflecting is that these are huge, contentious topics and people often feel uncomfortable being confronted about them. Although they might make us feel awkward, angry or any other feeling, it's okay to feel that way and important to recognise why you have those feelings and not just ignore them. (Kath)

As a result of this course, my standpoint on a lot of things has changed. It has raised a lot of questions and has left me questioning what I thought I knew, and therefore I have felt very challenged at times. (Liz)

In some senses human beings are always relational; that is, we understand ourselves in terms of our relationship to others, but in many western societies we have also come to understand ourselves largely as individuals and the focus is more on autonomy. So we may place less emphasis on our relationship with others or being 'other-directed'. Cultures that are more collective in their approach often place more emphasis on how others are feeling than on the self. Individualistic models of relating to others tend to minimise or disregard the power relations that are a part of all relationships, so acknowledging power as part of relational practice is a fundamental. Therefore our journey of becoming relational aims to make explicit some of the values and orientations that may have informed our sense of ourselves and others.

NURSING STUDENTS' JOURNEYS TO RELATIONAL PRACTICE

As future nurses, we must remain aware of a power imbalance. It is the nurse's role to ensure this power imbalance is transformed into a partnership and builds trusting relationships (Felicity)

In addition to understanding what is happening in the relational moment, we need to understand the social context of how groups within society are positioned in relation to each other. By being conscious of how people view themselves and how others view them in relation to the world we can then see the complexity of the situation and respond more meaningfully. For example, someone receiving a diagnosis that is life-changing may now have a more passive relationship with

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health providers, be seen only as a 'patient' or a 'diagnosis' and be thought about differently in terms of their future contribution and value in society.

In our research we noticed that students' thinking over time moved towards a more relativistic stance (i.e. noticing other ways of knowing). Consequently they were more able to incorporate ideas about difference and recognise that understanding differences between people was as important as understanding similarities. This enabled them to adopt a more inquiring stance towards those they were working with.

I also feel that understanding my own culture and identity has helped me to have an open mind towards other cultures and this has helped me to understand the prejudiced views I have about other cultures. (Sophie)

As expressed in the word clouds derived from students' more relativistic comments, the language used became more other-focused as the students moved through the module and thinking positions.

When stretching to relativism (Figure 1) students incorporated ideas about culture and difference. 'Culture', 'different' and 'understand' were the most dominant words, with 'think' and 'feel' and 'values' also included. Interestingly the word 'patient' was here replaced with 'people' a less objectifying term.

At relativism (Figure 2) students wrote much more about how they think and feel, these words

Figure 1: Stretching to relativism

Figure 2: Relativism

now being the most dominant terms. 'People' had become 'someone'. Without wanting to attribute too much significance to these findings, which could look different from another cohort, we did find the language shifts interesting as an indicator of where this group of students went to in their ways of knowing about the issues.

CONCLUSION

Developing relational practice is a way of being that enables nurses to work with uncertainty and complexity and is strongly linked to the principles of cultural safety. Through reflective practice, student nurses developed new ways of knowing that enabled them to be more conscious of practising in relational ways (see Figure 3) by recognising that people come into relationships from many different social contexts. The final article based on our research will consider what the concept of reflexivity can contribute to relational practice and cultural safety.

Figure 3: Ways of being in relationship

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N.B. References for this article are available in the online version, which can be found at www.nursingreview.co.nz.

POLICY

Māori nurse pay parity battle continues

In the latest battle in the pay parity war, the NZNO has presented a number of interventions to the United Nations Permanent Forum on Indigenous Issues on behalf of iwi provider nurses and health workers.

Health and Māori Development ministers have declined to comment on NZNO kaiwhakahaere Kerri Nuku taking a call for pay equity for iwi provider nurses to the United Nations.

But Te Ururoa Flavell, in his capacity as Māori Party co-leader and not the Minister of Māori Development, said that he "absolutely" supported pay parity for nurses working for Māori and iwi providers.

Nuku, the Māori co-leader of the New Zealand Nurses Organisation, said it was currently waiting for the non-binding UN recommendations after presenting a case to the United Nations Permanent Forum on Indigenous Issues in New York in May.

She says the presentation focused on building Māori workforce capability to better reflect the population it serves and the pay parity "plaguing our Māori and iwi health providers sector".

The call for pay parity for iwi provider nurses and health workers dates back to 2006 after the NZNO 'pay jolt' ratified in 2005 for district health board (DHB) nurses saw the pay gap widen between initially all DHB and non-DHB nurses. A gap then also emerged between Māori-led healthcare organisations and their counterparts employed by PHO-funded general practices because of different funding mechanisms.

An 11,000 strong petition was presented to Parliament in July 2008 backing the pay equity call and a subsequent 2009 Health Select Committee report called for a working group to look into the petition issues but the Government did not adopt the report.

Flavell said in 2012 the Human Rights Commission found that Māori and iwi health workers earned up to 25 per cent less than their colleagues in hospital settings. He said there were a number of contributing reasons for this, including the funding model.

"Our nurses do a wonderful job, whoever employs them, and I would like to see progress towards pay parity," said Flavell. Asked whether he supported NZNO going to the UN forum, he said he supported using available avenues to get better outcomes for whānau Māori, and highlighting whānau concerns.

"I also encourage the NZNO to continue its discussions with the Minister of Health and the Ministry of Health, as well as providers of health services to whānau. Much can be achieved through this engagement."

There was no comment from Health Minister Jonathan Coleman in response to *Nursing Review* queries about the ongoing pay parity issue and Nuku's approach to the UN forum.

Nuku said the NZNO presented a number of interventions to the forum to help address the issues, including the need for high-quality Māori workforce data collection to allow the sector to better understand the workforce capability nationally. It also asked for a commitment to indigenous health workforce equity, with currently seven percent of the nursing workforce identifying as Māori, compared with just under 15 per cent of the population – and the seven per cent figure had been static since the 1990s. It also sought better approaches to identifying workforce barriers and developing recruitment and retention initiatives.

See earlier story at http://goo.gl/4Qlw11.