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Advanced Practice Nursing Leadership Project

Moving Towards Moral Relational Nursing Practice

By

Margaret Eastman

Student #: 81-0404

University of Victoria, School of Nursing

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Project Supervisor: Rosalie Starzomski RN PhD, University of Victoria

Project Committee Members:

Gweneth Doane RN PhD, University of Victoria

Paddy Rodney RN PhD, University of British Columbia

In Memory of Evan Dylan Brett

Who triggered my curiosity to uncover the true meaning of moral relational nursing practice

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Abstract

This paper is the culmination of my Advanced Practice Leadership project. In it, I present a conceptualization of how I believe the development of trusting relationships between pediatric nurses and families in my practice setting could be enhanced if nurses adopted a morally grounded, theoretical guide to inform their practice. This premise is based on research findings that support theory guided nursing practice and my experience adopting a theoretical perspective to guide my own practice. In addition, there is a need to explore ways to enhance the development of trusting relationships between pediatric nurses and families that care for children living with complex health conditions since these children will access the health care system frequently over their lifetimes. I, therefore, believe that it is essential for pediatric nurses to adopt a morally grounded theoretical practice in order to meet the needs of these children and their families.

The Context of Moral Relational Practice with Families

Ethical Nursing Practice: Responsibilities and Values

Nurses are responsible for providing safe, competent, and ethical nursing care as governed by the eight primary value statements, embedded within the Canadian Nurses Association (CNA) Code of Ethics for Registered Nurses (2002), that are central to nursing practice. The eight values "are grounded in the professional nursing relationship with persons and reflect what nurses care about in that relationship" (CNA, 2004, p. 7). The eight primary values include; Safe, Competent and Ethical Care, Health and Well-Being, Choice, Dignity, Confidentiality, Justice, Accountability and Quality Practice Environments (CNA, 2002).

Threaded within each of the eight primary values is the need for nurses to develop effective communication. This view is further expanded in the value statement Choice where it is emphasized that nurses must be "committed to building trusting relations as the foundation of meaningful communication, recognizing that building this relationship takes effort. Such relationships are critical to ensure that a person's choice is understood, expressed and advocated" (CNA, 2002, p. 11). In other words, building trust through effective communication is foundational to developing the nurse-patient relationship.

The Nurse-Patient Relationship: A Moral Endeavor

The nurse-patient relationship represents the central location of nurses' work and is "often viewed as constituting the moral foundation of nursing practice" (Brown, Rodney, Pauly, Varcoe, & Smye, 2004, p. 132). Milton (2008) expands this view in her description of ethical nursing practice in the following:

> …to have an ethical nursing practice of straight thinking is to return to the acknowledgement of the importance of the nurse-person relationship, where there is

> emphasis on the person's story, the human dialogue of valued priorities, needs, and wants that gives meaning and purpose to human life and health. (p. 21).

In addition, Woods, cited in Brown et al., determined that the foundation of nursing ethics is focused on relationships and care. Furthermore, Corley (2002) describes nursing as a moral endeavor where moral standards "infuse its practice, and all nursing acts are fundamentally ethical" (p. 6).

Mitchell (2001) suggests that nurses need to examine their own moral development and the theories that guide their practice. She further explains that when nurses choose theories that enhance their ethical practice, "the confidence that comes from that choosing will help nurses have the courage to act according to the realities that each person and family brings to the situation" (p. 113). Mitchell's statement supports a need to join nursing ethics and nursing theory in order to support the development of moral relational nursing care.

Doane and Varcoe's (2005) practice of Relational Inquiry bridge together these two schools of thought. Their work has further expanded the bridging of nursing ethics and nursing theory by adding a typology of other approaches to support the advancement of moral relational practice. It is Doane and Varcoe's unique approach to support the development of ethical relational practice that will be central to this project. I will expand on this further in my subsequent discussion.

In the following sections, I will present a conceptualization of how I believe the development of trusting relationships between pediatric nurses and families whose children live with complex health conditions could be enhanced if nurses adopted Relational Inquiry as purported by Doane and Varcoe (2005) to inform their practice. My overall goal in writing this report is to foster the development of morally grounded trusting relationships between nurses and

families whose children live with complex health conditions. I also plan to share my paper with my nursing colleagues at the University of Victoria School of Nursing and other Schools of Nursing, where faculty teach family nursing, as a means of assisting them to better understand the practice of Relational Inquiry as experienced in the clinical setting.

I will begin by describing my own experiences with families whose children live with complex health conditions. I will follow by providing a historical overview of the changes that have occurred in the delivery of pediatric health care services over the past several decades and then describe how these changes have impacted the moral climate governing today's health care settings. This will lead me to a description of factors that either enhance or impede the development of trusting relationships between pediatric nurses and families. I will then provide an overview of theory guided nursing practice subsequently describing the practice of Relational Inquiry. Towards the end of my paper, I will discuss my journey to become an ethical practitioner including factors that led me to the non-ethical practice of othering and how I was able to reverse my non-ethical practice by adopting Relational Inquiry to guide my practice. I will conclude by presenting recommendations that practitioners in pediatric practice settings, including my own, might consider implementing to advance pediatric nursing practice towards the development of morally grounded relational practice.

Facing the Challenge: A New Population of Children with Special Needs

The Canadian Institute of Child Health (CICH) (2000) reported that the dramatic advances in medical treatment, health care technology and the delivery of health care services have increased the survival rates of Canadian children born with life threatening health conditions. This has resulted in an increasing number of medically fragile children being cared for at home by their families (Balling & McCubbin, 2001; Bond, Phillips, & Rollins, 1994).

Families end up living under constant stress as they try to find a balance between maintaining family normalcy and caring for their sick children (CICH, 2000; Malone, 1998). Hayes and McElheran (2002) describe this challenge as families "Trying to Have a Life" (p. 268). Trying to have a life means juggling the day-to-day expectations of family life in conjunction with caring for a medically fragile child at home. This is exemplified in the following extract from Hayes and McElheran's research:

> See the forest for the tress or the trees for the forest. And you're right in the thick of it, you just, you can't see what impact that kind of change on your family and the demands are having. He's your son and you love him and you're doing everything, naturally, for him, but you don't…see how it's impacting. (p. 273).

It is my belief that this description by an exhausted and frustrated parent represents many parents who are challenged to meet the day-to-day needs of their children living at home with a complex chronic health condition.

According to Müller, Harris, Wattley and Taylor (1992), there are several common characteristics seen in parents who care for medically fragile children. These characteristics include; (a) experiencing the loss of the perfect child, (b) trying to cope with additional family demands, (c) dealing with sibling rivalry, (d) blaming one's self for the child's illness, (e) feeling guilty, (f) experiencing loss of income as one parent needs to be at home to care for their medically fragile child, (g) experiencing separation between the family and child during hospitalization, (h) living with the day-to-day stress of the child's illness and unexpected hospitalization, (i) feeling exhausted caring for their medically fragile child around the clock, (j) experiencing interruption in family roles, (k) feeling isolated from family and friends, (n) experiencing activity and social restrictions in family life and lastly, (o) living the day-to-day

reality that their child might never reach adulthood. In addition, medically fragile children are also susceptible to acute illness and often need frequent hospitalization for treatment of either their acute illness or exacerbation of their chronic condition (Balling & McCubbin, 2001).

Parents arrive at the hospital already exhausted from caring for their sick children at home (Balling & McCubbin, 2001; Callery, 1997). Parents tell me that they stay at home for as long as they can hoping the treatment they have initiated will turn their children's illness around and subsequently, avoid hospitalization. In addition, emergency hospitalization adds additional stress to the parents as they sit and watch their sick child struggle to survive (Calley & Lauker, 1996; Dudley & Carr, 2004; Jarvis, 1998; Kasper & Nyamathi, 1998; Noyes, 1998; Wright & Bell, 2004). Parents also describe feeling exhausted, stressed, anxious, frightened, unsupported, alone, ignored, isolated, and always having to *put on a face* for their hospitalized children during these admissions (Dudley & Carr, 2004; Ygge & Arnetz, 2004). These feelings are further compounded when a parent stays at their hospitalized child's bedside. This adds additional stress to the family, as the parents have to juggle family responsibilities and commitments both at home and work even further in order to stay with their hospitalized child (Dudley & Carr, 2004).

Changes in the Delivery of Pediatric Health Care Services

Throughout my pediatric family nursing career, I have witnessed many changes in the delivery of pediatric health care services. For example, several decades ago, parents were expected to hand over the care of their sick children to health care professionals on hospital admission (The Welfare of Sick Children in Hospital, 2006). Parents were restricted from visiting their hospitalized children and were often excluded from medical decision-making in regard to their children's care. I believe this practice was based on the Cartesian belief that health care professionals are expert in knowing the needs of sick children and their families (Doane &

Varcoe, 2005). Dismissed from this belief is what the illness experience and hospitalization means to the child and family. For example, in my own family, my mother remembers how upsetting it was for her and my father to stand behind a glass wall to "visit" my baby brother. They stood watching him in pain and were not able to provide the comfort he needed. The doctors and nurses told them that it was in my brother's best interest not to have family around. Wright and Bell (2004) have described this action as nurses spending much of their "time and energy 'shooing' relatives away" (p. 3).

With the advent of family-centered care in the mid 1980s, parents were given the choice to stay with their children. However, today, there is an expectation that a parent stays at his or her child's bedside and actively participates in the child's hospital care. In fact, when a parent chooses not stay, nurses begin to question the parent's parenting abilities. In my experience, pediatric nurses do not reveal the real truth of their concern. That is, they need family members to not only provide loving care but to also provide supervision and safety for their children at the same time.

This shift in practice is an example of the changing moral climate in health care settings. I use the term moral climate to mean a practice environment in which nurses are respected and supported to provide safe, competent and ethical nursing care (Storch, 2004). However, the reality is that nurses in their everyday practice are dealing with increased patient acuity, staff shortages, eroding clinical resources while, at the same time, trying to navigate through a health care system driven by stringent inflexible practice policies (Rodney, Doane, Storch, & Varcoe, 2006). For example, five years ago in my practice setting, staffing levels were reduced based on the average daily admission census. At that time, patient acuity was not taken into consideration and front line nurses were not included in the decision-making process. Today, in spite of my

colleagues sending Professional Responsibility Forms, created by the British Columbia (BC) Nurses Union, to hospital managers to address these serious practice issues, it appears that little has been done to address the concerns.

These practice realities have the potential to create a climate driven by ethical and moral distress as nurses attempt to meet both their standards of professional practice and Code of Ethics for Registered Nurses that are set forth by the Canadian Nurses Association (2004) (Storch, Rodney, Pauly, Brown & Starzomski, 2002). Pediatric nurses, in my practice setting, tell me of the guilt that they experience when they leave parents to *fend for themselves* in the care of their hospitalized children. These guilty feelings can lead to the development of moral distress[1] and, after a period of time, to moral residue.[2] Moral distress leaves a negative effect on both the nurse and on patient care (Lützén, Magnusson, & Anderson, 2003). In addition, leaving parents to *fend* for themselves has the potential to impact the development of trusting relationships between the nurses and the families they are committed to serve. Parents have told me how frustrated and exhausted they feel being "stuck" having to fend for their children's care. This nursing lack of action is of particular significance to parents caring for children living with complex chronic health conditions since they are already exhausted and frightened before they enter the health care system. However, in spite of these practice realities, I believe nurses are in a position to enhance the nurse-parent relationship. In order to do so, nurses need resources to better understand what is important to these families, from the families' perspective, in the ongoing care of children living with a complex health condition.

Integrating Nursing Theory into Moral Relational Practice

The Development of Trusting Relationships: Nurses and Families

Trust is defined as an "attitude of optimism about the goodwill and competence of another that leads us to think we can count on the other person for something. Knowledge involves trust, and trust, knowledge" (Rodney, Brown, & Liaschenko, 2004, p. 154-155). Trust then is "the 'glue' that holds the relational matrix together" (p. 165). The relational matrix is described as "the connectedness and interdependence of individuals working in relationship with each other in organizational context" (p. 164). Thus, the need to developing a trusting relationship is important to the nurse-family relationship.

In a study conducted by Thompson, Hupcey and Clark (2003), where they examined the development of trusting relationships between parents of hospitalized children and pediatric nurses, nursing behaviors that either facilitated or inhibited trust were identified. Behaviors that inhibited trust included those that disregarded the expertise of the parent in knowing their child, those that ignored the needs of the child and family, and those that expected the parents to provide care that they were not comfortable with or that they were confident in doing. As well, behaviors that left parents feeling isolated, ignored or abandoned also inhibited the development of trust between the nurse and parents.

In contrast to the identified behaviors that inhibited the development of trusting relationships between pediatric nurses and parents, Thompson, Hupcey and Clark (2003) identified several behaviors that supported the development of trust. These included those interactions that provided a quick and honest answer to questions, those actions that reflected a caring concern for their child and family, those actions that showed a willingness to know the child as a unique person and not as a disease entity, and those actions that acknowledged the limitation of the nurse's nursing skills.

Parents have told me that, in some instances, nurses will pretend to know more than the parents do about their children's complex illness or the complicated technology needed to care for their children 24 hours a day seven days a week at home. I believe this action by the nurse dismisses the parent's expert knowledge of their child and the parent's ability to maintain complex equipment and perform intricate skills to keep their child at home. For example, during the admission process to the Pediatric Intensive Care Unit, I observed the interaction between the admitting nurse and a mother whose child lived with a complex health condition. The nurse proceeded to switch the child's home oxygen delivery system to the hospital oxygen wall unit. The child began to turn dusky in color indicating the child was not receiving enough oxygen to maintain his oxygen saturation level. The mother kept telling the nurse the oxygen was not connected properly to the wall unit. The nurse kept dismissing the mother's knowledge of her child and her expertise in managing equipment. The mother stood by helplessly and watched her child becoming increasingly distressed as he struggled to breath.

The mother finally took action by removing the oxygen connection from the hospital wall unit and then reconnected her child back to her own home oxygen delivery system. The child's respiratory effort to breath immediately improved and his color returned to normal. In the end, it was determined that the hospital oxygen wall unit was faulty and the mother was correct in identifying her child's needs.

Parents describe this kind of action by the nurse as trying to *save face* in his or her effort to maintain the position of being deemed the expert of their children's care. Therefore, I believe the nurse's behavior further distances the moral relational space between the parent and the nurse that, in turn, impedes the parent's desire to trust the nurse. In contrast, when a nurse takes on a stance of Relational Inquiry as suggested by Doane and Varcoe (2005), the nurse is enacting his

or her moral obligation to be an ethical practitioner by entering into a relationship from the *stance of being with* versus the *stance of knowing.* Adopting a position from the *stance of being with* shifts the nurse from being the expert to recognizing the expertise of the parent in caring for their child with a complex chronic health condition. As I will argue further in this paper, I believe practice guided by Relational Inquiry supports the nurse to recognize and acknowledge the *knowing* and *expertise* of the family versus the *knowing* and *expertise* of the nurse**.** I believe this shift in practice is vital to the development of trusting relationships between the nurse and parent.

Nursing Practice Guided by Nursing Theory

Nursing theory guides "innovations in nursing practice, education and research" (Molzahn, 2003, p. 102). Mitchell (1997) believes that when nursing practice is informed by nursing theory, nurses are guided "to know how to answer the call, how to be helpful with persons and families…This unique process of nursing cannot be broken into tasks, predefined in plans of care, or delegated to generic workers" (p. 71). Alligood and Tomey (2002) support Mitchell's claim in the following:

> The emphasis has shifted from a focus on knowledge about how nurses function, which concentrated on the nursing process, to a focus on what nurses know and how they use knowledge to guide their thinking and decision making while concentrating on the patient. (p. 16).

Leddy and Pepper (1993) describe how nurses have traditionally based their practice on their intuition, practice experience, or the way they were taught in their nursing programs. This led to the development of practice methods that were "rote and stereotypical practice" (p. 144).

Bishop (2002) expands this view by explaining that when nursing practice is not guided by a nursing theory, the "nurses' private conceptions of nursing may be incomplete, inconsistent and muddled. This leads to considerable problems in using the private theory as a sound basis for practice" (p. 50). Malone (1998) supports Leddy, Pepper and Bishop's claim. Malone explains that when a nurse does not have a guide to inform his or her practice, the nurse adopts a "laissez-fair approach to families, the nurse is focused on the needs of the individual and may discount the complexity of family life and its influence on how people comply or respond to the health care regimen" (p. 50). In addition, Doane and Varcoe (2005) describe that when nurses "take up habitual ways of practicing and viewing families, their views become constrained by the limitations of the theory they take up" (p. 47). Doane and Varcoe also believe that "theories are merely instruments at our disposal to help us understand family and to enable us to practice in knowledgeable ways. Theories help us challenge and expand our selective interests. Yet theories can also serve to constrain our view" (p. 48).

Traditionally, nursing practice has been governed by bureaucratic structures that focus on hierarchical structure and systems to promote efficiency. Nursing theories derived from this focus fall under the totality paradigm. These nursing theories promote efficiency within bureaucratic hospital structures by focusing on nursing action. Families are viewed as needing nursing action (Taylor, 2002). Orem's Self Care Nursing Deficit Theory (SCNDT) is an example of a nursing theory derived from a totality paradigm. SCNDT is an action theory that directs a nurse to find solutions to direct a family and their child to reach a capacity as determined by the nurse. Orem (1985) describes nursing as a helping service where nurses need to learn methods to assist families to reach their health potential. Foster and Bennett (1995) expand Orem's view by describing how a nurse is needed when a child or their family's ability

for “self-care demands are greater than the self-care abilities” (p. 121). Thus, the role of the nurse is to assist the family to get back to normal functioning.

The nursing process is derived from the totality paradigm. Mitchell (2001) describes the nursing process as a problem-solving process and “its related taxonomy of nursing diagnoses represents the theoretical residue of medicine” (p. 112). I believe faculty in BC Schools of Nursing are shifting away from teaching nursing theories derived from a totality paradigm. This is apparent in the BC Collaboration for Academic Education in Nursing (CAEN) (2008) approach to the development of nursing education. CAEN’s nursing curriculum is based on the philosophical underpinnings of phenomenology, feminism, critical social theory and humanism. Humanism supports nurses to view nursing “as a particular kind of human relating….that involves presence and awareness…(Doane & Varcoe, 2005, p. 99). Thereby, a humanistic approach “takes nursing practice beyond the subjective/objective dualism to a way of being and an approach that is objective/subjective, and intersubjective all at once” (p. 99).

In spite of this shift towards educating nurses to work with families from a new set of lenses, many of the nurses in my practice setting have been trained from within a totality paradigm. In addition, newly graduate nurses who work in my practice setting who have learned a humanistic approach to working with families are influenced to practice from within a totality paradigm from their peers. For example, when a child is admitted to hospital, the nurse collects data about the child. Included in the admission process, is a form the parent is asked to complete that asks questions about their child and family. The questions for example, relate to asking what time the child goes to sleep, what measures help the child fall to sleep, how the child is fed, what the child likes to eat, what size diapers the child wears and which family member will be staying with the child during the hospital admission. It is possible to argue that these questions

are relevant for the nurse to better understand the needs of the child from a health and healing perspective. However, dismissed from the nursing assessment is what the hospitalization means to the child and family and other factors that could support health and healing during the hospital experience.

Doane and Varcoe (2005) discuss the pitfalls of using predetermined nursing assessment and screening tools to assess families. Doane and Varcoe describe how these tools:

- Limit the relational connection between nurses and families.
- Limit the understanding of a family's health and healing experience.
- Determine how the family system is functioning and how to fix the problem.
- Create an intrusive experience for the family.
- Decontextualize both families and nurses.

Furthermore, the nurse ends up focusing more on the assessment form than on the family.

I experienced the pitfall of predetermined nursing assessment tools several years ago in my work as a public health nurse. I remember vividly my experience using a form to determine the needs of a child and family during a scheduled 15-minute immunization clinic. I was expected to complete the form, determine the needs of the child and family based on the information I gathered and then administer the immunization. I ended up concentrating more on the questions than I did the family. I began to examine this practice. On reflection, I realized that I was practicing from the stance of expert nurse and by doing so, while at the same time concentrating on completing the form, I stepped away from my relational connection with the family. In addition, I began to recognize that I was speaking *at* versus speaking *with* the family. Doane and Varcoe (2005) describe my action as the I-It relationship. In the I-It relationship, the nurse objectifies the family and becomes the holder of expert knowledge. This action is the

same action a parent experiences when the nurse dismisses the parent's expertise in caring for their medically fragile child at home. The authors describe this action as the nurse "wields the power in the relationship-it is the nurse who directs the conversation…who determines what is meaningful and significant based on the questions in the assessment form…" (p. 220).

I was determined to change my practice. I began to memorize the questions that I was mandated to ask. I believed that if I knew the questions ahead of time, I could then engage with the family in a meaningful way. I started to view each family member as a person versus an object. As I applied my new approach to working with families, I discovered that family members began to express what was important to them. Doane and Varcoe (2005) refer to this action as the I-Thou. In an I-Thou relationship, the nurse enters into the relationship with the family on an equal playing field. As I continued to practice the I-Thou relational approach to working with families, I began to realize that I was distancing myself from being governed by the totality-nursing paradigm. I focused less on efficiency and being directed by the biomedical model. I began to recognize the unique lived experience of families that I worked with in my everyday nursing practice.

In contrast to the totality paradigm, Rosemarie Parse created a human science nursing theory in the early 1980's called the Man-Living-Health Theory (Mitchell, 1990). The theory was later renamed the Human Becoming Theory (Parse, 1996). The Human Becoming Theory (HBT) brought a new perspective to inform traditional nursing practice from within a simultaneity paradigm. Nursing theories developed within the simultaneity paradigm are influenced by existential phenomenology where there is a " unification of time and space and an appreciation of the unity and wholeness of the human being" (Molzahn & Northrup, 2003, p. 74).

Parse made a deliberate exit from the traditional view of nursing as being rooted in the natural sciences and linked to medicine, to viewing individuals from a human science perspective. The Human Science perspective is concerned with understanding phenomena as experienced by the person (Mitchell & Cody, 1999). In this shift in practice, out went the nursing process and along with it, the nursing diagnoses (Pilkington & Jonas-Simpson, 1996). Arndt (1995) explains how "Nursing diagnoses have no place in this theory since Parse avoids labeling…labeling is reductionistic and may create ethical dilemmas" (p. 87). In addition, Parse uses the prefix 'co' on "many of her words to denote the participative nature of persons. Co means *together with.*..humans can never be separated from their relationships with the universe…linkages humans have with other people and with ideas, projects, predecessors, history, and culture" (Mitchell, 2002, p. 528).

Cody (2000), a Parse nursing scholar and Human Becoming Theory (HBT) researcher, explains that when a nurse adopts a theoretical framework to inform his or her practice, the nurse is influenced to critically examine the development of *self* (the nurse) in relation to *other* (the child and family). Cody examined his own development of *self* in relation to *other* as a nurse adopting the HBT to guide his practice. Cody described his experience as, "The human lives multidimensionally, cocreating reality with predecessors, contemporaries, and successor, all-at-one…Each dimension of the paradox shed light on the other" (p. 192). I believe that Cody's view corresponds to Doane and Varcoe's (2005) belief that nursing is a process of relational inquiry between *self* and *other*. In fact, I believe there are many similarities between Parse and Doane and Varcoe's approach to inform nursing practice. In addition, Doane and Varoce acknowledge that the assumptions embedded within the HBT are relevant to their work in family nursing. Furthermore, Parse's view of family is similar to Doane and Varcoe. Cody describes

Parse's view of family as "unbounded by structural, functional, or systemic assumptions…Parse does not propose a specific structure for the family…" (p. 281). Doane and Varcoe view families from a relational theoretical lens that "emphasize the interconnectedness of people and their world and offer insight into the importance of sociocontextual structures in understanding families….from a relational view, objective and subjective knowledge are inseparable" (p. 50-51).

Central to both the Human Becoming Theory, and the practice of Relational Inquiry, is a human science perspective that is grounded in phenomenology. Phenomenology explores "how human beings make sense of experience and transform experience into consciousness, both individually and as shared meaning…how they perceive it, describe it, feel about it, and talk about it with others" (Patton, 2002, p. 104). Nursing theories derived from a human science perspective examine the "meaning and experience of people, health, and nursing" (Doane & Varcoe, 2005, p. 98). However, Browne (2001) has argued that missing from this phenomenological perspective is the lack of regard to explore the:

- Structural determinants of health and illness that impact a person's ability to reach their optimal level of health.
- Structural determinants of health that have contributed to the illness experience.
- Structural determinants of health that do not address the need for improved access to health promotion and treatment programs or the resources required to support persons to reach their health potential.

In addition, Browne believes that the "conceptualization of health as an exclusively phenomenal (personal) experience make it difficult to promote a social mandate for nursing focused on addressing social conditions that constrain and limit opportunities for health" (p. 123).

Watson, cited in Doane and Varcoe (2005) summarizes the human science paradigm within the context of nursing as being based on:

- A way of being with *other* that is both relational and positioned in process.
- A philosophical belief that humans are free agents to determine their own choices.
- A scientific worldview that is unlocked and continually changing.
- A knowledge development process that includes empirical science as well as esthetics, ethics, values, intuition and a process for discovery.
- A belief based on holism that persons are nonreducible and interconnected with their world.

In summary, a human science perspective grounded in phenomenology, therefore, connects the here and now between "one's past, present, and future…From a here-and-now perspective, each moment is significant, irreplaceable, and imbued with potential" (Doane & Varcoe, 2005, p. 101). For example, a mother came by my office to obtain educational materials to learn about her baby's newly diagnosed asthma. The mother sat quietly as I explained to her the various concepts about childhood asthma. As I spoke to the mother, my bodily sense told me to stop talking and to provide the mother an opportunity to reflect on the information I had presented. The room became quiet. I sat close to the mother. After a period of time, the mother began to speak. She told me about the fears and concerns that she had for her baby. She also told me that she had lost a baby from an unexplained respiratory condition five years earlier. As I sat and listened to the mother tell her story, I realized how the mother's past experience losing a child impacted the moment and instilled additional fears for her baby's future living with a chronic disease. Furthermore, I also realized that when I provided time for the mother to reflect on the moment, she was given an opportunity to bring meaning to her fears.

Uncovering Moral Relational Nursing Practice

I believe the Human Becoming Theory (HBT) emphasizes the relational aspect of moral relational care. Since both the HBT and the practice of Relational Inquiry are similar in their approach to inform nursing practice, I decided to explore research studies that examined the impact of adopting the HBT to guide nursing practice. I am unaware of any studies that have examined the impact of adopting Relational Inquiry to inform nursing practice. My purpose in exploring the literature was two-fold: I wanted to learn about nurses' experience adopting the HBT to guide their practice and to also explore the hurdles and celebrations practice settings experienced introducing the HBT as a guide to nursing practice. In addition, those hurdles and celebrations will be included in my recommendations that pediatric practice settings may consider when adopting the practice of Relational Inquiry as a guide to nursing practice.

I uncovered two Canadian studies that examined the implementation of the Human Becoming Theory (HBT) to guide nursing practice in both pediatric and adult acute care settings (Mitchell, 1999; Santopinto & Smith, 1999). In addition, nurse participants from one of the studies published their experience adopting the HBT to guide their practice (Quiquero, Knights, & Meo, 1991). I also reviewed an article that highlighted a nurse's experience adopting the HBT to guide her practice from a phenomenological perspective (Mitchell, 1990). The reason I have included these studies and articles in my discussion is to illustrate that nursing practice guided by a human science perspective can make a difference not only to patients and families but also practice settings. I believe this is significant with the changing moral climates currently being experienced within the Canadian health care system. I also believe the study recommendations presented will provide me with the additional tools that I need to assist me in formulating

practice recommendations. In the following paragraphs, I will provide highlights from my literature review.

Mitchell (1999) examined the impact the Human Becoming Theory (HBT) had on nurses' practice and identified how the "nurses' perceptions changed from viewing the patient as a problem, to viewing the patient as a human being" (p. 394). In addition, she identified that the nurses judged and labeled families less and also began referring to the children and their families by name versus room number or disease entity. Mitchell, in her analysis, recognized that staff nurses began to record "patients thoughts, feelings, hopes, dreams and plans" (p. 388). In addition, it was identified that the morale of the staff also improved.

Santopinto and Smith (1999) looked at the impact the Human Becoming Theory (HBT) had on the parents of hospitalized children. They uncovered that the nurses' "attitudes, values and beliefs, and the organizational culture" began to change when using the theory (p. 345). They also found that there were qualitative changes in both the child and parent's experience. One mother wrote,

> Everyone was very friendly and accommodating. A pleasant change from the struggle and fight experienced previously…I wasn't happy with my child's last stay in the hospital. I was afraid to voice my concerns for fear that if he were admitted another time, the nurse would be resentful. That did not happen. (p. 340).

In addition, nurses were seen to be sitting less at the nursing station and spending more time with the family at their child's bedside.

Quiquero et al. (1991) describe their experiences of being nurse participants in a study that examined the impact of adopting the Human Becoming Theory (HBT) to guide their nursing practice. The authors explained that even though they believed they were *good* nurses, their

nursing practice was focused on "perfecting skills for efficient running of the unit. Completing tasks was a priority and efficiency required rushing from room to room to completing procedures…little time for talking and listening to patients…patients were judged and labeled…we focused on fixing" (p. 14) problems based on the patient's medical diagnosis or disease entity. The authors also discovered that the HBT "taught us to listen with our hearts and not just our ears…When individuals share their struggles, concerns, hopes and dreams, it makes us feel special and honoured" (p. 15).

Mitchell (1990), in her article, *Struggling in Change: From the Traditional Approach to Parse's Theory-Based Practice*, provided a personal account of her struggle to change her practice from the traditional problem-based approach to a practice guided by the HBT. Mitchell described how her belief of human beings shifted from the traditional view that an individual is a "sum of parts, who copes and adapts, to viewing the individual as a unity, who is greater than the sum of parts, and who is cocreator of life situations" (p. 171). That is, she began seeing individuals as unique human beings living their human presence in life filled with hopes, fears and dreams. In the following, Mitchell clearly articulates how her traditional practice was governed from a totality paradigm:

> I was skilled in assessing and judging people according to observed behaviours and test results. I expected people to behave and respond in certain ways. When they did not, I used labels like nonresponsive, noncompliant, or inappropriate. I diagnosed alterations in self-image, depression related to loss, and ineffective coping according to predefined norms. I was the expert, and my focus with patients was finding out what biopsychosocial problems needed to be managed or eliminated. (p. 172).

As Mitchell (1990) continued to study the Human Becoming Theory (HBT) from a human science perspective, and then applied her new knowledge to inform her clinical practice, she uncovered that she "began to appreciate the depth of my theoretical prejudice" (p. 172). In other words, Mitchell describes how she stepped away from her obligation to provide ethical care by allowing her prejudice to inform her practice. Mitchell also recognized that in order for her to provide safe and competent ethical care, she still needed to follow policy practice standards. Mitchell describes this experience as, "I am able to perform the necessary tasks and activities required of nurses in acute care settings. Ensuring that policies and procedures are performed safely and accurately is important" (p. 176). Mitchell's experience is parallel to Doane and Varcoe's (2005) belief that, in spite of nursing practice being informed from a moral relational perspective, nurses cannot step away from their moral responsibility to provide safe and competent ethical care. Doane and Varcoe emphasize the need to bring together multiple forms of knowledge to reach this goal, and, as well, as a critical scrutiny to their own actions, knowledge and taken-for-granteds.

Bringing Meaning to Nursing Theory: The Practice of Relational Inquiry

The practice of Relational Inquiry encompasses a typology of four approaches to understanding ways of knowing and understanding knowledge development. The four approaches include Empirical Inquiry, Contextual Inquiry, Ideological Inquiry and Ethical Inquiry (Doane & Varcoe, 2005). Centered between the four approaches is the process of Relational Practice. The joining of the four approaches in conjunction with the marrying of the process of relational practice constitutes the practice of Relational Inquiry. This approach draws on several forms of knowledge and recognizes that multiple forms of inquiry inform relational

practice. Relational Inquiry also asks nurses to examine themselves in relation to other (the family) from multiple perspectives.

There are three key elements in the process of Relational Inquiry. The three key elements include paying attention to self (knowing self), looking around self (what is happening in the context of self's environment) and looking for the connection between self and other (working across difference) (Doane & Varcoe, 2005). This process asks the nurse to be in synchrony with the other by following the lead of the family versus the lead of the nurse. The nurse then walks alongside the other (the patient/family) as the other experiences health and healing. Thus, the traditional practice of the nurse using nursing assessment tools to analyze and determine the needs of the patient/family based on the expert knowledge of the nurse is set aside. However, this new approach to nursing practice does not mean that a nurse shifts away from his or her legal and moral responsibility to perform clinical assessments. For example, a nurse monitoring a patient's response to clinical treatment would incorporate objective knowledge of the condition and evidence-based practice standards in his or her assessment.

On the other hand, from a Relational Inquiry perspective, the nurse, during his or her assessment, would also explore the patient's subjective experience of the treatment. In addition, by shifting away from the stance of expert, any power imbalance that might occur between the nurse, as the expert (the knower), and the family (the receiver), will be diminished. That is, being in relation or being in synchrony, cocreates a connectiveneness between the nurse and family. Doane and Varcoe (2005) encourage the nurse to take up a stance of inquiry "where knowledge is located in the relational process of knowing" (p. 262).

Doane and Varcoe (2005) also emphasize that our "bodies are a site where many forms of knowing come together….The body allows one to navigate and flourish…by offering a site when

multiple knowledge (for example, personal, experiential, theoretical, contextual, cultural) comes together and imply direction" (p. 160). This creates a bodily sense of knowing, for example, the *gut* feeling that many nurses experience in clinical situations. For example, several years ago as a junior nurse caring for a young child that was born with a chronic cardiac condition, I entered the child's hospital room and experienced an immediate bodily sense that something appeared different about the child. I conducted my nursing assessment and did not identify any change in the child's vital signs, skin color, breathing pattern or activity level. In spite of not identifying anything tangible to support my *gut* feeling, I decided to acknowledge by bodily sense and called the pediatrician. The doctor listened to my concern. I believe that, in spite of there being no clear clinical indication that the child's health was deteriorating, the doctor acknowledged my concern, and then, chose to provide additional clinical support to monitor the child's health status. The child was transferred to the Pediatric Intensive Care Unit for observation. I informed the family of the transfer. The child died a few hours later from progressive heart failure.

The body is also a site of emotion (Doane & Varcoe, 2005). For example, when pediatric nurses experience a feeling of *guilt* by leaving families to *fend for themselves* in the care of their hospitalized children, the nurses are experiencing "value feelings-they mark what matters to us" (p. 157). In this case, believing they are not providing nursing care in the manner they choose triggers the nurses' to experience an emotional bodily response that may lead to the development of moral distress. While it is beyond the scope of this project to explore the many facets of a bodily sense of knowing as purported by Doane and Varcoe, I believe it is imperative that, as nurses, we look at the factors that have shaped our own unique sense of knowing by examining the contextual factors that have created our own moral development.

Following a Path Towards the Development of Moral Relational Practice

Finding One's Inner Sphere: Learning about Self in Relation to Other

Watch your thoughts: they become words.

Watch your words: they become actions.

Watch your actions; they become habits.

Watch your habits: they become your character.

Watch your character; it becomes your destiny

Outlaw, cited in Crocker & Johnson (2006, p. 181).

The Canadian Nurses Association Code of Ethics for Registered Nurses (2002) guides my ethical decision-making. I have also adopted Relational Inquiry as purported by Doane and Varcoe (2005) to guide my nursing practice. I believe that in order for me to practice within the scope of an Advanced Practice Nurse, it is imperative that I reflect on my own moral development. My examination of *self* in relation to other during my graduate studies uncovered how my view of family was influenced by my own beliefs, values, assumptions, experiences, ancestry, culture and spirituality. For example, my upbringing in a middle class, Caucasian family provided a backdrop for me to view family from a structural and functional perspective. Each family member had a specific role and duty to uphold within the family framework. There were also expectations and assumptions placed on each family member. Expectations and assumptions included completing secondary education, presenting oneself in a manner that reflected the family's social values and refraining from becoming a friend with a person deemed *different* by the family. Being viewed *different* was based on religious beliefs, skin color, family structure and societal position.

My family's worldviews influenced how I viewed *others* that then led me to practice the concept of othering in my interactions with *other* (families) in my clinical practice and personal

life. I also believe that I got caught up in a world of complexity. I use the term complexity to describe the *isms* that shaped my beliefs and values about *other*, for example the ism of racism and colonialism. I believe that when I became *stuck in complexity*, I interrupted my moral connectedness with the patient. However, by adopting a relational approach to understand my practice, while at the same time adopting Relational Inquiry to guide my practice, I was able to *re-connect* with patients through the inclusionary practice of othering. I will explore the concept of othering further in my upcoming discussion.

The Ethical Practice of Othering

Canales, cited in Varcoe (2004), describes othering as a way we engage with others. Othering can be described an inclusionary othering or exclusionary othering. Exclusionary othering occurs when the nurse "utilizes the power within the relationships for domination and subordination" (p. 419). Doane and Varcoe (2005) explain that when we hear nurses use words such as they, them, or those to describe the *other*, exclusionary othering is occurring. When nurses adopt these words in their language to describe *other*, the nurse takes on the stance of expert, that then reduces *other* to be objectified and labeled as a disease or problem. For example, during my graduate course work, I examined the language used in my everyday practice setting to describe families. I heard my colleagues use words such as weird, demanding, non-compliant, difficult, smelly, clueless, dumb, those natives, the family in room 300 bed A, the family whose baby has cancer or referring to a family as funny. I found it disturbing to work in a practice setting in which a family's uniqueness was not honored. Doane and Varcoe summarize my experience by explaining that when a nurse distances himself or herself from other, the nurse's "capacity to respect, honour, and promote people's health and health process is hindered" (p. 176).

I recently practiced exclusionary othering, in spite of knowing the consequences of othering, in my work with a family who cares for two children living with chronic complex health condition. I began to find the mother was demanding in her requests for service, always interrupting me and other members of the health care team in our day-to-day practice and was always in *our face*. I began to feel angry and short tempered in my interactions with the family. I also began to distance myself from the mother. I began to experience feelings of guilt for my actions. I finally came to the realization that I was practicing exclusionary othering in my interactions with the mother. Fortunately, I was able to reverse my practice once I incorporated the concepts of Relational Inquiry to explore my actions. I asked myself, "what is really going on here"? I discovered that I had not seen the mother and family from within the stance of Relational Inquiry. Because of this, I was dismissing the mother and family as persons worthy of my care. In addition, I began to understand that my beliefs and values, as well as the healthcare teams' beliefs and values, were in conflict with the hopes and dreams that mother held for her children. Once I examined what was relationally happening within the particulars of the situation and context of care, I asked the health care team to meet as a means to explore with them what we could do as a team to support the mother and family. I started the meeting by explaining how I had stepped away from my ethical commitment to *walk along side of the family* as they struggled to experience their journey of health and healing. As I listened to each health care team member describe his or her frustration working with the family, as a team, we reflected on the context of the situation to better understand the perspective of the mother and her family.

We began to rethink our *knowing of this family*. We started to connect through difference in order to support the family in reaching their health and healing goals. Our practice of exclusionary othering then shifted towards the practice of inclusionary othering. For example,

we invited the mother to meet with the team to discuss what was important to her and her family. The team learned from the mother that her ultimate goal was to support her children to experience new opportunities and to continue to care for her children at home in spite of the children's increasing medical needs to stay alive. The team, together with the mother, developed a plan of action to support the mother in reaching her goals.

In contrast to exclusionary othering, inclusionary othering occurs when the nurse chooses to find worthiness in the family and views the family to be worthy of nursing care (Canales, 2000). The nurse enters into a relational space with the family; in other words, the nurse connects through difference. Liaschenko (1994) uses the term *making a bridge* to describe connecting through difference. Making a bridge occurs when the "intersubjectivity of the nurse meets the subjectivity of the patient, creating the possibility of understanding and therefore redemption" (p. 84). In addition, Peternelj-Taylor (2004) explains that if we explore the "relational and contextual factors that contribute to the enactment of this phenomenon, it is argued that othering reflects a contemporary practice issue of moral significance-one that addresses the provision of competent and ethical care" (p. 132). Peternelj-Taylor further describes how connecting through difference with *other* creates an "empowering and transformative experience, one that promotes inclusion over exclusion" with *other* (p. 132). Parse's Human Becoming Theory (1999) presents a similar analogy to Liaschenko and Peternelj-Taylor by explaining "humans coauthor their becoming in mutual process with the universe, cocreating distinguishable patterns which specify the uniqueness of both humans and the universe" (p. 5).

Doane and Varcoe (2005) present a synthesis of relational actions a nurse may choose to adopt to address connecting across difference. These include:

- Working to know the *other's* world.
- Connecting with *others* as allies in friendship.
- Developing a critical consciousness of *self's* own power, knowledge and privilege.
- Viewing families and people as different from yourself but worthy of unconditional positive regard as human beings.
- Taking action to name discrimination by paying attention to the language used to refer to or describe *other*.
- Avoiding stereotyping *other*.
- Taking action to attend to families' and patient's claims of discrimination.

Doane and Varcoe believe that when nurses adopt these strategies to inform their practice, they would be enacting relational practice "in a meaningful manner across differences" (p. 313).

Moving Forward

Pediatric Practice Informed by Relational Inquiry: My Journey

If I believe so much must change, I must be willing to change myself

Francis Moore Lappe cited in Chinn (2001, p. 6).

In my preceding discussion, I presented the need for pediatric nurses to adopt a morally grounded theoretical practice in order to meet the needs of a growing population of families who care for children living with complex chronic health conditions. I also presented factors that would either enhance or impede the development of trusting relationships between these families and nurses. I then explored the need for nursing practice to be guided by nursing theories derived from a human science perspective. Subsequently, I examined my own moral development to become an ethical practitioner including factors that led me to the non-ethical

practice of othering and how I was able to reverse my non-ethical practice by adopting Relational Inquiry to guide my practice. Each step that I have taken thus far to explore the various concepts that support the development of morally grounded theoretical practice have become the backdrop I needed to continue my own moral journey.

Throughout my nursing career, I have strived to provide safe and competent ethical nursing care. However, for most of my nursing life, my practice was driven from a totality paradigm in which my nursing practice was focused on efficiency and determining the needs of those in my care. For example, during my diploma-nursing education, I was programmed in how to determine the needs of patients. I was taught how to design nursing care plans that incorporated my goals for the patient. I was also taught to refer to a patient as the client. I was told that when a nurse called a person a patient, it implied the person was in need of nursing care. The term client however, denounced this need and suggested the person sought nursing action from a business clinical perspective. Little emphasis was ever placed on the family.

As my nursing journey continued in my work with children and their families, I continued to be influenced by the totality paradigm. I became very efficient completing my tasks, determining the needs of families and creating care plans that determined the needs of the child and their family. I also recognized that I told families what to do. However, in the late 1980s, I started to view families differently. I was introduced to the Family Centered Model of Care (FCMC) in my practice setting. The FCMC encouraged pediatric nurses to respect the expertise of the family in their knowledge and care of their child, to respect diversity and to support the uniqueness of each family (Ahmann, 1994; Kitchen, 2005). I discovered that by practicing from a FCMC perspective, I began to be less direct in my interactions with families.

My understanding of families started to change again when I began my undergraduate nursing degree program in the early 1990's at the University of Victoria School of Nursing. One particular course, a communication course taught by Gweneth Hartrick, made a significant change to my understanding of families. The purpose of the course was to teach students how to effectively communicate with patients and their families. However, embedded throughout the course, students were supported to look at the development of their belief and value systems in their engagement with *other*. As I became to learn what factors influenced the development of my beliefs and values, I began my lifelong journey of self-exploration to understand *myself* in relation to *other*.

In the mid 1990s, I was hired to establish a pediatric asthma, allergy and eczema outpatient program. The program was designed to be a collaborative educational program between a hospital agency and a public health nursing agency. As part of the program design, nursing managers from both agencies approached Dr. Gweneth Hartrick from the University School of Nursing to provide an educational opportunity to prepare the team for their new roles. The purpose of the education was to focus on enhancing the team members' understanding of health promoting family practice. In Dr. Hartrick's response to the request for education, an educative-research project was proposed (Hartrick, 2000). As one of the study participants, I participated in-group education sessions that supported me to reflect on my understanding of family nursing, as well as health promotion practices with families and learn what constituted family and family care. My experience of participating in the research-education project assisted me to reflect on what I knew about families and what I knew about myself in practice. As I continued my journey, and reflected on my new knowledge, I began to practice nursing from a

relational perspective. However, I came to a pause in my journey, until I entered graduate school at the University of Victoria School of Nursing.

In my first graduate course, I explored the good and the bad of nursing theory. I learned about the need for nurses to adopt a theoretical guide to inform their practice. In addition, I was introduced to the Human Becoming Theory (HBT). Discovering the HBT triggered my curiosity to restart my journey of self-exploration. I began to incorporate the concepts of the HBT to inform my practice. As I practiced my new approach to working with families, I realized that families responded to me in their own unique way. I also began to see families within context. During my second graduate course, I was introduced to the study of health care ethics. My third graduate course provided me the tools that I needed to better understand the social and political contextual features that shape the delivery of healthcare services. In subsequent graduate courses, I was encouraged to critically reflect on my own practice, the practice of others, identify factors that enabled or impeded health and healing, to conduct literature reviews and, lastly, to discover ways in which I could influence a change in practice as an advanced practice nurse leader.

As I incorporated my new knowledge into my practice, and continued my journey of transformation, I could never finds the words to describe how I practiced until I was introduced to the family nursing text *Family Nursing as Relational Inquiry: Developing Health-Promoting Practice* (Doane & Varcoe, 2005). As I read each page, I discovered the language that described my approach to practice. I also found a family nursing text that synthesized all of my graduate course work and practice experiences. For example, I learned about the links between the process of Relational Inquiry within the practice of Empirical Inquiry, Contextual Inquiry, Ideological Inquiry and Ethical Inquiry. I am still traveling my reflective journey and expect to

experience bumps and twists along the way. The difference now is that I have the practice of Relational Inquiry to help me find the correct road signs to lead me on my travels. In summary, I began this portion of my discussion with a quote by Francis Moore Lappe cited in Chinn (2001), "*If I believe so much must change, I must be willing to change myself*" (p. 6). I believe that I have to educate, support and lead my nursing colleagues to follow a similar journey.

Creating Morally Grounded Theoretical Practice

As I came to understand the development of *myself* in relation to *other* throughout my graduate course work, I questioned how I might begin to influence a change in how pediatric nurses in my practice setting viewed and worked with families. I decided to explore the steps Doane and Varocoe (2005) highlight that guide a nurse to take up an active stance to move forward the art of Relational Inquiry in family nursing. These steps include:

- Choosing to take an active stance.
- Identifying the questions to ask.
- Identifying the issues by asking, what is really going on here?
- Working the context.
- Seeking and then enlisting support.
- Moving forward.

In my past experience striving to influence other changes in my practice setting, I recognized that the readiness or willingness of the nurse to embrace the change was an essential component to the process. I also learned that nurses in my practice setting preferred to build on their existing knowledge, did not embrace what they deemed to be academic jargon, enjoyed attending local conferences that focused on pediatric practice and were interested in pediatric ethics. In addition, I have also learned how essential it is to identify key stakeholders in my

practice setting that would provide the additional support needed to introduce change. This is evident by a small group of nurses that approached pediatric nursing managers to develop a poster that described their practice working with families using the concepts of the Family Centered Model of Care. This same group of nurses is in the process of updating the standard pediatric hospital admission form. I believe the timing is right to introduce the concepts of relational practice.

I recently met with a group of the nurses to discuss factors influencing the moral climate of the unit. As I listened to the nurses' express their desire to practice differently, I asked the nurses if they would like to learn more about the Family Centered Model of Care from a relational practice perspective. The nurses expressed interest in learning a new approach to working with families. In addition, newly hired nurses working on the unit are recent graduates from the University of Victoria School of Nursing. These nurses have studied the concepts of Relational Inquiry and nursing ethics in their undergraduate course work. I also recognize an opportunity exists to partner with the University of Victoria School of Nursing faculty to explore the possibility of adding a research component to my endeavor. My reason for approaching the faculty is two-fold; a need for nurse researchers to examine Relational Inquiry in pediatric nursing practice and the need to partner with experts in the field of family nursing that would provide additional support in the educative process. I decided to prepare a list of actions that would lead me towards my goal of advancing pediatric nursing practice in my practice setting towards moral relational nursing practice. These actions are as follows:

- Action One: Action one would center on rewriting the Family Centered Model of Care (FCMC) poster from a relational perspective. The focus would include examining the

language used to describe the FCMC practice and inviting families to be part of the process.

- Action Two: Action two would be to host a local Family Centered Care Conference that would focus on the development of relational centered care with families. Families would be invited to actively participate in the conference design and in the conference discussion. In addition, funding already exists to host the conference with minimal registration cost to the attendees.
- Action Three: Action three would focus on building the capacity of nurses that have expressed a willingness to work with families differently. The educational component attached to the research study could provide the support needed to educate the nurses about the practice of Relational Inquiry.
- Action Four: Action four would focus on redeveloping the pediatric nursing admission assessment form, from a Relational Inquiry perspective. Families would be included in the redesign. In addition, the other pediatric practice settings have adopted a relational approach to working with families in the design of documents. An evaluation component would also need to be considered as part of the implementation process.

In summary, I believe an opportunity exists to seek the support and approval of pediatric nursing managers to take my practice recommendations forward. I believe the timing is right to advance my project further by implementing the recommendations and actions that I have presented.

Conclusion

My intent throughout this project has been to present a conceptualization that highlights factors that lead to the development of moral, relational, family nursing practice. I have also

attempted to trigger readers' curiosity to scrutinize their development of *self* in relation to *other* as a vehicle to assist them to examine the theoretical perspectives and everyday practices that inform their nursing practice. In addition, I have provided a synthesis of what constitutes moral relationships between the nurse and family. I have also provided an in-depth analysis of factors that support the development of trusting relationships between pediatric nurses and families who care for children living with a complex chronic health condition. Furthermore, I have provided an examination of the benefits and pitfalls of adopting nursing theory to inform nursing practice. I have emphasized throughout my discussion the need for nurses to scrutinize their practice to avoid the non-ethical practice of Othering. In addition, I have presented recommendations that may assist pediatric nurses to support the creation of moral, relational nursing practice.

In conclusion, I leave readers to ponder on the following reflection from a mother when asked about her experience with the health care system while caring for her child living with a complex chronic health condition:

> *When you fix, you see someone as broken, and when you help, you see someone as weak. When you serve, though, you see someone as whole. Serving is more likely to create a relationship of equals rather than one of hierarchy* (Crocker & Johnson, 2006, p. 254-255).

Endnotes

[1] Jameton cited in Corely (2002), defines "moral distress in the nursing context as a painful feeling and/or the psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires, but cannot carry out that action…"(p. 637). The CNA Code of Ethics for Registered Nurses (2002) makes reference to moral distress by referring to moral distress as "ethical distress" (p. 6).

[2] Moral residue is a result of unresolved moral distress that " each of us carries from those times in our lives when in the face of ethical distress we have seriously compromised ourselves or allowed ourselves to be compromised" (Webster and Baylis cited in CNA, 2002, p. 20).

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