Same Person Different Nurse

A study of the relationship between nurse and patient based on the experience of shifting from secondary care to home-based nursing.

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Abstract

This study focuses on power themes in the nurse-patient relationship. The study is a critical reflection of my practice using a humanistic perspective from Hartrick Doane and Varcoe's (2005) model of relational family practice. It reviews the literature relating to power relationships in communication between nurses and patients and compares the ability to provide relational care in the home with hospital care.

Practice examples demonstrate the shift in power relationships that I have noticed since changing roles from hospital based to home care nursing. This is related to cultural, socio-environmental, historical and traditional influences on power in communication.

The study is based on my reflection of the paradigm shift in my practice. I moved from a problem solving approach to an empowerment, strengths based approach within partnership. The ethical challenges of discussing my practice in relation to clients have been managed by scrambling patient data so that it is not related to a single person and is focused on my nursing practice.

Table of contents

Acknowledgements

Chapter one

Introduction

This study is a humanistic analysis of nurse-patient relationships. It is based on my experience, which looks to examine the power in these relationships. My interest has been stimulated to investigate the relationships I have known as a nurse with patients in secondary health services and consider the relationships I now have with patients in the primary health service, specifically home based community nursing. This has also been triggered by experiencing improved connections with people, particularly Mäori, and reading literature which supports the impact of relational practice and empowerment for those experiencing chronic conditions.

The relevant literature, in particular Hartrick Doane and Varcoe (2005), is used as the framework for analysis of themes in developing relationships that are empowering in the community. This is different from my experience of relationships in hospital due to constraints of historical practice models and power in relationships. I will describe practice examples to demonstrate this shifting paradigm in nurse–patient relationships (Hartrick Doane & Varcoe, 2005; National Health Committee, 2007). This study examines power primarily from Hartrick Doane and Varcoe's perspective on power (2005).

The study is an exploration of the concept of power in the relationship between nurse and patient. The phenomenon that power and knowledge are intimately and productively related, (Barker, 1998) is reflected through practice examples. These relationships will be examined using Hartrick Doane & Varcoe's (2005) perspective of nurse-patient relations. The project is contextualised through the recent change in my role in the primary sector. The origins of a philosophical change in approach (emergence) will be considered to examine traditions that influence power in relationships (Barker, 1998).

The relational themes that I have experienced as a nurse will be deconstructed. These include cultural, changing status to be a guest, language and history and tradition. They will be considered from the perspective of a nurse who has practiced in both hospital and home based settings as a reflexive practitioner, with understanding of the influences of my

background and culture. Nursing is an experience lived between people however family nursing is a relational living experience (Hartrick Doane & Varcoe, 2005, p.4).

My values and perspective are formed by my background, theories and experiences. Therefore I will position myself within this context. Hartrick Doane and Varcoe's (2005) theory of health reflects my thoughts on how and when this occurs.

The theory of health as expanding consciousness articulates nursing intervention as a relational process where the nurse enters into partnership with the family, often at a time of chaos, with the mutual goal of participating in an authentic relationship through which the nurse and the family may emerge at a higher level of consciousness (Hartrick Doane & Varcoe, 2005, p. 105).

The concept of power needs to be understood because this paper will examine power in relation to nurse-patient interactions in a hospital environment and compare this to that in a home-based environment. Hartrick Doane & Varcoe (2005), in their model of relational nursing practice, describe power as useful and unavoidable. Manias and Street (2000) suggest that to use this approach the nurse assumes a position of power which she attempts to share and thereby empower and she must reflexively examine what kind of practice is possible when the nurse admits their power. The above authors also hold that power is negative only when used in such a way that a person's behaviour would be altered if the power influence over them was different, thus affecting choice and having a restrictive effect (Manias & Street, 2000).

Historically, power was enforced using punitive measures, such as withdrawal of health care services, to deal with non-compliance (Henderson, 2003). Those who experienced this may resort to an appearance of compliance which may be covert resistance as it is potentially the only reality available for them to prevent power being exerted over them further. Admission of what has led to the creation of passive individuals allows new practice development (Manias & Street, 2000).

Historical Context

Mäori are disproportionately high users of health services, sometimes accessing late and with poorer health outcomes and reduced life expectancy of 8-9 years in comparison to non- Mäori (Jensen & Smith, 2006; Lakes District Health Board, 2005). Mäori make up 35% of the population in the region which is significantly higher than the national average of 15% (Lakes

District Health Board, 2006). This means that many of my clients are older Mäori with a background of potentially disempowering relationships with health professionals (Ramsden, 2005).

Colonists destroyed Mäori social order until it was irreparably harmed and British protection was required (Ramsden, 2005). This is a relational experience and its repetition impacted negatively on such areas as traditional healing and tikanga around death (Durie, 1998; Durie, 2005; Papps, 2002; Ramsden, 1990).

Because of this a relative absence of traditional Mäori healing has developed in our health services (Ramsden, 2000). This has limited choice and therefore power to exert choice for this particular group. I will describe how redefining relationships in the community can empower Mäori (Ramsden, 2000). The Primary Health Care Strategy (2001) is addressing this inequity and funding traditional providers to reinstate choice (Lakes District Health Board, 2006).

Despite resistance from Mäori, power was exercised over them and eventually, after colonial times, passivity at least appeared to reign (Durie, 1998; Hartrick Doane & Varcoe, 2005). Power in social relationships can separate reality and possibility in choice. The exercise of unilateral decision-making removes choice and limits possibilities for Mäori due to the predominantly Päkeha health work force placing value on a scientific model and compliance to this while largely ignoring traditional methods (Hartrick Doane & Varcoe, 2005; Spence, 2005; Papps, 2002; Ramsden, 1990; Ramsden, 2000). However, cultural competence allows a nurse to establish an effective health care partnership and this aligns to Hartrick Doane's work by encompassing self-awareness in relation to others (Papps, 2002; Ramsden, 2000; Stein-Parbury, 2005). Ramsden (2000) discusses developing trust early in relationships between Mäori patients and Päkeha nurses or risk being seen as unsafe. She also considers that the inherent history of distrust between the powerless and power holders which must be understood in order to practice.

<u>Power and Nursing</u>

I have chosen Hartrick Doane and Varcoe's (2005) view of relationships and power as being in existence only in relation to something or someone else. The patient will be considered in relation to the nurse. It must be acknowledged however, that both the patient and nurse will be subject to multiple influences. Hartrick Doane and Varcoe's (2005) perspective on power sees power as being in existence only in action as a force. Its relevance is when it is exercised over

someone to repress their nature, instincts, class or individuality. "Empowerment is defined as not something that occurs purely from within nor is it something that can be done for others. Rather power, and thus empowerment, is enacted in relationship" (Hartrick Doane & Varcoe, 2005, p. 33). The words 'power', 'empower' and 'relationship' will be used in the context described above.

The purpose of this research is to explore the paradigm shift that I, as a nurse, have experienced in the exercise of power in relationships when taking into account the patient's home and social circumstances and how these impact on their health. Hospital and ward nursing has been described as nurses being accustomed to routine and therefore possibly treating patients in a routine manner rather than aligning themselves alongside another person as can occur in the person's home (Stein-Parbury, 2005). Although this could be considered a generalisation it does have some basis historically and examples of my practice will demonstrate a shift from this 'routine' treatment to a more patient-focused model.

I was part of an entrenched routine that caused me moral distress when I was caught between resource constraints and knowing that I should practice in a more relational family-focused manner (Hartrick Doane & Varcoe, 2005). Self reflection and moral identity are key factors to understand about myself as a nurse (Hartrick Doane, 2002; Hartrick Doane & Varcoe, 2005; Rodney, Varcoe, Storch, McPherson, Mahoney, Brown, Pauly, Hartrick, & Starzomski, 2002).

As a nurse I must consider and own my values and beliefs and recognise how these can impact on my relationships and my struggles to practice effectively by empowering people to make choices relating to their health (Hartrick Doane, 2002). I must take into account my up-bringing and world view. I am a female päkehä from a traditional, middle class, nuclear family, with two children of my own. I was educated in Catholic schools and brought up with Christian values. I began my nursing education in the mid nineteen-eighties when an emphasis on cultural safety was being introduced into tertiary education for nurses (Deikelmann, 2003; Papps, 2002; Ramsden, 1990; Ramsden, 2000).

This background and upbringing has influenced my decision to become a nurse and also what I hope to achieve. Having values and ethics that mean wanting to 'do good' and a sense of social and moral obligation and understanding of what I consider ethical practice enables me to be aware of factors that can lead to moral distress. This awareness also helps me to understand and reevaluate my moral identity (Hartrick Doane, 2002).

Nursing originated from Catholic nuns and it therefore includes Christian values of social justice and moral obligation. Having a privileged and educated background has made me realise that different life experience can limit opportunities in health (wellbeing) and socioeconomic experience. I realise I am able to influence others' health experience and possibly outcomes and am interested in empowering people to achieve their health potential (Hartrick Doane & Varcoe, 2005; Spence, 2005). I have experienced the positive benefits on health when an educative and therapeutic relationship can be developed with mutual respect and shared goals to develop shared solutions to problems (Peplau, 1988). I know that my experience of family is not the same as others' and that family should be defined by each person (Hartrick Doane & Varcoe, 2005).

Perspective

As I describe my current practice I am attempting to critically analyse my historical work behaviour and contextualise other ways of working that may have their place in the continuum of health care that people with chronic conditions experience, and to describe the paradigm shift in relationship power I have witnessed.

There are also certain viewpoints and actions which constrain relationships through disempowerment, such as a biomedical model (Spence, 2005) with the emphasis on disease and problem-solving rather than living well with a life-long condition. My role is to facilitate self management of symptoms to empower people to recognise early and treat an exacerbation of their condition to reduce preventable hospital admissions as well as improve quality of life.

By being deliberately mindful of power within relationships I am applying Hartrick Doane & Varcoe's (2005) perspective in nursing situations and relationships. This perspective does not deny health professionals their specialisation and expertise (Lupton, 1995). Rather, these are utilised in ways that promote greater equity between families and nurses. This can promote equitable power relationships by empowering people to be experts in their health and allowing them to both find solutions to their needs and have confidence that they can do this (Hartrick Doane & Varcoe, 2005).

This perspective will be applied to examples of practice and will demonstrate how my practice has changed following my recent study and a change in role. I will reflect on how I have practiced in hospital and compare this to the primary sector, in particular home-based nursing care. The paradigm shift is from my hospital nursing position where I would know and do for,

to reimagining and allowing strengths to come from the individual within their family context. This shift involves changing nursing habits from problem solving to allowing solutions to be choices (Ramsden, 2000). The focus on problems becomes a focus on strengths (Hartrick Doane & Varcoe, 2005).

Chapter Two

<u>Method</u>

The chosen approach uses Hartrick Doane and Varcoe's (2005) work to understand relationships, and the theme of power within these, in hospital and home based care. A humanistic approach is used to redefine relationships and can be applied through the shift in strategy focus to primary based health care as in the Primary Health Care Strategy, (King, 2001; Ngata & Dyall, 2001; Ramsden, 2000). Understanding can be gained by recognizing what this might mean in relation to power for patients and nurses (King, 2001; Ramsden, 1990; Ramsden, 2000).

Hartrick Doane and Varcoe (2005) agree with the perspective that people, when they are not being scrutinized, may develop more meaningful relationships. This is because the value of the nurse-patient relationships may not be supported, for example, in a task-focused approach to care (Spence, 2005). In examining how tradition has developed, historical knowledge is revealed through a humanistic lens which may be adverse to global theory but is the norm in a particular region, for example in relation to Mäori culture in New Zealand (Hartrick Doane & Varcoe, 2005; Ramsden, 1990; Ramsden, 2000; Stein-Parbury, 2005).

Self awareness is the beginning of culturally safe practice, therefore it is important to question myself (Ramsden, 2005). What does this mean to patients and to me as their nurse? What have their health care experiences been? How can I listen to their experience and consciously remove assumptions that I may have made to increase my self consciousness using a humanistic lens (Hartrick, 1997; Ramsden, 2000).

Hartrick Doane and Varcoe's (2005) approach to relational theory emphasises the difference between utilising a biomedical model based on absence of disease and treating disease process with a socio-environmental approach which places emphasis on living a meaningful life and what influences that. They also discuss habitual practices such as a nurse who has a hurried gait creating the impression of being busy (tradition/habit), which then influences the patient's experience and behaviour (Spence, 2005). When this approach is compared with home visiting and being a guest in a person's home without pressing tasks to be performed a person can experience a very different relationship and an impression of available time can be created.

The literature has been reviewed to support Hartrick Doane and Varcoe's (2005) theory of power relationships between nurses and patients. The theory describes this relationship as being required to be enacted with recognition of power dynamics with the intention of promoting more equitable relationships. This means that by acknowledging our own position we are better able to shift power to the client. This can be done from the position that those experiencing health problems and needs hold the power and that it belongs to them (Connor, 2004).

The goals of Hartrick Doane & Varcoe's (2005) approach are to build on strengths in families and recognise difference without siding with any particular member of the family, thereby influencing power relationships. They describe this approach as working across differences and recognising and acknowledging this. It also involves working across different cultures, and rather than being problem focused, to look within the family to find strengths and support them to build on these (Roberts & Wilson, 2005).

According to Hartrick Doane and Varcoe (2005) this relationship begins by entering into relation, being in collaborative relation, enquiring into family health and healing experience, following the lead of families and learning to let be. This model will be applied to practice examples while acknowledging that protecting patient privacy has been an ethical challenge. I work in a small community and therefore the focus will remain on my practice and the paradigm shift within this. Practice examples will be a collection of relational experiences rather than a particular client example.

The situations that I describe are reinvented based on these real experiences. A guiding ethical principle will be to do no harm and this includes practicing in a manner that is culturally safe. If my intended readers, who are also nurses and bound by privacy constraints, believe they recognise a situation they must understand that the example of practice chosen has been jumbled to make a point, not to describe a client's experience.

The relationship begins by 'entering into relation'. This means understanding yourself and the patient as relational beings. It also means reflecting on how the patient has been described by others and what preconceptions may have developed, and then consciously reimagining the person while shifting preconceptions and bracketing them away from this new relationship. In my practice context this begins by imagining what it may mean for a person to have a chronic lifelong condition and wanting to understand this experience (Roberts & Wilson, 2005).

Following meeting the patient I want to actively listen and look for connection. This may be by gaining an awareness of what is around them, whether in hospital or home. It may be family or friends, photographs, collections of art or decorations, a cared for garden or something else that looks important to them that we can talk about to establish a relationship (Connor, 2004). For me this is most important if I have to redefine the connection after sometimes being involved in their care as the clinical nurse leader in hospital, to be clear that I am no longer that same nurse despite the fact that I am the same person.

I follow their lead by listening as they talk about their needs. It is up to me to follow through with the clues they have offered me and this may involve asking about their previous health experiences. This skill helps to develop a 'strengths' based approach which shifts the emphasis from problem-solving and allows the client to be the expert with the skills to develop their own solutions and encourages an equitable partnership (Connor, 2004; Hartrick Doane & Varcoe, 2005; Roberts & Wilson, 2005).

I am also aware that I am not there to solve the problem, as I was in the solution focused hospital role, but to notice and suggest options if asked and to build on what their strengths are (Connor, 2004). Sometimes this leads to a role of broker or intermediary between service providers, but this is not a given. This establishes a sharing of power and therefore leads to empowerment. Learning to let be and accept choice to reject health care has been my hardest challenge (Ramsden, 2000).

Relationships are based on experiences and therefore as a nurse I will present a different aspect of myself to different situations. I am a different nurse to patients in hospital than the nurse I present to community patients. In interacting with doctors I am different again and how I develop these relationships is my choice.

Literature Review

The literature search has been focused to include *power relationships* in nursing and it was narrowed to the key words: *Secondary or primary health care*. There was no literature found comparing nurse relationships between the sectors directly and due to constraints on the size of this paper the review is limited to nursing relationships and power. Sites searched using EBSCO host include CINALH, PROQUEST. The literature is considered current and relevant when nurse-patient power relationships are themes and is the inclusion criteria.

How nurses communicate is identified in nursing research as fundamental in power relationships (Connor, 2004; Henderson, 2003; Hewison, 1995; Lupton, 1995; McCabe, 2004; May 1990;). This is often because of the type of communication encounter or language used during these encounters. Hartrick (1997) discusses dialogue as central to actions of family nursing, linking this communication to empowering family with choices and seeking to use this dialogue to develop shared meaning.

May (1990) focuses his research on how poorly we as nurses achieve therapeutic communication and this is relevant. In contrast to this McCabe's (2004) study demonstrates that when nurses use patient-centred communication they are able to enhance patient experience. She argues however that this is seldom valued by institutions and health care management.

Communication in discussion of nurse-patient power relationships is noted by McCabe (2004), who compares the approach of task-centred versus patient-centred communication. The difference here is that if the communication is patient focused then they are participants in their care and are then empowered to make decisions. This opposes the sense that nurses can make assumptions about their patients needs if the nurse is task-focused.

The nurse's hurried gait gives an appearance of being busy and is described by Hartrick Doane & Varcoe (2005) as doing the bare minimum required for a patient. Thus busy appearance affects the patient's care as they are then enacted into a role of compliance or may be afraid to interrupt this busy person with their concerns (Spence, 2005). An example of this is performing a task without eye contact or conversation with the patient, which could feel like punishment.

Communication between nurses may also label a client. This may be because nurses dislike them or have constructed them as 'difficult' or 'non-compliant' by sharing information in a judgmental way (Ramsden, 2005). This person may also be described as 'demanding'.

This language then affects patients' care. Reward is used if the patient is seen as compliant and the patient may be punished if labeled as difficult, by nurses delaying answering bells or withholding pain medication (Henderson, 2003). This is exerting power negatively over another person and has stemmed from communication (Davidhizar, 2005; Henderson, 2003). The literature refers to a hospital environment; however this can equally occur in a primary health situation. On reflection I have done this both in the community and hospital by

14

expressing or giving an appearance that I am busy and immediately the client will assume that I am not interested in their needs (Spence, 2005). This is important because the nurse will never enter into effective relation with this approach.

Henderson (2003) and Hewison (1995) study nurse-patient communications within direct patient care and identify that nursing agendas are prevalent in interactions and associated with a lack of patient choice. Recurrent themes of nursing as a task-oriented profession constrained by medical influences and interprofessional relationships which prioritise science (technology and tasks) above communication are amongst conflicts faced by nurses (Adams, 2002; Freshwater & Stickley, 2004; McCabe, 2004). Kuokkanen and Leino-Kilpi (2000) concur that a key barrier to improved communication between nurses and patients is the fact that nurses themselves are an oppressed group dominated by head nurses and doctors who display patriarchal and authoritarian leadership styles.

May (1990) describes this as an implication that talking to patients is not seen as work in the ward environment. The power of senior nurses influencing junior nurses' interactions with patients is analysed as what has become the norm. As tradition influences practice, despite the age of this article it is considered relevant. This is further supported by Wilson, Kendall and Brooks (2002), when they discuss moral distress caused by lack of a supporting management structure allowing nurses to practice ethically by doing what they perceive to be a good job.

There is evidence in May's (1990) study that suggests that junior nurses have more interactions with patients. However their experience and ability to provide effective therapy in these interactions may be less than more experienced nurses. They are also less likely to share the information gained with the team, particularly medical staff, as they have less communication with them. They may not have the skills to interpret important communication or follow through to effectively resolve an issue. The relationship of power and surveillance is obvious here (Hewison, 1995; Kuokkanen & Leino-Kilpi, 2000). The junior nurse may not want to be seen as wasting time talking to patients as the value of this is underrated in a traditional hospital setting.

McCabe (2004) argues that student nurses spend time in communication with patients as they have not yet been socialised into a task focused approach and do not yet have as many demands on their time. Patients reflected that they could really talk to these student nurses as

they took time to listen, however the above author claims that the information was not processed to have therapeutic results.

The senior nurses' or clinical leaders' perspective on this will influence how much time is spent talking to patients and it is biomedical tasks by which the nurses' performance may be judged and valued (Hartrick Doane & Varcoe, 2005; McCabe, 2004).

May's (1990) perspective is solely focused on a hospital environment. However the scrutiny of nurses' practice in community environments also influences relational communication (Aranda & Jones, 2007). Legislative requirements including the Health Practitioners Competency Assurance (HPCA) Act (2003) place emphasis on peer review which means that a nurse's practice is scrutinised by a colleague whose expectation of skill level can be a biomedical model (Nursing Council of New Zealand, 2005).

This perspective assumes that task-focused biomedical model nursing is best for the patient but the reality may be that this is neither good for the patient or the nurse (Aranda & Jones, 2007). May (1990) also describes the power of nurses in setting agendas within patient interactions that are disabling for patients, as they do not lead the topics of interaction. This is described as defensive nursing and he suggests this use of power must be changed because this model leaves nurses morally distressed and patient experience negative (Hartrick Doane, 2002). This is because nurses are good people and are left wondering at times why they feel that they have not done a good job (Hartrick Doane, 2002).

Henderson (2003) concurs with May (1990) that nurses involving patients in care requires information sharing which senior nurses may be reluctant to do as they would then be sharing their decision making powers. This is described as holding a position of expert status, which some nurses feel they must retain. This may stem from a perspective of nursing history when nurses were discouraged from becoming emotionally involved as this was not seen as professional (Adams, 2002).

Hartrick Doane & Varcoe (2005) describe shared power relations as not denying the health professional their expert status but using their skills in new ways to promote greater equity between families and nurses, therefore promoting effective partnerships. Connor (2004) and Stein-Parbury (2005) concur with this perspective.

Henderson (2003) also suggests that a partnership can only be effective when nurses consciously relinquish power and open their communication to patients (Spence, 2005). In the ward situation this would be a culture change from a task-focused approach to an emphasis on time in effective therapeutic communication (Connor, 2004; McCabe, 2004; Ramsden, 2000).

Another key theme to emerge from the literature is the importance of partnership as a tool for empowerment (National Health Committee, 2007; Stein-Parbury, 2005). There is a significant volume of literature which describes knowledge sharing to involve patients in decision making and to develop self-management skills. This theme crosses the spectrum of primary and secondary health care and health disciplines (National Health Committee, 2007; Stein-Parbury, 2005).

At a policy level questions of the system arise, in particular whether our system encourages communication in acute services. I believe that it does not with an emphasis on reducing length of stay and resource constraint (Aranda & Jones, 2007; Connor, 2004). However the New Zealand Government's Primary Health Care Strategy (2001) has legitimised primary health care as a distinct domain of practice, different from that of the acute care sector. This has made effective communication possible with an emphasis on home-based care for nurses which shifts power from a biomedical task focused agenda to a patient constructed needs-based agenda (Hodgson, 2006; King, 2001).

Alongside this strategy is the framework for nursing, "Investing in Health", to challenge their current practice models and promote engagement in partnerships to achieve the shared goal of heath for all (Ministry of Health, 2003). Within this framework nurses are encouraged to share power and authority in decision-making and enter into committed processes of mutual benefit (Ministry of Health, 2003). There is also an emphasis in these documents on developing relationships based on information sharing and health education with patients and on self-management rather than creating dependency based on inequitable power relationships.

Connor (2004) places emphasis again on effective communication, education and recognition of other influences on health. The salient issues affecting health are described as: prior relationships with health professionals, beliefs and values and socio-economic and educational needs (Lupton, 1995; National Health Committee, 2007; Ramsden, 2000; Wilson,

Kendall & Brooks, 2007). This approach suggests a collaborative multiagency approach to health which is new to health agencies (King, 2001).

Lupton (1995) also points out that despite a focus on consumerism and patient empowerment, the patient also frequently has a need for faith and trust in the expert health professional which is in contrast to the focus of self-management programmes designed to develop expert patients (Connor, 2004; Flinders Human Behaviour and Health Research Unit, 2006; Stein-Parbury, 2005).

Stein-Parbury (2005) describes sharing information versus giving advice. Sharing information offers expert knowledge and allows and empowers patient choices. Giving advice risks offering solutions that need to be owned by the patient to be effective, as the recipients of advice may not be equipped or resourced to follow the suggested path.

Achieving patient empowerment and sharing of power in decision-making will involve effective, therapeutic communication and willingness for health professionals to relinquish power. The notion of partnership involves shifting from a task-focused to a communication or relational focused approach to nursing care (Hartrick Doane & Varcoe, 2005).

While a task focused approach may often be regarded as negative this approach is appropriate and essential when a person is in high need of acute services. Even when an authoritative or directive approach is necessary, showing respect and using relational skills can improve patient and nurse experience (Connor, 2004; Stein- Parbury, 2005). Hartrick Doane and Varcoe (2005) suggest that communications in hospital also need to be focused and effective due to time constraints rather than limiting the relational connection. Using these task-focused encounters to understand and reflect the patients' feelings makes their experience more meaningful (Stein-Parbury, 2005) and interactions need to be relational for individual families (Hartrick Doane & Varcoe, 2005). This use of power to achieve hospital and health care planners' agendas is seen repeatedly with regard to what information is shared or withheld, what solutions are offered to such issues as barriers to discharge and how nurses can side with a particular family member to achieve their agenda (McCabe, 2004).

The source of particular information is traditionally a basis for power conflict. For example, doctors traditionally give patients information about diagnosis and prognosis. However, in my experience this is not always timely for patients and families (Henderson, 2003). The patient has to wait for the doctor and may not have the support they would like at the time they are

told. Nurses often use delaying tactics, including closed communications, deliberately to avoid truth rather than use this time to communicate relationally and follow patient leads (Henderson, 2003; McCabe, 2003). Wilson, Kendall and Brooks (2007) demonstrated that patients had learned not to discuss emotional issues with their medical consultant and compartmentalised their emotions away from their biomedical needs, because doctors have encouraged this Cartesian approach to their role.

Despite the fact that some literature has shown that less value is placed on talking to patients than being expert at tasks, other literature discusses how nurses are more willing to relate emotionally to clients. This is mainly based on research on patient experience that found that they tended to perceive the nurse as more approachable and empathetic than the doctor and viewed the nurse as an intermediary. A patient may be able to cry and talk with nurses however nurses are endangering this privilege by being technology and science focused and time constrained (Davidhizar, 2005; Lupton, 1995; May, 1990; Stein-Parbury, 2005). This perspective may be more dominant and intensified in the primary sector because it is away from institutional constraints and surveillance. The Cartesian viewpoint of objectifying and separating mental and physical health is challenged today (Hartrick Doane & Varcoe, 2005).

The notion of nurses as predominantly women and therefore more compassionate is an influence in this perspective because of the impression that women talk about emotional issues better than the predominantly male dominated medical profession (Lupton, 1995; Hartrick Doane & Varcoe, 2005). Recognising and being aware of other perspectives is necessary when using a humanistic lens as a framework for nursing. For example, applying a feminist perspective when working with women and acknowledging historical influences, assumptions and meaning for them may open communication by identifying shared experience (Hartrick Doane & Varcoe, 2005; Lupton, 1995).

Ricken (2006) describes power relationships as part of everyday life, unavoidable and influential. "In everyday life power means influencing others in one's own favour or to one's own purposes and even being able to enforce one's own will against others and their possible resistance can influence social inequality and economic meaning" (p. 544).

This has occurred historically in Päkeha influence over Mäori although this is not exclusively a Mäori issue and effecting change by understanding this enormous impact on social inequality is important for nursing (Durie, 1998; Durie, 2005; Jansen & Smith, 2006; Ramsden, 2000.

Chapter Three

Refection and Discussion

This discussion relates to the shifts and themes that I have noticed and all are related to power between the nurse and patient. The themes that I will develop further are history and tradition, shift of status of the nurse to guest, language and culture and the impact of these on power within the nurse-patient relationship.

History and tradition:

Having practiced in secondary health services for the past twenty years, I have come to understand that as a nurse in a hospital I was responding to crisis (Hartrick Doane, 2002). I became uncomfortably aware, through reflexive practice, that I did not have adequate resources to spend the time required with patients to be as effective as I should, causing moral distress to me (Connor, 2004; Hartrick Doane, 2002).

Like many nurses I conformed rather than resisted traditions to fit in (Hartrick Doane & Varcoe, 2005; Stein-Parbury, 2005). There are many reasons for this including the hierarchal structure and historical oppression of nurses and women (Gastaldo & Holmes, 1999). Dominance of the biomedical model has disempowered patients but alongside them nurses shift from at times being oppressed to being the one with power over either colleagues or patients (Adams, 2002; Ramsden, 2000). If nurses are experiencing oppression are they more likely to oppress or repress? A choice occurs at this time and nurses may chose to empower, and question or resist tradition. Influence in this choice will depend on the character of the organisation (Henderson, 1994).

When a client is admitted to hospital or referred to a health care provider a body of knowledge about that person has been collected through surveillance, questionnaires and interpretation, including objective and subjective judgments (Connor, 2004; Gastaldo & Holmes, 1999; Hartrick, 1997; Hartrick Doane & Varcoe, 2005; Ramsden, 2000). Some nurses will perform tasks and miss patient cues while assessing patients, therefore not developing conversations that have potential to empower (Hartrick Doane & Varcoe, 2005; Stein-Parbury, 2005). I have been responsible at times for intentionally shortening assessments or conversations because at the time I have been too busy or have not had the energy required to fully engage and develop the partnership (Spence, 2005). This has occurred both in the community and in a

20

hospital ward. Watson (1988) professes that stress is increased through not engaging fully by caring. I can now manage some of these situations by better understanding influences on health and improved understanding of the person in their own environment. In developing a critical viewpoint and questioning the way things are done I have developed personally (Connor, 2004).

There are times when social issues are the patient priority and I have questioned what I am contributing as a nurse. However there are also times when complex medical and nursing action needs to be taken and I am required to use all my knowledge to make clinical decisions. The social knowledge gained will assist decision making as the patient has discussed their needs and therefore I can advocate for them if necessary. What is clear to me is that this role in primary health is clearly not about my needs as a nurse but is focused on patient needs and priorities. It is also clear that social and health needs are inextricably linked to wellbeing (Durie, 1998). Using this knowledge I am able to share power through knowledge, enabling possibilities that are realistic for patients through choice (Connor, 2004).

As the nurse leader in the ward, for example, I would arrange family meetings with the team to plan discharge. These meetings had the agenda of ensuring a safe discharge but the focus was very much on preventing delays to discharge and on bed management strategies. This came about because of our focusing on problem identification and solution rather than a focus on partnership in crossing differences and building on strengths (Hartrick Doane & Varcoe, 2005; Roberts & Wilson, 2005).

On reflection, facing a group of professionals in this way would have been an extremely disempowering meeting for the patient and their family. The agenda was set and although I believed myself to be patient focused the setting, the language, the preoccupation with barriers to discharge and problem focus meant that this discharge plan was not relational practice and the communication and outcome were predetermined, at least to some extent. These meetings could have been transformed using a more relational approach; the timing of interaction with the team may be better placed (Hartrick Doane & Varcoe, 2005).

 I also felt there was inadequate time to spend talking about patient education needs in hospital. In many cases patients were educated by nurses to tick boxes for discharge on the required form and the person was often too ill or anxious to fully understand the information that they had been given. This is an example of using tools narrowly rather than following the lead of patients, which can result in a failure to understand the real needs of the patient

(Hartrick Doane & Varcoe, 2000). A subjective nursing opinion is at risk of becoming a known truth for that patient in subsequent interactions with health professionals (Hartrick Doane & Varcoe, 2005). In this way because the education has been 'done for' a patient, it has been assumed that they knew about their illness from a technical perspective. This perspective does not consider their ability to 'live' with the illness and therefore their participation is muted (Hartrick, 1999; Hartrick Doane & Varcoe, 2005; Lupton, 1995). This is relevant as knowledge relates intrinsically to power and therefore empowerment (Lupton, 1995; Ramsden, 2000).

Studies suggest that even when nurses have time they avoid fully engaging in therapeutic relationships as they have beliefs that they must remain professionally objective and thereby retain power in the relationship (Lupton, 1995; Wilson, Kendall, & Brooks, 2007). This may be because nurses see the patient as a set of tasks or a diagnosis (biomedical knowledge) to be treated in a particular way with less emphasis on power imbalance knowledge (Papps, 2002; Ramsden, 2000). Economic influences on health and the withdrawal of hospital responsibility for long term care has consequences for families and nurses when working with people with chronic conditions which may impact negatively or positively on patient care (Hartrick Doane & Varcoe, 2005; National Health Committee, 2007;).

Shift to Guest

Changing the nurse's role to that of a guest in the patient's home offers choice to the patient (Muir-Cochrane, 2000; Ramsden, 2000). In allowing the patient to lead the conversations the nurse is able to establish what the patient wishes to speak about. This also allows the patient to hold power and leads to the nurse following their lead by the cues they offer (Hartrick Doane & Varcoe, 2005).

Recognising they are their own experts and can develop their own solutions to their needs encourages empowerment (Durie, 1998; Hartrick Doane & Varcoe, 2005). Emancipatory interest from nurses guides patients through problems towards autonomy, freedom and responsibility (Hartrick, 1997; Ramsden, 2000) therefore when I now see patients I see the person not the problem.

Recent changes in the primary sector place emphasis on health promotion and prevention. For example, in the Primary Health Care Strategy, (King, 2001) nursing is anticipated to hold a more influential position as advanced nursing practice and nurse practitioner roles are developed (Ministry of Health, 2003).

22

Home based care is the tradition of nursing, and where nursing began prior to the development of hospital settings. Hospitals were regarded as a place to promote better hygiene and surveillance by observing patients in a controlled environment where health professionals were placed in positions of authority (Lupton, 1995). In the last two decades however the strategic direction has turned full circle to promote family as caregivers with nursing support in the home (Adams, 2002). The intention is to support redefinition of power relationships between nurse and patients, empowering people to self manage with recognition that they are experts in their health thus redefining nurse-patient relationships to an equitable partnership (Flinders Human Behaviour and Health Research Unit, 2006; National Health Committee, 2007).

Redefining the relationship to that of guest and simply offering choice of time and place and discussing previous health care experiences and how they can be improved are all ways to improve the health of a family as often there are other family members around (Ramsden, 2000). Accepting gifts such as refreshments is also important (Durie, 1998; Muir-Cochrane, 2000). Some clients have given me produce and have told me they want to repay me the Mäori way. This could have been ethically challenging as my position may be more comfortable financially than many clients. However, the basis of ethical practice is to do the right thing and for this client to give something back was important in our power positions. They were offering me some symbolic help after I had given them assistance. Durie (1998) describes sharing food as being a leveler which removes distance between people. Conscious awareness of this theoretical perspective allows responses as a nurse to follow the patients lead, 'rather than unconsciously giving theory authority over families' (Hartrick Doane & Varcoe, 2005, p. 96).

Hartrick Doane and Varcoe (2005) discuss this as sociopolitical knowing, which includes strategic awareness about policy, the profession and nursing practice but I would also emphasise an awareness of historical power relations with other health professionals and management structures, particularly regarding local tradition (Adams, 2002; Ramsden, 2000). As a nurse I have recognised that relationships that patients have had with health professionals in the past influence their readiness to trust me. Patients have asked "How long will you be around?" and challenge me to enable confidence before they will confide (Ramsden, 2000). However after I have spent time with them they frequently comment that they have never had this approach from a health professional and have never spent this amount of time being able to reflect on their influences on their own health.

Conversely, linking this knowledge of patients in the community into secondary care setting through collaborative communication enables health professionals in hospitals to have greater understanding of the socio-environmental impact on health (Lupton, 1995; Stein-Parbury, 2005). This is achieved by attending team meetings in hospital and voicing or brokering for patient needs in these forums. This shifting paradigm has changed my views and challenged my traditional practice methods (Ministry of Health, 2003).

I have therefore established new relationships and this along with satisfaction patients express when they achieve success are the reasons I remain in nursing. I am certain I am not unique in having a sense of loneliness and at times frustration on this journey. These times are described as the 'hard spots' by Hartrick Doane and Varcoe (2005). As I have discussed earlier, the 'letting be' has been hard for me to learn to do (Ramsden, 2000). By using informal and formal processes to reflect and discuss these issues it has become easier to allow families to make their choices, which I may have predetermined expectations for, and for me to compartmentalise these expectations rather than become frustrated (Ross, 2008). I have been socialised into working in a problem solving way and am now practicing to 'unlearn' this behaviour. Ethical challenges do occur however and applying ethical awareness to situations can mean challenging a patient's decision and discussing it further with them, in the form of caring action (Van Hooft, 2003).

The model that people are able to find their own solutions has not always been my experience. There are times when insight is limited and safety compromised. These situations require health professionals to find solutions and it would not be acceptable to 'let be' in these situations based on ethical principles of 'doing no harm' (New Zealand Nurses Organisation, 2001). However when I have experienced this, I have found that there may be another person who has made a connection or a referral who can be enlisted to support this situation. Using the skills of other family members and health professionals is the key to achieve a suitable outcome (Ramsden, 2005).

Language shift

Using language to describe patients can be negatively using power over them. Naming and openly discussing words that create stigma and discrimination and the language used in this can assist to work across differences (Hartrick Doane & Varcoe, 2005). Words such as 'compliant' are used to describe people who do as they are told by health professionals and

are then considered to be a good patient because they follow expert advice (Lupton, 1995). This is in contrast to partnering in decision making. Compliance often occurs without question, understanding or involvement which may lead to subsequently stopping treatment without realizing the effect of this (Lupton, 2005; Hartrick Doane & Varcoe, 2005).

Nurse responses will influence outcomes and impact on future relationships with health professionals (Hartrick, 1997). Therefore it is critical to increase awareness of language and identify therapeutic relationships as part of nursing in relation to power relationships (Ramsden, 2000). It is also important to increase the value placed on the nurses' role of talking to patients as a vital connection in therapeutic regimes. Peplau (1988) describes nursing functions as educative and therapeutic and the thin line between these being blurred as nurses increasingly understand how past experiences and relationships impact on current health needs.

My view of my experience as a nurse in hospital was that I had a very limited understanding of the patient's world. I struggled to understand their life 'outside' this insular environment, especially the patient with chronic conditions who had multiple admissions and became known as a 'frequent flyer' (Hartrick Doane, & Varcoe, 2005). Nurses may reflect on the experience of a complex discharge or a person labeled as a social admission and feel that they are missing a vital connection with this person. This may appear as passivity or apparent compliance but as a nurse you sense that they wish to resist but do not articulate why. I would now simply ask questions to find out whether the patient wants another option, or offer other choices, thereby allowing the patient to be empowered to discuss their needs and consider other options and the nurse to follow that lead (Connor, 2004; Hartrick Doane & Varcoe, 2005).

I chose to critically reflect on this language and its meaning to patients and how language would affect them. For example, would they be reluctant to return and delay hospital admission inappropriately? This is an example of nurses using language to exert power (Hewison, 1995). The language used may also be chosen to demonstrate an expert nurse status (Davidhizar, 2005).

The language I utilise in my current role is different from a clinical task-focused nursing position. It is less clinically focused and more inclusive. When interacting with a client my language is softer, with everyday words and less jargon than is embedded in the clinical

setting. However my role shifts and clinical articulation of findings (Pirritt, 2005) is also imperative in a biomedical or clinical environment.

Cultural Shift

My awareness of culture has been heightened, as culture can be suppressed by clients in hospital. If a person is in an unfamiliar environment and feels unwell, their control of events is reduced and reliance of whanau and others as support networks increases (Connor, 2004; Stein- Parbury, 2005).

Surroundings may affect Mäori more than Päkeha as hospitals as an institution have been described as breaching Tapu or sacredness in many ways (Durie, 1998). Traditionally, Mäori built whare which were used to house the ill and dying, these whare were then destroyed as a means of sanitation so to enter into treatment in a building that a relative may have died in can be detrimental to spiritual health, *Taha wairua* (Durie, 1998). Acknowledging and naming stigma can help to cross differences in culture and beliefs. "Every person and family lives within a socio-historical context that helps shape their identity and social relationships. This socio-historical context can lead to restriction of choices, limited resources, and a state of perceived powerlessness" (Hartrick Doane & Varcoe, 2005, p.33).

In New Zealand influence of power has deep implications for Mäori and these are both historical and current (Durie, 2005; Ramsden, 1990; Ramsden, 2000). When considering empowering Mäori there are additional considerations that impact on practice (Durie, 2005; Ramsden, 2000).

Reflection on this theory can be useful to consider ethical and cultural issues that arise. Tolich (2001) describes Päkeha as often opting out from caring for Mäori as they are afraid of offending. This perspective is not my experience and I have had significant feedback and tokens of appreciation. One example of this is that one local Kaumatua group approach me when they want to have a health speaker to advise on health initiatives in the area. This indicates acceptance and trust. It is possible to practice in a relational way that is acceptable and hence influence change (Tolich, 2001). Acknowledging difference, valuing indigeneity and adapting skills to these differences are vital as is developing relationships with key people who can support practice (Durie, 2005). Again communication, inclusion, respect and acknowledgment of difference and recognition of shared goals are strategies that are intrinsic in nurses' practice (Durie, 2005; Ramsden, 2000; Spence, 2005).

26

Cultural forces that are not able to be comprehended by others require community involvement to empower that community (Tolich, 2001). Therefore a community based service gives a context for improving power and communication relationships in the health professional encounter with Mäori (Durie, 1998; Ramsden, 2000). I have noticed that Mäori clients who I have met in hospital and who have had to relinquish their cultural position and adapt an appearance of compliance are very different in their own environment where the cultural aspect of their life is more prevalent and obvious. The importance of noticing this shift is to redefine our relationship (McKinney & Smith, 2005).

Regarding medications, it has been my experience that Mäori are reluctant to advise health professionals that they access traditional medicine such as Rongoa. In contrast, in the community that I work in this is part of primary health and health promotion to actively include traditional therapies into overall well being (King, 2001; Ramsden, 2000). Because this is the attitude, patients discuss the benefits and healing gained from this which may not be acknowledged in hospital. When I reflect on past experiences and critique my practice I question why I did not do more, but also realise the power of tradition in social organisation (Barker, 1998).

Implementing Hartrick Doane and Varcoe's (2005) model has allowed me to increase awareness of my own cultural position in relation to power. I recognise that some issues facing Mäori are not personally familiar to me. However establishing this as a beginning point and developing a relationship which recognises some commonality may be an enabling factor in empowering a partnership relationship (Spence, 2005). Achieving this relationship of trust is sometimes demonstrated by patients asking for me to act as an intermediary for them between other health professionals. This is another instance of crossing cultural differences (Hartrick Doane & Varcoe, 2005; Papps, 2005; Peplau, 1988; Ramsden, 2000; Tolich, 2001). For example, as I am a woman with children, we may have a connection.

Once this connection is established the relationship can change and sometimes patients may position me in a role as power broker or intermediary between other health professionals, particularly medical colleagues, thereby improving access. They often reflect back that they can talk to me but don't understand the doctor and ask if I can be with them or talk for them. Nurses often use their collaborative skills to communicate between roles in interdisciplinary practice advocating for the patient to prevent duplication and promote effective patient care

(Higgins, 2008). Therefore I need to be clear what the patient and their families' abilities, values and goals are.

Treaty obligations to Māori include the offer of informed choice in where and how health care is provided (Ramsden, 2000). For example research on Māori health has demonstrated that they require health professionals to show respect, have regular face to face contact and acknowledge preference for where contact and care should take place (Durie, 1998; Ngata & Dyall, 2001). It has been my experience that when visiting patients at home they are more likely to disclose real issues for them that may give the appearance in hospital of non compliance or resistance to treatment offered.

The following client is described in intentionally broad terms to prevent identity disclosure. However I am aware that this can over simplify a complex situation. I recently had a client who was referred as 'non compliant' with medications. Through reimagining I was able to consider what might have shaped this woman's beliefs. Previous contextual constraints that may have been placed on her can be interrupted by practicing relationally (Spence, 2005). I noticed my reaction and expectation when reading the referral, which is an example of self observation. I had already assumed some cultural generalisations, including the possibility that she may not be confident to discuss issues with her doctor, possibly because of the historical influences and perceived power imbalance.

Recognising what view and assumptions I had regarding her ethnicity, address and diagnosis, and consciously attempting to redefine these to openness supports me to enter into relation with her (Ramsden, 2000; Spence, 2005). Using Hartrick Doane and Varcoe's (2005) model I made contact by phone explaining who I was and my role as a family nurse. This was to try and establish a trusting relationship early on (Ramsden, 2000; Spence, 2005). I do this by sharing more of myself and my personality than I would have in hospital. It is a more personal relationship, which helps to establish an equitable partnership (Hartrick Doane & Varcoe, 2005).

The language I choose is selected to engage her in a new way of working, such as that I will work with her to support her to achieve her health goals. I am clear that it is what she perceives as her needs that I will focus on. Everyday language is used and I do not mention her health issues but use words that are positive towards a healthy life. This is using strengths based rather than a problem focused approach (Hartrick Doane & Varcoe, 2005).

When I went to her house, we discussed photographs of her grandchildren. This led to a discussion on how she is writing her *Whakapapa* (genealogy) which she was desperate to have for her family when she was gone and we talked about the importance to her of achieving this. She saw it as her legacy for her children and grandchildren and did not want the information lost. This is an example of using cues to connect across difference and recognising the importance of whanau on wellbeing (Durie, 1998; Hartrick Doane & Varcoe, 2005).

She also talked about how busy she is with her mokopuna as she is the main caregiver, a traditionally feminine role (Hartrick Doane & Varcoe, 2005). She stated that her medication made her tired. This gives a perspective of how she sees herself and her position with in her family. Understanding economic influences that have forced her daughter away to work and what this means to the extended family contextualises what her caregiver role means to her (Ramsden, 2005). When considering this I can understand her reluctance to take medication that makes her feel that way and I expressed this to her, an example of implementing Hartrick Doane and Varcoe's (2005) model by listening for who this person is and her living experience then following her lead. As I explained the risks of her condition and why we as health professionals worry and try and control it or help her manage the risk I related this back to how she had said she felt. I suggested that better control may improve her symptoms of feeling unwell and tired and that taking the medicine at night rather than in the morning may help prevent her feeling tired. This was a suggestion phrased not to be prescriptive but to offer choice. We planned to review and I had offered other options. We discussed relaxation and exercise and the impact that this can have on her feeling of wellbeing. "Shared power relations do not deny health professionals their specialized expertise and skills. Rather, professional expertise and skills are used in new ways such that greater equity between families and nurses results" (Hartrick Doane & Varcoe, 2005, p. 33).

Her expression visibly relaxed and she smiled then described feeling relieved as she had not wanted to stop taking the medications but felt strongly that they made her unable to carry out chores that needed to be done. She wanted to, and enjoyed looking after her grandchildren. She wanted to keep doing this and was proud to do her chores independently. I could have offered assistance through home help however her sense of independence may have been offended. This latter suggestion would be a problem solving approach rather than building on strengths by encouraging her sense of value through her role as care giver. She was more than willing to try the suggested change of timing for taking her medications and then make an

informed choice. This therefore empowers her to be her own expert in health care decisions (Roberts & Wislon, 2005).

This kind of approach involves knowledge, recognition of her role in life and impact of this on health, therefore shifting power of decision making with options that may assist her overall health and wellbeing. I could have just reiterated what the doctor had advised however this was clearly not working for her, hence the decision not to take her medication.

Understanding how the medication affected her life allows us to work together with her resources to seek a solution. Revisiting and continuing the relationship will enable me to continue to listen for challenges and what this family values. However contact with her has been difficult. This may be that she is exercising choice or it may be her busy lifestyle. If it is her choice then I need to let her be, however I will keep trying for a bit longer as this is the most difficult shift for me to make, letting be after years of being trained to problem solve and having a personal and professional sense of ethical responsibility for doing my best (Hartrick Doane & Varcoe, 2005).

I have several patients involved in Iwi work as elders in the tribe. There are enormous demands on these people at present with settlement of land claims, and a focus on improving the economic status of their people. The work is vital to their Mana and role in the community. This work frequently takes them to meetings at short notice.

In referral from secondary services they have been described as having complex chronic conditions for management. The language used frequently constructs them as non compliant whereas possibly for various reasons their health has not been a priority. An example of the challenges faced by these clients is nutritional planning when they have insulin dependent diabetes and may be missing meals because of meetings or being served inappropriate food choices. They also may not have privacy to take inject their insulin and end up omitting it because the logistics are too difficult. As I have a flexible work schedule and offer a home based service I am able to fit in with their time obligations and take time to understand the choices that otherwise could be seen as non compliance without an understanding of their commitments (Ramsden, 2000). We can work through choices to fit medication regimes and other treatment into their life, with their life being central, by following their lead and building on strengths as in Hartrick Doane and Varcoe's (2005) model. This also gives me a sense of achievement as the feedback received has been that they are now able to manage better which makes them feel well and empowered.

Many of the people I engage with are also the older population whose life experience is significantly different to mine. For example, I have not experienced economic depression, war, racism or oppression of feminism to the extent they may have. Giving recognition for the life they have lived and loss they have experienced establishes rapport and asking simple questions to understand what has been meaningful in their lives allows time to let them express their current needs in relation to their past life (Stein-Parbury, 2005).

This approach may have the effect of removing the constraints of the assessment tools that we as nurses are required to complete to assess patients. Often these are designed to be quick to complete and can be tick box type questionnaires. These can be used as closed questions but nurses can choose to use them with a more open view and relational enquiry by being alert to cues and being ready and able to respond to them (Spence, 2005). It is important that the assessment form completed is understood as my interpretation or a subjective perspective and not an absolute truth (Hartrick Doane & Varcoe, 2005). Understanding some historical and sociopolitical influences is important when understanding relational nursing practice (Ramsden, 2000; White, 1995).

Partnership

In recognition of nursing requirements to be culturally safe an understanding of history and self awareness is the initial step to practicing safely. To practice in a way that is culturally safe the client should describe their care as culturally safe. Therefore my relationship may begin with either a telephone or a face to face meeting, offering to meet the person at their home. When involved with Māori it may be more appropriate to be introduced face to face, known as "kanohi ki te kanohi or the known face Māori" (Roberts & Wilson, 2005, p. 161) and then I consider the need to find an intermediary for introduction. Face to face meeting depends on far more than overt messages. Conveying emotion and feelings through expression may be considered more important than words which can be considered superfluous (Durie, 1998). Non-verbal greeting such as kiss or hongi if initiated by the client, may be appropriate or a hand shake (Roberts & Wilson, 2005).This is valid when seeking affirmation that the client feels culturally safe and "demonstrates that you have given thought to showing respect" (Roberts & Wilson, 2005, p.163).

My experience when working with Māori is that consideration for privacy is important to manage in a small community. I give consideration to asking my client who they have important relationships with as social support and who they would like to know about their

health, if anyone, and respect this information, I always check in before I discuss their care with other providers. I frequently use the Mäori liaison person at the hospital as an intermediary if they are known to that person, or another health professional involved in their care. Ramsden (2000) describes trust needing to be developed very early in the relationship or we may not be culturally safe to practice (Spence, 2005).

Once trust is established through face to face meeting I am then able to extend an invitation to a partnership to participate in their ongoing care with my support. I offer many opportunities for them to decline by saying that it is their choice to participate and it is not a problem if it's not convenient. I am also aware that if they choose not to be home or to answer the door they may be exercising choice (Muir-Cochrane, 1999; Ramsden, 2000). I have become more sensitive to these cues and can offer them a phone contact if they change their minds as sometimes timing is a critical issue. I try to observe what is important to them without judgment and with an awareness that people may not wish to be observed or assessed (Ramsden, 2000).

This is a significant shift in approach for me that I have learned as a primary health nurse. I have learned new ways of being with a client that is focused away from a biomedical model. It has also been a significant shift for me within this relational partnership approach for me to be comfortable with a clients' right to choose their own path (Hartrick Doane & Varcoe, 2005; Ramsden, 2000).This is an example of relational theory in practice and how recognising cues can empower a person to make health choices. This is not manipulation or exercising power over a person because it is about enabling their choices without surveillance or judgment.

Conclusion

In this study I have analysed the shift that I have noticed in nurse-patient relationships in comparison between hospital and community based nursing. I have discussed the potential empowerment of patients when utilising Hartrick Doane and Varcoe's (2005) model of relational enquiry. The shift in power has been described when using this model in practice examples.

A humanistic lens has been used to analyse the influences on these relationships, particularly the paradigm shifts that I have noticed in my practice. Themes have been identified as cultural shift, partnership development, shift to guest and language discourse. I have discussed self awareness and historical influences on my ability to practice in a way that promotes partnership through empowerment. By practicing with a relational approach as Hartrick Doane and Varcoe's (2005) model describes, dominant discourses can be interrupted, thus empowering patients in a partnership. This has been demonstrated through practice examples and discussion.

Working in a patient focused manner, such as my home based role, allows the patient's needs to be the priority rather than tradition or the nurse's needs. This is in comparison to what I noticed as a ritualized nature of a hospital ward where routine tasks are performed using a problem focused approach. At individual practice level nurses are able to make choices when engaging with patients and nurse leaders should encourage more reflexive dialogues that promote a person's or family's belief that they have the expertise to find their own solutions to their needs (Connor, 2004).

The literature has been analysed to support Hartrick Doane and Varcoe's (2005) model of relational practice and power within this. There is evidence to demonstrate that relational practice can be implemented into brief or sustained relationships to promote empowerment. This is especially evident when an organisation values communication.

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