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Relational Practice and Nursing Obligations

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Nursing relationships and the enactment of nursing values and goals in contemporary healthcare contexts are becoming increasingly challenging. Using a relational inquiry lens, the authors examine the interface of relationships, ethics, and effective nursing practice and the way in which personal and contextual elements continuously influence and shape nursing relationships in many ways. The nursing obligations underpinning relational practice are examined, and the way in which relational inquiry can enhance nurses' ability to navigate through the highly complex, multifaceted, and contextually dependent moments of contemporary nursing practice is illustrated. **Key words:** *context*, *difficulty*, *ethics*, *intentionality*, *nurse-patient relationships*, *reflexivity*, *relational inquiry*, *relational obligation*

BY the close of the 20th century, the image of the "lady with the lamp" administering tender loving care to a wounded soul had faded. More contemporary images depict nurses rushing between too many patients, grappling with technology, paperwork, and limited resources. These changing images reflect not only a shift in the nature of nursing practice but the changing contexts of healthcare. Moreover, they highlight the need for broader understandings of contemporary nursing relationships, including the integral connection between "therapeutic" relationships and "ethical" relationships.

Relationships in nursing typically have been understood in congruence with liberal individualism and its companion paternalism; that is, the relationship between the individual nurse and individual patient is seen as the relationship of importance. The nurse is considered as an autonomous agent with free will who is able to make choices. There is an assumption of therapeutic intent on the part of the nurse, and responsibility for achieving health outcomes through "good" relationships is vested in the nurse. As Browne[1] argues, such ideologies underpin much of the nursing theory.

Understanding relationships in this way ascribes responsibility to the nurse to foster therapeutic relationships and thus to provide better care and achieve better outcomes. Supporting this understanding is a wealth of literature focused on concepts and behaviors that have the potential to enhance relational engagement. For example, concepts such as respect, presencing, trust, mutuality, and so forth are frequent topics in the relationship literature in nursing. Less common in this literature are discussions of the multitude of factors that shape and at times, determine the connection between any individual patient and nurse. Yet, these other personal and contextual factors frequently make trusting, respectful, and therapeutic relationships challenging. For example, workload, patient acuity, staffing ratios, and supportive (or unsupportive) collegial relationships can shape whether a nurse even views "presencing" with a particular patient as an option. Furthermore, a nurse's personal identity and social location shape his or her interpretations, willingness, and capacity to be in relation with particular patients in particular situations.

In this article, we argue that although nurses are handed the responsibility and

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obligation for therapeutic nurse-patient relationships, and given descriptive indicators of "good" relationship behaviors, often missing is an examination of how nurses might meet this nursing obligation within highly complex, multifaceted, and contextually dependent moments. Specifically, we wish to consider nurse-patient relationships, using a relational lens that takes multiple contexts and relationships into account. Moreover, we highlight the way in which familiar relationship concepts such as trust, empathy, and respect work in concert with ethical concepts such as obligation, responsibility, and "good" action. We critically examine the concept of obligation, and using a relational understanding, suggest 3 obligations underlying nursing relationships. It is our contention that responsive, compassionate, therapeutic relationships, and ethical and competent nursing practice are integrally connected and that relational inquiry can support the enactment of both. Our intent is to examine the way in which a relational lens of inquiry can enhance nurses' capacity and ability to navigate through the challenges and competing obligations of contemporary relationships in healthcare.

CONNECTING RELATIONSHIPS, ETHICS, AND NURSING EFFECTIVENESS

Gastmans contends that relationship is "a foundational condition of nursing practice."[2(p495)] Tschudin describes relationships as "salutogenic" in the sense that they contribute to health more essentially than we often are aware.[3(p35)] Similarly, Tarlier[4] contends that responsive relationships are one way where nurses "make a difference" and influence clinical outcomes.

Tarlier[4] outlines that within the nursing literature, "good" relationships are conceptualized as being founded on 3 essential elements: respect, trust, and mutuality. Respect includes 5 characteristics (1) treating others as inherently worthy and equal; (2) acceptance of others; (3) willingness to listen to others; (4) genuine attempts to understand other's situation; and (5) sincerity.[5] Trust is developed through the processes inherent in respect. At the same time, trust rests on the patient's belief that the nurse will assist him or her in achieving a good outcome.[4] Baier defines *trust* as "reliance on others' competence and willingness to look after, rather than harm things one cares about which are entrusted to their care."[6(p25)] Baier describes trust as involving a "reliance on another's good will not just dependable habits."[6(p234)] Mutuality refers to a relationship as a negotiated, collaborative process where both people participate, choose, and act.

Armstrong[7] describes that nurse-patient relationships typically have been viewed in terms of human interactions, communication skills, and collaborative action.

However, describing the significance of relationships to ethical nursing practice, Bergum[8] purports that in essence, relationships are a moral space where one enacts not only responsiveness but also responsibility. Similarly, Nortvedt[9] argues that nurse-patient relationships are the site where moral responsibilities and professional duties are generated. As Gilligan described "the most basic questions about human living—how to live and what to do—are fundamentally questions about human relations, because people's lives are deeply connected psychologically, economically, and politically."[10(p14)] Everyday interactions between patients and nurses, between nurses and other healthcare practitioners, and between nurses and their practice contexts involve complicated networks of mutual dependencies. Bergum contends that "with relational space as the location of enacting morality, we need to consider ethics in every situation, every encounter, and with every patient."[8(p487)]

A review of the literature reveals that overall being in "good" relationship not only is considered more responsive to others in the sense of being more respectful and trustworthy but also results in more ethical and effective care. It is this integral connection of relationships, ethics, and effective nursing practice that we

wish to highlight and explore further. Within both the relationship literature and the ethics literature, it is argued that nursing practice requires a deep sensitivity to what is significant to patients in particular situations. Unfortunately, there has been little integration of these different bodies of literature. Subsequently, there has been very little discussion about what is required to develop and enact that sensitivity and/or the knowledge, capacities, and skills required for ethical and responsive nursing relationships within the complexities of current healthcare milieus. For example, as social inequities deepen and neoliberal ideologies hold individuals responsible for their own health and well-being regardless of how poverty, disability, remote geographical locations, or other inequities determine health; notions of obligation, responsibility, accountability, and efficiency are as vital to nursing relationships as are notions of compassion, responsiveness, trust, and respect. Thus, nurses require a broader understanding of relationships and their significance to ethical nursing practice.

An example: Interaction in the emergency department

During a long wait in the emergency waiting room to have a laceration sutured, I watched an elderly woman and her mature adult daughter get increasingly impatient "to be seen" and have the mother's injured leg attended to. At one point, the daughter went to the reception window to declare in an exasperated voice that they had been waiting for close to 3 hours, she was not sure how much longer her mother could tolerate sitting in the chair and that if they were not seen soon, they would just leave. The nurse behind the window replied in an assertive voice that the emergency policy was to see patients in order of medical priority not waiting time and they would be seen as soon as it was possible. Shortly afterward, I was called into the stretcher area. A few minutes later as I lay on the stretcher after having my laceration sutured, another nurse popped her head into my cubicle saying that she would be with me in a minute to apply a dressing she was just going to assist a patient onto a stretcher. From behind the curtain, I could hear that the other patient was the elderly woman. As the nurse assisted her onto the stretcher, the nurse exclaimed "that's quite a gash on your leg." In response, the elderly woman began to tell the story of falling at home. The nurse quickly interjected, cutting the story off by stating "well at least it isn't too serious and we will be able to suture that up fine." In response, the woman ignored the nurse's words and once again began to tell the story of her fall. Once again the nurse interjected to keep the focus of the discussion on the leg wound. At this point, the daughter spoke up saying "She fell two days ago and just called me this afternoon—imagine she was home by herself with this and she didn't even call me." As I lay in the next cubicle, I could "hear" the nurse in that moment making an important relational decision. There were a few seconds of silence (where I believe she was weighing her promise to return to me with the more compelling obligation to listen and respond to the elderly woman and her daughter) and then she replied "You live alone do you?" Through these few words the nurse entered into relationship in a meaningful way, simultaneously letting the woman know that she was "seen" and acknowledging the significance of her injury within the larger contextual-personal underpinnings of her life. Although the "easily fixed wound" was the physical evidence of her trauma, there were much more meaningful elements that needed attention relationally for healing to occur. As the elderly woman accepted the nurse's invitation and began to reveal the "whole" of her experience through her story, she communicated her shock in falling, her fear, and vulnerability as an elderly woman living on her own and the fierce independence, strength, and capacity she had. By creating the relational space for the woman to tell her story, the nurse provided an opportunity for the elderly woman to weave the various elements of her experience together and narrate herself and her situation into a

manageable form. By the end of the story (which took a matter of approximately 2–3 minutes), the woman concluded much as the nurse had initially concluded—that the wound was easily fixed and she would be fine to return home on her own.

This story exemplifies the significance of a nurse-patient relationship and the profound difference it can make in promoting health and healing. At the same time, the story highlights the competing and, at times, conflicting obligations through which nurses find themselves navigating. Although the elderly woman had come to the emergency department to have her leg sutured, what was most meaningful and what she needed to sort through was what the fall and injury meant within the context of her life. That is, as an elderly woman living alone, the fall underscored her vulnerability and called her independence into question. Thus, for the relationship to be therapeutic and nursing practice to be effective in addressing the woman's health and healing needs, the relational space for this contextual understanding needed to be created. However, the story also highlights how personal and contextual elements (eg, a nurse's sense of responsibility, feeling obligated to another waiting patient, the normative values of healthcare culture) shape what happens in any nursing moment and how the pressures of competing demands and values can lead to certain things being privileged over others (eg, privileging treatment and procedures over the promotion of health and healing). The story also draws attention to the competing obligations that nurses may face as they try to "do good" within the competing values, demands, and expectations. The nurse in the story was obligated to both patients—yet attending to one meant not immediately fulfilling her promise to the other. At the same time, emergency department norms pressurized her to function in certain ways.

As nurses, we are obligated to ensure that our nursing actions promote health and healing, are ethical, and are safe. However, determining what actually constitutes "ethical," "safe," and "health/healing promoting" practices, in particular situations, can be challenging because the specific behaviors and responses are arrived at in the particularities of the relational moment—as we engage with, and respond to, specific patients in particular situations. For example, promoting the health and healing of the elderly woman in the above story required that the nurse create the relational space for the woman to reach the "outcome" that she was able to continue to function independently in her life. In contrast, as a patient in the next cubicle, the nurse's pleasant demeanor and dressing application were sufficient to address my health and healing needs.

RELATIONSHIPS, ETHICS, AND NURSING OBLIGATIONS

Nursing obligations are the site where the integral connection between responsive relationships and ethical practice comes to the foreground. Peter and Liaschenko highlight that proximity to others is one way that nurses understand what their obligations are. "Proximity beckons moral agents to act, and therefore has an impact on moral responsiveness."[11(p219)]

Armstrong describes that the concept of obligation "runs deep in contemporary western society"[7(p115)] and has dominated much of existing ethical theory and practice. Subsequently, obligation-based ethics (eg, principle approaching grounded in consequentialism and/or deontology) have been popular within nursing and remain so.[7] Within the philosophical and ethical literature, obligations have been conceptualized as external to the person[7] and most often are articulated in the form of codes or principles such as the obligations of beneficence, autonomy, and justice. As externally derived and sanctioned entities, obligations in the form of codes are expected to reinforce professional and societal values and give coherence to professional behavior by disclosing the profession's values and duties.[12] The norms included in codes are determined by the nursing philosophy of a

particular country, and at the same time are influenced by the moral problems nurses face in their everyday work.[13]

One of the main criticisms of existing conceptualizations of obligation-based ethics and the principles/codes that arise from them is that they usually present overly simplistic understandings of ethical practice. For example, obligation-based ethics focus on right and wrong action[7] and theoretically assume that there is a definitive "right" response to a situation.[12] At the same time, as implying that a right answer and/or response can be determined, most existing codes that express nursing obligations do not discuss how nurses might actually enact their ethical obligations in their everyday practice.[7,12,14,15] Codes are usually confined to idealistic prescriptions that neither explain how the concepts relate to actual practice nor provide guidance for particular nurses in particular relational moments.[12] Furthermore, within extant liberal orientations, codes of ethics tend to promote the values of individualism. In the US and Canadian contexts respectively, Bekemeier and Butterfield[16] and Kirkham and Browne[17] argue that codes of ethics encourage us to presume that western societies are essentially egalitarian, and while we are directed to be aware of broader social issues, we are not committed by our professional values to action.

OBLIGATIONS AS EXTERNAL ENTITIES

At the same time that existing conceptualizations of nursing obligations have been criticized for not offering practical direction, the conceptualization of obligation as an external and universal entity has been criticized for failing to address important features that shape ethical practice including context, historical changes, culture, character, and relationship.[12] In not addressing these features, obligation-based ethics cover over certain types of questions that are integral to everyday nursing practice and may also disguise the lack of agreement about values that dominate nursing situations.[12] For example, Provis and Stack describe how caring work is ripe with conflicting obligations and how the interface of personal and organizational obligations can cause uncertainty about what is the "right thing to do" when these obligations run counter to each other.[18(p6)] They offer the example of a caregiver who, interpreting her use of bath towels through the values and norms of the organization, worried that she was being "extravagant." "You're always told how much it costs for linen and that sort of thing... I like to put an extra towel over their shoulders to keep them warm while I dry them with the other towel, so that may not be cost conscious." Even in the smallest moments, various obligations pull us in different directions. Yet obligation-based ethics do not address what happens when nurses are obligated in conflicting ways, when, for example, their obligations to different patients are in tension and/or when their obligation to their organization is at odds with the obligations they feel to patients.

Interestingly, Pattison highlights that although obligation-based ethics and, in particular, ethical codes rest on the assumption of the "thoughtful, autonomous 'ethical' practitioner who possesses independent critical judgment, practical wisdom, and the capacity to act responsibly and with regard to the hinterland of wider human values and principles,"[14(p7)] codes of obligation may actually militate against the emergence and survival of such practitioners. For example, following a review of "the inherent ethical defects of a number of codes," Pattison concluded that codes may "do little to develop or support the active independent critical judgement and discernment... (and) may, in fact, be in danger of engendering confusion, passivity, apathy and even immorality."[14(p8)] Indeed, in our teaching of ethics, despite our attempts to support enactment of all values simultaneously, nursing students (both new to nursing and experienced nurses) using Codes often revert to a "pick 1 value" mentality, wherein they use 1 value (eg, such as one related to autonomy) to override other values,

and support their chosen direction rather than guide their choices. Similarly, research has highlighted how viewing ethics and obligation, as something that is rationally determined outside of one's own practice, can lead to confusion and inaction.[19,20] Nurses have not been alone in articulating the limitations of existing conceptualizations of obligation. Within the broader field of philosophy, writers offer criticisms and alternative conceptualizations. In particular, Caputo[21,22] addresses the need for an understanding of obligation that raises questions rather than prescribes answers, opens space for the complexity and difficulty of ethical decision-making, and offers direction for how ethics and "good" relationships might be lived within the challenges of everyday life. Caputo's reframing of obligation has informed our view of obligations and relationships in nursing.

REFRAMING OBLIGATION

Bauman[23] describes that within philosophy, ethics has been dominated by a modernist approach to the search for truth that has focused on looking for absolutes and universals of morality. According to Bauman,[23] modern thinkers believed that rather than being a natural trait of human life, morality was something that needed to be created and injected into human conduct. Obligation, conceptualized through this universal perspective, resulted in a decontextual, depersonalized understanding of obligation. It also resulted in ethical challenges being responded to through normative regulation.[23] In contrast, Caputo's[21] discussion locates obligation and ethics in the relational moment, for example, in the moment when a nurse finds him or herself in the midst of people, contexts, and multiple, competing demands. Drawing on deconstructive hermeneutics, Caputo calls for a way of understanding and responding to obligations that entails both interpretation and deconstruction.

In contrast to the understanding of obligations as something external to the person, Caputo contends that obligations are local events—they are matters of flesh and blood. According to Caputo, obligation is the feeling that comes over us in very binding ways when others need our help or support and we feel bound to respond. "When I feel obliged something demands my response. It is not a matter of working through a set of principles to conclude whether one is obliged."[21(p22)] Caputo asks, "Does one really 'conc lude' that one is obliged, or does one not just find oneself obliged, without so much as having been consulted or asked for one's consent?" Caputo's description echoes the experience of the nurse of the emergency department in the above story. Although the nurse initially attempted to extricate herself from the situation, she ultimately felt bound to listen to, and create the relational space for, the elderly woman to "do her healing."

While one may find one's self obliged, one's personal values and contextual constraints may mute the sensing of those obligations. For example, initially the emergency department nurse in the above example seemed more "bound" by her obligation to the organizational norms. Similarly, how the nurse values elderly persons will shape her sense of her obligations in this case. What if the elderly woman had been, for example, intoxicated? Would the nurse's sense of obligation and her actions change? Should they change? This example highlights how determining our obligation to particular patients in particular moments of relationship involves looking carefully at our own responses, "thinking hard"[7(p115)] about the nursing values and obligations to which we are committed, and inquiring into the particularities of the moment and the various elements that are shaping that moment to ensure that our relational goals and behaviors are aligned with the nursing values and obligations we espouse. "Thinking hard" includes thinking about our own biases and to whom we are obligated. It is our contention that nurses are obligated to all persons, most immediately on an individual basis to all those within their care, but also collectively to those who require their care. Thus, a

relational conception of obligation applied to nursing relationships suggests that new conceptualizations of nursing obligations and relationships are required.

BRINGING A RELATIONAL INQUIRY LENS TO RELATIONSHIPS

Although existing conceptualizations of relationships that emphasize concepts such as respect, trust, and mutuality offer a good starting point for therapeutic relationships, a relational inquiry lens expands the understanding and thereby the potential of relationships. This inquiry lens highlights that enhancing nurse-patient relationships requires more than individual nurses taking up caring attitudes or presencing behaviors. In contrast to a decontextual view of relationships that considers the nurse to be an autonomous agent who exercises free and intentional choice, relational inquiry foregrounds the way in which personal and contextual forces shape both nurses' and patients' capacities for relational connection and thereby health and healing. Relational inquiry involves a reflexive process where one is always assuming and looking for the ways in which people, situations, contexts, environments, and processes are integrally connecting and shaping each other. This inquiry process rests on the assumption that people are contextual beings who exist in relation with others and with social, cultural, political, and historical processes. Within this contextual existence, each person has a unique personal, sociohistorical location that affects and shapes that person's identity, experience, interpretations, and way of being in the world. It is assumed that the values, knowledge, attitudes, practices, and structures that dominate the sociocultural world within each person's life are passed on through relational interactions. Subsequently, people's experiences, interpretations, and actions are products of a multitude of relational interactions and processes. In this way, people are both shaped by and shape other people's responses, situations, experiences, and contexts. Not only nurses, but patients, their families, other healthcare providers, and actors beyond the immediate healthcare context such as policy makers and the media, continuously negotiate and shape one another. Nursing practice as a process of inquiry focuses on the question "How might I most responsively and effectively be in relation to promote health and healing?"[24]

Using this inquiry lens, relationships among people are viewed as sites, opportunities, and/or vehicles for meaningful experience and response. It is possible to be in a relationship with another person without practicing responsively in the sense we are discussing. For example, one can enter into a relationship in ways that distance or objectify people ("the GI bleeding in room 8"; "at risk youth"), as is the case in many healthcare relationships. Thus, there is an important distinction between relationships that are determined and regulated primarily by the adoption of dominant social customs and practices, and relationships that are purposefully shaped through a relational inquiry where one consciously chooses within the apparent possibilities for action, or even works to create new possibilities. Overall, a relational inquiry directs a more in-depth look at the values, experiences, goals, and concerns shaping action within particular moments of practice and a conscious consideration of possibilities and intentional, responsive action.

The significance of context

Relational inquiry requires that we move beyond the surface(s) of people, situations, and relationships—beyond the "iceberg" pattern of interaction where a substantial portion of the elements shaping the interaction is unseen and/or ignored. For example, the iceberg pattern of relationship may include a nurse engaging with a smiling, friendly demeanor while going about the tasks of morning care, yet never really connecting with the patient in a meaningful way to inquire into what the patient is experiencing. Although a friendly,

cheerful demeanor can certainly be responsive, it may also serve as a veneer that at best covers over and at worst does not allow space for people to be themselves, express their experience, and/or reveal what is particularly salient. A cheerful smile and a friendly demeanor can be used to effectively dismiss a patient's request for care that a nurse does not feel he or she has time to provide.

Particular contexts contribute to this iceberg pattern of relationship because the normative patterning within those contexts cues certain behaviors and responses. For example, healthcare contexts contain strong messages about what is and is not of importance. The business-driven, economic, cost-efficient values combined with the devaluing of nurses for being "too emotional" or "too involved" offer strong pressure to pattern one's actions in ways that enable the organization to work.[7] Similarly, the intricate combination of conflicting values, goals, and desires that the particular nurse brings to the relationship can serve to contribute to the iceberg pattern of interaction. For example, if a patient is in pain, the situation is ambiguous and/or there is no clear-cut best way to respond, nurses may pull back as a result of their own vulnerability and uncertainty.[25] Being unable to "make it better" or "stop the tears," nurses might focus their attention on other more controllable and concrete tasks. Or, as a result of the combination of practicing within a service model, "fix-it" culture, and their own compassionate desire to alleviate suffering, nurses may take up the treatment-cure values and goals, and shape their relationships with patients accordingly. A nurse may focus on a laceration rather than the lacerated person. Feeling a sense of responsibility and a desire to "help," they may attempt to use relationships as a means to an end: to do, to treat and fix the patient, or to meet the needs of the organization.[2,8] Within these dynamics, nurses may be inclined to distance themselves from situations that they see as "unfixable"—such as people who under liberal ideology are seen as creating their own suffering, people with addictions, people in poverty, women in abusive relationships, and so on. Relational inquiry requires us to look beyond the tip of the iceberg when engaging with patients because, whether nurses are aware of the influence of contextual and personal elements or not and whether nurses attend to them or not, those elements shape the health and healing experience.[24,26]

RELATIONAL INQUIRY AND NURSING OBLIGATIONS

Such an inquiry process is underpinned by 3 nursing obligations, all of which are predicated on the overarching obligation to all persons, regardless of their circumstances or characteristics. These include the obligation (*a*) to be reflexive and intentional, (*b*) to open the relational space for difficulty, and (*c*) to act at all levels to effect the potential for health and healing. Although for the purpose of discussion, we separate these 3 obligations, it is important to emphasize that not only do these obligations overlap and complement each other but they form a synergistic whole. For example, being reflexive and intentional provides the access to and a way of being in difficulty. Similarly, acting at all levels affects the contextual and personal factors that impede reflexive and intentional practice and so forth.

The obligation to be reflexive and intentional

Nortvedt contends that "*relationship itself* is a source of special responsibilities and professional qualities."[9(p116)] Through relationships, nurses see patients' needs and interests as particular reasons to act.[9] However, seeing patients' needs and interests as particular reasons to act requires conscious and intentional participation and, as we have argued, involves looking beyond the surface of people and situations. For example, in the story above, the nurse did not initially respond to the elderly lady's need to tell the story of her fall. Furthermore, looking beyond the surface requires looking critically through the veil

created by biases (such as ageism), structures (such as how healthcare is organized), and ideologies (such as individual responsibility).

Similar to Walker's[27] description of moral oblivion where there is a lack of awareness of the moral demands that are being made, when nurses are oblivious to the relational elements (eg, the personal and contextual elements) shaping their decisions and actions, they are more likely to be at the mercy of those influences, and thereby less likely to exercise their clinical judgment effectively. That is, they are more likely to be practicing *in relational oblivion*. Practicing without such awareness impacts nursing care in a very practical way and ultimately makes meeting nursing obligations all but impossible.

As Provis and Stack[18] report, sensitivity and compassion are often at odds with organizational directives. Nurses increasingly find themselves rationing their care in ways that marginalize meaningful relational engagement.[9,28] Nortvedt contends that what is often central to nursing practice is not how to give the best care for one's patients but how to minimize harm to patients created by sociocontextual circumstances. For the emergency department nurse, apparently it was her felt sense of obligation that overrode the competing demands of a patient in the next cubicle and the organizational press to treat the physical injuries of patients quickly and efficiently. And, this obligation sparked the nurse to reflexively consider her options and intentionally decide to create the relational space for the woman to tell her story. As Bauman has described, "when competing moral demands arise in the moment, it is the moral self which feels, moves and acts within the context of that ambiguity."[23(p34)]

In essence, Caputo's[21] deconstructive hermeneutic approach to obligation requires nurses to be humanly involved and interpreting, yet simultaneously critically analyzing, and at times deconstructing the values, structures, and processes that are constraining ethical nursing responsiveness. This reflexive process requires acknowledgment of the ambiguity of relationships, ethics, and nursing care. Moving beyond both prescriptive regulation and personal interpretation, it involves the nurse "activating herself as a knowledgeable practitioner"[29(p255)] to critically examine the values, goals, and intents shaping the nursing moment and ultimately relationships. It involves using not only knowledge and information but also practical judgment, and approximates what Aristotle termed *phronesis*.[22,30]

Simply put, reflexivity enlists the moral self and simultaneously enlists nursing knowledge, experience, and judgment. In so doing, reflexive inquiry moves nurses to look at both what they are doing and how they are doing it. It creates the space for a self-conscious consideration of the relational means and ends and consideration of how nurses are conserving, renewing, inventing, and/or changing these means and ends. For example, a nurse might more consciously weigh conserving towels in relation to conserving warmth and comfort of her patients and in relation to the consequences of providing (or not) such comfort. As such, relationships are enhanced through a reflexive process of intention, attention, interpretation, critical scrutiny, and reconstruction. That is, relational practice involves a conscious intent to act toward the espoused values and goals of nursing, attention to the particularities of people and situations, a critical consideration of one's own and others' interpretations, and very often a reconstruction of decisions, actions, and norms that may be at odds with the values and goals of nursing.

The obligation to open relational space for difficulty

As nurses respond to their obligation to be reflexive and intentional, they simultaneously find themselves obligated to "be in difficulty." As they look beyond the surface of relational encounters and begin to see people and situations through a relational lens, they find themselves in close proximity to and/or experiencing the inherent difficulties of health and healing situations. For example, they may

come into closer proximity with suffering, uncertainty, and/or conflict. Similarly, they may find themselves experiencing intense emotional responses—both their own and of others. Caputo describes the challenge of being in the abyss of difficulty and the suffering that is part of that experience. He describes this difficulty and suffering as something that "humbles us, brings us up short, stops us in our tracks. . . something which both strikes us down and draws us near."[21(p275)] At the same time, Caputo contends that within the abyss of difficulty

> There is suffering and there is suffering. Short-term suffering may easily belong to long-term flourishing, to a larger economy of pain and suffering which is understood by anyone who understands the economy of life itself. To spare others pain, and hard work and suffering may easily mean to spare them everything that gives their life worth and a greater long-term felicity.[22(p29)]

It is for this reason that Caputo argues for the importance of being in difficulty as it presents itself and of entering the abyss of difficulty and suffering not to succumb or surrender but to be "instructed by the abyss, to let the abyss be, to let it play itself out."[21(p278)] It is only by opening the relational space to be in the difficulty that one is able to move beyond breaking down or detaching.[31]

Along a similar vein, Mitchell and Bunkers[32] argue that the danger to nurses is not in witnessing difficulty and suffering but rather in turning away when suffering appears. In contrast to others who have argued that experiencing suffering and difficulty over time may lead to what is discussed in nursing literature variously as "burn out," "care giver fatigue,"[33–35] or in the case of violence, vicarious trauma,[36–38] these authors support Caputo's contention that if one enters into nursing situations without the need to fix or make the difficulty/suffering better but rather to open, be in, witness and be instructed by it, the difficulty/suffering can be a pathway toward meeting the relational obligations to both our patients and ourselves.

Nursing has long focused on suffering, at both an individual and a social levels. Yet within the neoliberal dominance of western thinking, where individualism is central and biomedicine powerful, suffering that arises from physical pathology has received greater attention. Our obligation to be in the difficulty also extends to examining and acting on suffering, as it arises through relational dynamics. To return again to the situation of the elderly woman with the laceration, the example illustrates how understanding the way institutional power operates to limit the nurse's time to attend to the woman's needs allows the nurse to work against these dynamics to alleviate, rather than be complicit with or further suffering. Furthermore, the nurse can inquire as to how other social forces, such as ageism or poverty or gender, might be operating in this woman's life to foster suffering and might be operating to shape the nurse's own sense of her obligations and her actions.

Difficulty and/or our experience of suffering is not separate from who we are—from our own interpretive frames and the interpretive frames that dominate the larger social world in which we live and practice.[31] How we understand any situation and how we define it and attend to it are subject to our individual and collective understandings and interpretations, and the systems that shape these understandings/interpretations. There is a tendency to think of difficulty and suffering as something negative and as something to be avoided. However, difficulty is at the heart of ethically responsive nursing care. Framing difficulty as an inherent feature of nursing relationships paves the way, not only for more ethical but also for more effective and efficient nursing relationships. For example, the emergency department nurse in the story above reflexively and intentionally created the relational space for the difficulty within the situation to "play itself out" (eg, she opened the space for the woman's fear, vulnerability, and the nurse's own competing obligations to come into relation) and in a matter of 2–3 minutes she not only supported the woman's health and healing but also

responded to her own feelings and needs by making a nursing decision to provide the care she felt was required. Thus, she was able to conclude the encounter with her identity as an ethical "good" nurse intact.[8]

Understanding "difficulty and suffering" as windows into meaningful relationships and as the base for ethical decision-making and responsive nursing care creates the relational space for nurses to better understand multiple and competing obligations, goals, and perspectives, to raise questions and inquire into the particularities of each situation and ultimately develop the clarity and courage to act in health-promoting ways.

The obligation to act at all levels to effect health and healing

Bergum contends that attention to relationship as an ethical endeavor has a way of dismantling the distinctions of different levels of care. "...what happens at the bedside is not cut off from the broader levels, but is part and parcel of the same system."[8(p487)] Because each nursing moment is shaped by our own actions, by the actions and responses of others, and by the contexts within which we work, relational practice involves the nursing obligation to act at all levels including the intrapersonal, interpersonal, and contextual levels. Developing relational nursing practice requires that we continually think through not only what it is we are doing, but also what it is that is shaping and influencing what we are doing. At the same time, it requires that we closely examine how we are responding in particular situations and intentionally act toward nursing values, goals, and obligations.

The emergency department story highlights how relational action is required at all levels. Although the nurse was able to act both intrapersonally (reflexively questioned herself and her options) and interpersonally (responded to the woman's need to tell her story) to affect the situation and possibly prevent similar situations in the future, action at the organizational level is required. For example, the policy that people are seen according to medical priority may not adequately address the needs of elderly patients. To assume that it is equitable to treat a 20-year-old in good health and an 80-year-old in frail health the same in terms of waiting time is not health promoting.

The nursing obligation to act at all levels requires accepting that we cannot control all conditions of practice and at the same time not abandoning the attempt to exert influence. Walker argues, "our thinking about responsibility must encompass the reality that our impact on the world and each other *characteristically* exceeds our control and foresight."[27(p15)] As Walker notes, our "potent but blinkered agency" requires considerable efforts and skill to achieve the understanding required to fulfill our obligations adequately. Neither fatalistic acceptance of the wider conditions of practice nor naïve under-appreciation of the power of those conditions will be an adequate basis for meaningful action.

Overall, the nursing obligation to act at all levels rests on the understanding that relational concepts such as respect, trust, mutuality, and presencing require and in many ways can be enacted only through action at all levels. For example, to enact trust—to be trustworthy requires action at all levels. Potter[39] describes a trustworthy person as someone who can be counted on to take care of those things that others entrust to that person. An interesting distinction that Selman[40] makes when examining the concept of trust is the distinction between trusting nurses as individual people, and trusting them as representatives of nursing and of an institution. From a relational practice perspective, this distinction is an important one. Provis and Stack[18] point out that given the nature of healthcare situations, patients, in their vulnerability and need, are left with little choice when it comes to having to put their trust in nurses. For example, when they present at an emergency department with a deep laceration that needs suturing, patients have no choice but to stay and wait to get stitched up and to put their trust in the nurses. Yet, as the emergency

department story depicts, in many cases there may be a conflict between what a patient ultimately needs and what the institutional policies direct. It is at this disjuncture between individual and institutional levels of action where "the difficulty" of enacting trust and of being trustworthy also arises for nurses and where it becomes evident that the enactment of trust necessitates action at all levels. For example, if the way in which patient care is organized does not allow for nursing practice that is adequate to address the healthcare needs of patients, as was the case for the elderly woman with the laceration, how do nurses meet the nursing obligation to be trustworthy without addressing the organizational constraints? If healthcare institutions are truly about promoting health and healing, nurses' obligations/trustworthiness as individuals and as representatives of nursing and a particular institution need to be aligned. Thus, the nursing obligations to be trustworthy and "take care" of those things with which patients are entrusting nurses ultimately means that nurses are obliged to attend to issues of workload, acuity, organizational policy, availability of resources, and so on.

As Walker[27] describes, at the larger contextual level it is imperative to create active, accessible moral-reflective spaces so that ongoing inquiry and deliberation takes place. Close "relational" inspection of the contexts of practice may reveal how "good practice" is constrained. In a recent study we conducted with nurses in different practice settings, the fact that unmanageable workloads and high patient acuity made good practice very difficult took most of the nurses' attention, and overshadowed ideas about possible actions the nurses might take. In one setting, the nurses initially focused almost exclusively upon how their manager made "good practice" more difficult, for example, making decisions without consulting the nursing staff led to less effective care. Changing a certain kind of intravenous tubing, a seemingly small decision, led to lengthy delays for patients and increased the nurses' workload unnecessarily. The level of frustration and anger with the manager initially overshadowed examination of other influences on practice.—For example, how relationships among the nurses themselves might have contributed to an unsupportive work environment and ironically to confrontational relationships within which the manager was increasingly reluctant to consult with staff. Thus, looking critically at the context of practice *involves looking at* not only *wider influences, but also how we ourselves practice in relation to those influences*.

CONCLUSION

Nortvedt describes that several philosophers have elucidated how relational proximity and the face-to-face encounter generate particular kinds of moral responsibilities. Encounters with vulnerability, pain, and suffering compel a response. "To encounter a patient's pain or the worries of a relative is to be addressed morally."[9(p117)] Although the close proximity of nurse-patient relationships may serve to "address us morally" and heighten the feeling of obligation, Bauman[23] argues that proximity to others can also lead to a mixture of ambiguous responses. On one hand, proximity is what calls us to action, what compels us to help. At the same time, such proximity can overwhelm and spark the flight response. Nursing relationships and the enactment of nursing values and goals in contemporary healthcare contexts are incredibly challenging. Thus, an understanding of relationships that turns attention to the connection between attitudes, intentions, judgment, and action—one that connects responsibilities, roles, and identities to relationships—is required.[41] Such an understanding highlights not only our obligations but the ways we might better meet these obligations. By looking beyond the surface of one-to-one encounters, by considering what shapes those encounters—nurses and patients, colleagues and contexts, we can act more intentionally and direct our actions in ways that foster trust, respect, compassion, and mutuality in contexts as well as in ourselves and with others.

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