Mindful Attentiveness:

Rekindling the Nurse–Patient Relationship

BY CAROLINE PORR

A nurse's gaze upon a patient's face can be characterized as intentional and selfless, achieving connection and relationship. Or that gaze can mirror a dismissive glance that sabotages the foundation for discourse and caring interaction. The gaze upon another's face, a familiar everyday occurrence, carries poignant significance after the illness and death of a family member. I recall watching for those moments during which nurses purposely directed their gaze toward the face of my loved one. I also recall recoiling with disappointment when nursing routines permitted a mere glance. Nurses' casual glances discounted value and closed the window of opportunity for relationship.

What has happened to our profession's legacy as a humanly involved process of relational practice (Doane, 2002)? What insights can be gleaned from nursing literature about the nurse–patient relationship?

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THE NURSE–PATIENT RELATIONSHIP

Conceptualization of the nurse–patient relationship began with Peplau (1952/1988) and was expanded by interactional nurse theorists (King, 1981; Paterson & Zderad, 1988; Travelbee, 1971). Peplau's (1989) Interpersonal Relations in Nursing theory focuses attention on the critical therapeutic value of the nurse–patient encounter. Her collaborative,

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capacity-building interpersonal process includes "presencing" with patients to address unique health needs effectively.

Due to the preeminence of biomedical science and technology, clinical practice gradually underwent a shift in emphasis from interpersonal competence to the quest for enhanced skill performance and technological expertise (Dekeyser & Medoff-Cooper, 2004). Consequently, the teaching–learning of therapeutic relationships was replaced by a skills-based, stimulus–response approach. Rather than teach students to attend fully to the patient to find ways to come to know him or her and act accordingly, instructors were training nursing students how to interact with patients using learned behaviors to convey understanding of health/illness experiences.

Morse (1991) challenged what she referenced as an oversimplification of empathy and other concepts relevant to the nurse–patient relationship, to mere communication techniques and rote imitation. Nursing students were insulated from emotional involvement that enables enriched insights into client suffering and effective therapeutic engagement (Morse, Bottorff, Anderson, O'Brien, & Solberg, 1992).

The mechanistic, habitual approach to relationship training and the absence of meaningful relational connection correlated with diminishing nurse–patient interaction at the bedside (Jarrett & Payne, 1995). Based on May's (1990) review of the literature, the nurse–patient exchange was predominantly superficial, task oriented, and perfunctory. Nurses seemed to purposely avoid relational depth by not delving into psychosocial issues. According to Morse's (1991) *Negotiating the Relationship* theory, these relationship descriptors are characteristic of professional detachment. Professional detachment is a mode of relating used by nurses during what Morse termed the clinical relationship, which occurs when the patient requires only routine care and the nurse is seemingly less committed. In contrast, the connected and therapeutic relationship encompasses a higher level of nurse involvement and intensity.

FOSTERING A CARE ETHIC

Doane (2002) also questions the emphasis in nursing curricula on the acquisition of behavioral communication skills for building relational capacity because they "not only fail to include essential elements of the human relational process, but override nurses' spontaneous ability to be in caring human relationships" (pp. 400–401). She strives for an "awakening of the heart" in nursing students, which she believes will diminish the propensity for habitual, routine patterns of interaction with patients. When encouraged to be real and acknowledge their feelings, nurses are simultaneously more supportive and experience the spark of human caring (Doane & Varcoe, 2005). Caring is identified by nurse theorists Newman (1994), Leininger (1984), Watson (1988), and Boykin and Schoenhofer (1993) as the essence of nursing.

Whereas some may view competence in terms of skill proficiency, hospital administrators cite caring as the core of quality nursing services (Niven & Scott, 2003). Practice literature shows a resurgence of interest in relationship for the expression of care constructs such as empathy, sympathy, compassion, and trust. Kendrick and Robinson (2002) claim Western nursing encompasses tender loving care through "beneficent attending" as the primary objective of caring engagement (p. 291). The ethic of loving care is echoed by Watson (2003) as the foundation and vital component of engagement in healing practice and compassionate service. Caring science researchers recommend that the discipline commit to making warmth and genuine engagement in caring a sense of duty (Helin & Lindstrom, 2003).

INSTRUMENTAL NURSE–PATIENT PARTNERSHIPS

Government leaders and representatives, professional nursing bodies, and administrators also depend on high-quality nurse–patient relationships. Interpersonal models advocating *partnerships* with shared decision making (Bull, Hanssen, & Gross, 2000), empowerment (Brown, McWilliam, & Ward-Griffin, 2006; Oudshoorn, 2005), and negotiation (Trnobranski, 1994) have been endorsed and analyzed across the healthcare arena.

Growing fiscal constraints have exerted pressure on healthcare systems to deliver accessible and appropriate services at an affordable cost and meet

consumer demands. As partnership models enhance patient involvement and accountability, they also serve as a strategy to achieve cost-reduction targets. Relationships with providers are recognized as the vehicle through which patients can access the knowledge and skills for decision making and assume greater responsibility for their healthcare.

Mutuality has been introduced as another consumer-based, interaction style of relating in which nurses and patients work together to achieve mutually defined goals. Ostensibly, providers are to establish mutually satisfactory partnerships with their patients, who in turn become better consumers and more active in their care (Henderson, 2006; Henson, 1997).

ENACTING MORAL PRACTICE

Nevertheless, the nurse's ability to form a therapeutic relationship is deemed the most significant dimension of nursing practice and quality of care (Canadian Nurses Association, 2007; Potter & Perry, 2007). Patients continue to view the nurse–patient relationship as key to their healing and recovery and lament the loss of this essential contact with nurses (Shattell, 2005). Nurses bemoan diminishing patient contact. In fact, the ever-increasing relational distance is correlated with professional moral distress (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005).

Ethics justify the principles, norms, or codes of professional conduct. That is, ethics substantiate what ought to be done. Many argue that adhering to codes of conduct is not enough to meet patient suffering, protect vulnerabilities, and return healthcare services delivery to humane patient-centered care (Bergum & Dosseter, 2005; Helin & Lindstrom, 2003). Stressful work environments and inadequate resources demand both an ethical and a *moral* practice ethos. The nurse's professional decision to assist her patient is more accurately regarded as a moral act in response to a moral concern and a moral imperative (Henderson, 2001; Tarlier, 2004).

How do we actualize mindful attentiveness of the other under the stressful constraints of chaotic working conditions?

Trnobranki (1994) claims there is dissonance between administrative and policy level expectations for collaboration and empowerment-forming relationships and the *reality* of interpersonal dynamics in acute care settings. Indeed, cost-driven, technocratic care environments have meant less time to establish relationships and a deemphasis on interpersonal competence (Benner, 1998; Davis, 2001; McCabe, 2004). The groundwork research to offer insights into the process by which the healthcare provider and patient work together has been lacking. This void may contribute to misconceptions, specifically that the mere existence of the nurse–patient dyad constitutes a partnership.

Despite the barriers to relationship and moral practice, nurses still can make a meaningful connection. It is vital that nurses put forth the necessary efforts to engage morally with those entrusted to their care (Hagerty & Patusky, 2003). Bergum and Dosseter (2005) advise nurses to adopt a relational ethics approach ensuring that moral values (e.g., nonmaleficence, beneficence, autonomy, justice), upon which ethical principles are based, exert an impact on practice because they are placed within the "context of intricate, close-up relationships" (p. 104). The relational ethics approach highlights the critical nature and significance of nursing's fiduciary relationship for ethical and moral practice. The nurse–patient relationship under the auspices of the relational ethics approach is termed *relational engagement,* and is about *mindful attentiveness of the other.*

How do we actualize mindful attentiveness under the stressful constraints of chaotic working conditions? What is the source and essence of our moral resolve? As Christian nurses, we can rely on the amazing strength of Christ when we are too humanly tired to extend one more selfless embrace (Philippians 4:13). It is *his* love, care, and compassion—the benchmarks of our moral practice ethos—that we seek to emulate. We can trust God to supply our every need, and his promise to uphold us (Psalms 10:17, Ephesians 3:16; Hebrews 13:5).

MINDFUL ATTENTIVENESS

The practice literature bears witness that the interpersonal relationship between nurse and patient is an integral component of healthcare services delivery. Notwithstanding, as Christian nurses, can we intentionally and selflessly gaze upon the faces of our patients without Christ at our side? Can we alone ensure that compassion and concern are embedded within our

gaze, enabling us to see wide eyes, trembling lips, and forbidding frowns? Or might we extend only a fleeting glance in abdication of responsibility for what we may see? How do we mitigate against exploitation of this simple yet symbolic gesture so as not to neglect those in our care, especially when we are performing nursing work in formidable trenches?

We can look to Jesus who gazed with compassion and helped those in need (Matthew 9:36, 14:14; Mark 6:34), even while suffering on the cross (John 19:25-27). Scripture shows us the critical importance of God *looking* upon people, bringing favor (Lick, 2008), and we must do the same. We can seek help from the Holy Spirit, whom Jesus promised would teach and empower us (John 14:16-17, 26, 16:13-15).

We also can draw inspiration from Florence Nightingale (1820–1910), who sought the divine wisdom, will, and power of her Heavenly Father. Imagine Nightingale with lamp in hand in the midst of gruesome war conditions. Through dim light, she strains in selfless gaze upon each patient's face to comprehend the uniqueness and carefully identify every nuance. Nightingale bids the face to speak and, armed with sacrificial resolve beyond human understanding, is able to respond, serve, and meet every need. Her dedication to those in her care is reflected in her comment: "God's precious gift of life is often literally placed in her hands" (Nightingale, 1969, p. 126).

A renewed embrace of such a high calling will facilitate and enable *our* mindful attentiveness of the other and in so doing, ensure that we establish authentic, meaningful, caring relationships. With God's help, we can offer effective, healing nurse–patient relationships.

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