Original Article

Factors Involved in Praxis in Nursing Practice: A Qualitative Study

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Abstract

Introduction: Praxis is a process of applying knowledge in nursing practice to advance emancipatory goals in society and in the world and to eliminate any injustice and discrimination in care. Praxis requires the coherent application of patterns of knowing in nursing practice; however, understanding nursing knowledge is complex and using experiential knowledge alone cannot help us achieve it. The aim of this study was to determine the factors involved in praxis in nursing practice.
Methods: The method adopted was qualitative. The researcher interviewed 19 nurses and attended eight observation sessions in different hospital departments. The findings were analyzed using conventional content analysis.
Results: Findings from analyzing interviews and observations indicated that desirable and humanistic attributes and effective nurse-patient communication are facilitators of praxis. In contrast, prejudice, occupational barriers, negative thoughts, and discriminatory beliefs are barriers of praxis in nursing practice.
Conclusion: If we consider praxis as the simultaneous application of all patterns of knowing alongside efforts to create social justice, factors that drive nurse performance toward social justice, facilitate praxis, and factors that contribute to varied degrees of discrimination and injustice, inhibit praxis. By identifying these factors, nurses may identify and eliminate social justice barriers to care.

Introduction

Nursing practice refers to the professional behavior of experienced nurses. However, the theory-free practice cannot produce fully sophisticated, desirable care in the complex field of nursing. Theory and practice have a mutually supportive effect on each other and can be gained when they are both developed and considered.[1]

The goal of caring affects the performance of nurses and their decisions. Caring describes terms such as "worrying about", "valuing", "protecting", "taking responsibility for" and "giving help to help-seeker", which are characteristics of nursing care behaviors. Caring is the primary goal of nursing practice, which is to centralize nurses' thoughts and behaviors, to value others, and to help them.[2] Watson, of course, believes that nursing care is of an intangible, intrinsic, and highly subjective nature, but when non-caring behaviors emerge, it will pose a significant threat to the quality of health care.[3]

Chinn and Kramer[4] have introduced the "Model for Knowing and Knowledge Development" as an explanation of how nursing knowledge development is integrated with performance. This model is based on Carper's four fundamental patterns of knowing, including the empirical, aesthetic, personal and ethical patterns,[5] to which the later pattern of emancipatory has been added. For Chinn and Kramer, knowledge and knowing through all patterns is an urgent need for effective nursing care, and wise action is likely when these patterns are integrated to support social justice. The word praxis is not just a fancy word for nursing practice. A nurse who executes orders and completely heals a wound is good and effective, but it is considered as a praxis when the nurse neutralizes any social inequality in health care services.[4]

The term praxis according to Cambridge online dictionary[6] means the process of using a theory or something that you have learned in a practical way. Praxis refers to practical human behavior that can be artistic, ethical, or political, but its central meaning is the application of knowledge in practice. Therefore, nursing is a form of praxis itself, because epistemological questions in praxis are among the essentials of nursing discipline. In general, the use of the phrase praxis has a

sense ranging from liberal to radical. In liberal expression, praxis is confined to reflecting one's views on his/her own performance, but in radical expression, praxis reflects his/her views on the world and in pursuit of liberation goals in society and in the world.[7]

According to Carr and Kemmis, praxis bridges the gap between theory and practice because performance cannot be considered without thinking and therefore assumptions such as "performance is separate from theory" are completely wrong.[8] Newman considers nursing praxis as a two-way process between patient and nurse aimed at helping the patient and caring for him/her. Praxis in artistic care is to establish relationships of compassion, trust, and sympathy, and to accept the risk associated with the patient, which the nurse considers the patient to be an integrated human being with an inherent ability to grow and recover.[9]

Thus, according to Chinn and Kramer's viewpoint when four patterns of knowing including ethical, personal, empirical and aesthetic patterns are integrated with emancipatory pattern, and the nursing practice is aimed at social justice, praxis and emancipation are achieved. In this process, emancipatory knowing is used as a lens for observing existing social injustices for which some steps can be taken with a reflective action to emancipatory change.[10] Emancipatory Nursing Praxis (ENP) refers to a middle range theory of social justice developed from a grounded theory study with implementing processes, including becoming, engaging, awakening and transforming. Emancipatory praxis helps nurses to understand social injustice.[11]

Patterns of knowing are interrelated and affected by one another, and their integration is an essential need for effective nursing care.[12] However, when the knowledge of each of the patterns is developed separately without coherence with the whole, it leads to uncritical acceptance, superficial interpretation, and relative use of the patterns of knowing which are called "patterns gone wild".[4] It refers to the dilemma created when some patterns have been used isolated from the others.[13] One prominent example of pattern's gone wild is the emphasis on empirical knowledge as the sole basis of evidence-based practice.[14] For this reason, it is argued that nursing care, if based solely on objective and genuine knowledge, may not be safe, and maybe of lower quality, and be disease-centered rather than person-centered.[15]

Nurses need to utilize innovative and transformative caring knowledge to apply praxis in nursing practice and seek health and wellbeing for the human integrity of their clients and thus need to develop the political, social, economic knowledge and body of nursing knowledge to apply them in nursing practice and provide advanced care.[16]

Emancipatory nursing praxis as a theory suggested by Chinn & Kramer provides a suitable framework that clarifies nurses' role to change current injustice in the society. Nurses as individuals who provide health services can engage in praxis in a deliberative and reflexive way.[11] Praxis promotes nurses to identify the sociopolitical factors dealing with social justice and wellness of the patients.[10]

Despite the importance of praxis in nursing practice, there seem to be few studies to have seriously considered it. In a hermeneutic phenomenology, the study found that, in order to form praxis in nursing practice, theory, research, and practice should be integrated with each other. Such caring is an effort to create a sacred and natural environment and compassion, and is a trust-based caring.[9] A review of the literature on the relationship between theory and praxis emphasizes the complexity of this relationship and states that until knowledge is transferred from classroom and university to clinical settings, the integration of theory and practice may not be achieved.[17]

Therefore, nursing literature acknowledges the importance of praxis in nursing practice, but few studies are related to its factors in nursing practice. Hence, the present study was conducted with the aim of identifying the factors involved in praxis in the nursing practice.

Materials and Methods
The main study was carried out from June 2018 to January 2020 in nine educational and three private hospitals in Tehran, capital city of Iran. Qualitative research is a kind of inquiry process for understanding and discovering a social or human problem in which the researcher makes a comprehensive, yet complex picture, analyzes the words, and provides precise details from the viewpoints of informant people and actually guides the study in its natural context.[18] Denzin & Lincoln[19] also believe that, qualitative research is an activity in the field which makes the world visible. Research in the natural context leads to an understanding of real sense or real interpretation of the phenomenon in terms of what it means to people.[20] The study used conventional content analysis that is a popular method for analysis in describing the content of a text or a phenomenon especially in social subjects.[21,22]

Using purposeful sampling, the participants interviewed included clinical nurses with different years of service from beginner with less than one year of clinical experience to 28 years of clinical experience. Observations were also made to complement the qualitative data on nursing practice in different wards of university and private hospitals. Sampling continued until data saturation was achieved.[22] Finally, 19 nurses including 12 females and 7 males between the ages of 23 to 54 were interviewed.[23,24] In this study, we used semi-structured in-depth interviews as well as observations.[24] For this purpose, 19 semi-structured in-depth interviews ranging from 50 to 128 minutes as well as 8 sessions of observation in burn, urology, emergency, internal, general ICU and Post-CCU wards with a duration of 2 to 8 hours and a mean of 5 hours were utilized. Usually, the first item of each interview was

"Describe a care situation where you used knowledge and thinking at the moment." Then, "How do you apply your knowledge in care of patients?" Subsequent questions were asked based on the participants' responses to explore factors involved in nursing practice. The researcher attempted to allow the interviewee to respond freely in the interview process and not to interfere with his or her views. At the end, the interviewee was asked to add any point that was not asked about, but might help the study. The interviews were recorded with the permission of the interviewee and then typed and transcribed.

On each session, observation of important events, including the manner of caring, nurse communication with the patient and his/her companion, and researcher interpretations of what was observed, were recorded.[22] The role of observer as participant has been used to engage the participants.[19] To this end, the researcher collaborated with the nurses in each ward to answer patient questions, educate patients based on the educational pamphlet available in the ward, obtain vital signs, assist with medication, blood glucose checks, and assist with patient transfers. Upon entering the ward, the researcher was faced with nurses' reactions for their sense of uneasiness and change in their behavior as a result of their awareness of observation, therefore the researcher tried to stay longer in the field to gain the trust of the nurses and prevent their change of behavior. During the observations, each question that came to the researcher's mind was asked in an open-ended manner, and field notes were taken. Data collection including interviews and observations continued until data saturation that was determined by completing categories and obtaining redundant data. Data collection including interviews and observations continued until data saturation that was determined by completing categories and obtaining redundant data. [25]

The present study has been reviewed and confirmed by Ethics Committee of Iran University of Medical Sciences with ethical code of IR.IUMS.FMD.REC.1396. To enter each hospital and ward, the aims of the study and the role of the researcher when observing, were made clear to the hospital administrator, nursing director and head nurse of each ward and after their agreement, observations was made. Participants in the study were aware of the aims of the study and willingly participated in the study. After the informed consent forms were signed, the interviews were conducted. The participants had the opportunity to leave the study at any time without any problems, and this didn't have any impact on their working conditions and career at all.

Data were analyzed according to conventional content analysis. In this way, the interviews and observations were transcribed and read repeatedly to gain immersion and sense of the whole. Using notes about the differences among codes or units of analysis were found. Using a developing scheme for codes in an organized and comprehensive framework, subcategories and categories were emerged to themes.[21]

Guba and Lincoln (1985) have proposed criteria of credibility, transferability, dependability and confirmability for measuring the validity and reliability of qualitative studies. In this way, obtaining credibility of the findings, the supervisor reviewed transcripts of interviews, observations and coding. The researcher spent more time on observing the context. Also, member check method and peer review were performed. Achieving dependability and confirmability of the findings, audio and text of interviews, codes, subcategories, categories and themes were saved as the files in personal computer. Audit technique was done with the help of two nursing professors and two PhD students. Field notes and full description of field of study were applied to gain transferability. Researcher self-awareness of the assumptions and biases were used to limit subjectivity and obtain authenticity.[22]

Results

Nineteen nurses participated. Their characteristics are presented in table 1 and facilitators and barriers of praxis in nursing practice are shown in table 2.

Facilitators of Praxis

Based on the analysis of the study findings, desirable and humanistic attributes and effective nurse-patient communication are facilitators of praxis and simultaneous application of patterns of knowing in nursing practice.

Desirable and humanistic attributes

One of the topics related to the theme of praxis facilitator is desirable and humanistic attributes. One of its subcategories is moral values. One of the nurses talks about his ethical goal of helping patients that is beyond their duty:

"*I often do things for the patients that are not my duty; it happened so many times that I gave my phone number to the patients, and they called me outside the hospital time, even when a patient had a wound, I went his/her home and bandaged his/her wound. I'm doing these things so that I can lessen the pain of human beings, this is the purpose of my life... I love to remove even one human's pain*". (P.6)

Another desirable and humanistic attributes is the nurse's own religious beliefs. Most interviewees see God as a witness to human behavior as well as rewarding good deeds. One of the participants said:

"*That night, I was awake all night and was washing the feet of feverish patient. I was always thinking that this would have a positive impact on my personal life and would not be overlooked by God. Therefore, I felt good and positive*". (P.7)

Other subcategories of desirable and humanistic attributes are nurse's emancipatory beliefs. One of the nurses talks about care for patient who has different political orientations:

"*I am OK with politics, no matter what faction the patient is from, whether I like it or not. I always try to do my*

Table 1. Participant's characteristics

No	Sex	Education	Age	Marital status	Work experience (year)	Current ward	Previous wards	Hospital type
1	Female	MSN	41	Single	16	CCU	Emergency, Internal, Cardiology	Public
2	Female	BSN	37	Single	10	Burn	Burn Emergency	Public
3	Female	MSN	44	Single	20	CCU	Internal	Public
4	Female	MSN	37	Married	11	CCU	Surgical	Public
5	Female	BSN	35	Married	11	Pediatric cardiology	Pediatric (surgical, orology, Neonatal)	Public
6	Male	BSN	30	Married	8	Orology	General ICU, Emergency	Public
7	Female	BSN	34	Married	11	Orology	Orology, nephrology	Public
8	Male	PhD	34	Married	10	Kidney Transplant	Emergency, Neurology, Operation Room	Public
9	Male	BSN	34	Married	8	Emergency	Emergency	Public
10	Female	BSN	36	Single	10	ICU-Open Heart	Oncology, Hematology, CCU, General ICU	Public
11	Female	BSN	54	Married	28	Cardiology	Operation Room, CCU, Internal, Surgical	Private
12	Female	BSN	46	Married	17	Endoscopy	NICU, Emergency, Genycology	Private
13	Female	BSN	39	Married	16	Internal-Surgical	Emergency, General ICU, Post CCU, Pediatric ICU	Public
14	Male	BSN	35	Married	12	Orology	Emergency, General ICU, ICU Open Heart	Public
15	Male	BSN	34	Single	10	CCU	Operation Room, Emergency, Dialysis, Internal	Public
16	Male	PhD	30	Single	6	Internal ICU	Emergency, Oncology, Neurology, ICU	Private
17	Female	MSN	45	Single	22	CCU	Emergency, Internal	Public
18	Male	BSN	27	Single	10 m	Internal	Internal	Public
19	Female	BSN	23	Single	6 m	CCU	CCU	Public

responsibility properly". (P.17)

Humanitarian beliefs are another sub-category of desirable and humanistic attributes. One of the participants states the reason for giving financial help to a poor patient:

"*However, every human being wants to help one another, therefore I do everything, whether in the hospital or out of the hospital, to give help to everyone, especially the patients*". (P.9)

Nurses in their workplace, especially when entering the nursing profession, are influenced by the behaviors and beliefs of nursing educators and their colleagues. One of the participants talks about the impact of role models and other colleagues:

"*When I started my Compulsory Nursing Service Plan, the people I was working with, had a lot of influence on me, I was with people who were very responsive, people who were very human-friendly, they had an impact on me. If I spend a lot of time for the patients and talk to them respectfully, I look at them as a human being, those people gave me this perspective*". (P.13)

Patience and peace are the other subcategories of desirable and humanistic attributes. One of the participants talks about her patience:

"*My colleagues always say that I am very calm and patient. If a patient or his/her companion comes to me 20 times from night to morning and asks me questions, I will answer and will not get angry with him/ her*". (P.9)

Another desirable and humanistic attributes includes vitality, energy and a love for the profession. One of the participants talks about her love for the nursing profession and patients:

"*God knows, I swear, I never discriminate between patients ... I have been working all these years with a sense of love for my job, I love my patients, I love them...*". (P.11)

Sympathy and compassion is another desirable and humanistic attributes that leads to nursing praxis.

One of the field notes shows the nurse's sympathy for the patient:

"*The patient that had returned from echocardiography had to take hydrocortisone. Her nurse went to inject the drug, but the patient had no serum for the drug infusion ... he returned from the patient's room and told me that he goes to get a serum. He continued: "I can do it with IV straightly, but it's not good, it might hurt*".

Being aware of one's own weaknesses is another desirable and humanistic attributes. Just as every nurse is aware of his or her positive characteristics, they can also be aware of their negative characteristics, recognize, and seek to eliminate them. One of the interviewee talks about her negative qualities:

Table 2. Categories and subcategories of praxis facilitators and inhibitors

Themes	Categories	Sub-categories
Praxis facilitators	Desirable and humanistic attributes	Moral values
		Religious beliefs
		Emancipatory beliefs
		Humanitarian beliefs
		Influence of role models and others
		Patience and peace
		Vitality, energy and love for the profession
		Sympathy and Compassion
		Awareness of self-weaknesses
		Willingness to accept criticism
	Effective nurse-patient communication	Communication with children, adolescents and young people
		Communication with middle-aged and elderly people
		Identification with the patient
		Identification with patient's family
Praxis inhibitors	Prejudices	Mentalities related to diagnosis of diseases
		Mentalities related to the patient previously known
		Other mentalities towards patients
	Occupational barriers	Discrimination among nurses from the superior authority
		Excessive workloads and unwanted shifts
		Financial problems
		The impact of ridicule and behaviors of colleagues
	Negative thoughts	Lack of control of negative emotions
		Unwillingness to accept criticism
	Discriminatory beliefs	Ethnic beliefs
		Beliefs about marginal population (foreign nationals, addicts, prisoners and homeless people)
		Beliefs about high social status
		Beliefs about low social status
		Tendency/ non-tendency toward patients based on their severity of need for care
		Tendency/ non-tendency toward patients based on their feedback
		Tendency/ non-tendency toward diagnoses of some diseases

"*My weakness is that I forget certain things, that is, I am a little forgetful and absent- minded, therefore if my colleague doesn't remind me of that, I might forget something and make a mistake*". (P.19)

Being aware of one's weaknesses and accepting mistakes can lead to acceptance of criticism, and one with this spirit will seek to correct one's own mistakes. One of the participants said:

"*I do not bother with criticism because I feel that criticism leads to my improvement and growth of my personality*". (P.12)

Effective nurse-patient communication

One of the categories that could facilitate praxis in nursing practice is effective nurse-patient communication that is related to the awareness of the behaviors of different age groups and of how to communicate with them.

For example, one of the participants talks about the

child care:

"*In taking care of the children, we have to pay attention to their age. You have to be kind to the three to four-year-olds, every time you want to do a procedure for him/her; you should provide him/her with a small gift, even if just a chocolate, to get their attention first, to let us do something for him/her. Older kids, for example, seven or eight-year olds can be given the chance to participate in the process, for example the nurse can give them the scissors and ask them to cut the medical tape or ask them to put this cup of medicine here. In this way, they can participate in the process and it will be easier to get along with them*". (P.5)

One of the interviewees talks about the behavioral difference of elderly people with young people:

"*Elderly people have more patience compared with young people, they are more patient and more tolerant, and it is easier to communicate with them*". (P.14)

Another subcategory of effective nurse-patient

communication is identification with patients and their families.

One of the participants talks about the impact of identification on patient privacy:

"For doing anything such as bandaging or even taking electrocardiogram (ECG), I always draw the privacy curtain to make sure that the patient is not exposed to others... because I always think about how I expect not to be exposed to others, therefore I do this for my patient". (P.11)

About the identification with patient's family one of the participants noted:

"When we are caring for a patient, we have to know that the patient is a human being and you can love him/ her, just as you love your mother. I always say to myself that the patient is like my mother, s/he is in pain, and my mother was in hospital and was in pain. Therefore, my entire job will be to control the pain". (P.16)

Barriers of Praxis

The analysis findings of the interviews and observations indicate that prejudices, occupational barriers, negative thoughts and discriminatory beliefs are praxis barriers in nursing practice that inhibit the cohesion of patterns of knowing.

Prejudices

Prejudice is the nurse's prior mentality towards the patient, which can include illness-related mentalities, previously known patient-related mentalities, and other mentalities toward patients.

One of the participants talks about patients with a diagnosis of renal failure:

"... when they say that a man with kidney failure is coming in, I think he probably needs dialysis, his skin color is yellow, and he has low general health conditions; given his diagnosis, we assume that his communication skills are poor...". (P.8)

Sometimes, a patient's history of hospitalization, his/her behaviors and feedback, form nurse's mentality that may be negative.

One of the participants talks about his mentality of patients with a previous hospitalization:

"Patients who have had several hospitalizations and had many problems, are patients who are—cynical, shouting, fighting, demanding, we know them beforehand, when they are hospitalized again, we say ...Oh My God, Like the previous times, he/she is going to pick up fights and shout at everybody...". (P.6)

Some other mentalities of nurses toward the patients inhibit the application of praxis.

For example, below is one of the negative mentalities raised by one of the interviewees:

"Some patients and their companions are inept. If they see you treat them respectfully and calmly, they will be more aggressive. For example, we had a patient who would only shout. The more I was silent, the more the patient shouted.

Once I shouted, and he started to be quiet...That is why I always try to react to the patient and his/ her companion in accordance with their own behavior...". (P.18)

Occupational barriers

Occupational barrier is another praxis barrier to nursing practice. One of the occupational barriers is discrimination among nurses by superior authorities. In an informal interview conducted in one observation, the nurse talks about the impact of discrimination between staff and the unfair treatment of head nurse with a colleague:

"It happens many times that, at the beginning of the shift, the head nurse turns a colleague off. Many times, I saw a nurse sitting in the station for a couple of hours, while nervous, and when the patient calls her, the nurse will not answer or answer the patient back angrily...".

Excessive workloads and unwanted shifts are other occupational barriers. One of the interviewees talks about the impact of excessive and unwanted work shifts:

"I always prefer to work in the morning and evening - a day off, if they make me work in the evening and night, I really can't stand it. After ten o'clock at night, my brain cannot understand a number of things. I'm tired and this tiredness can affect my caring and my behavior". (P.7)

Financial problem is another occupational barrier that can affect nursing care and practice. One of the interviewees says:

"When I didn't travel for months, when the hospital didn't pay our salaries on time, when I have a financial problem, definitely when I come to the hospital, I'm in a state of distress, the care I have to provide for my patient with affection and kindness will decrease. My tolerance will decrease". (P.10)

Another barrier includes the impact of ridicule and the behavior of colleagues. Sometimes, inappropriate nursing practice becomes a culture of caring among colleagues in a ward or hospital, and nurses who operate against that culture are ridiculed.

One of the interviewees says:

"It happened many times that you have been doing things that were against the culture of that organization, for example, resuscitating for an hour or an hour and a half. This way, when you have been ridiculed, after several years, you will try to behave like your colleagues". (P.15)

Negative Thoughts

Negative thoughts Inhibit praxis in nursing practice. One of these characteristics is the lack of control over negative emotions. One of the interviewees says:

"I can't really hide my emotions when I'm really tired or mentally stressed, and at that time, I might get angry if the patient or his or/her companion asks for something unreasonable or talks illogically. I will not shout but answer them rudely...". (P.13)

Non-acceptance of criticism is another praxis inhibitor and part of negative thoughts. In such cases, the nurse will

not accept his/her own mistake and will not try to correct it. One of the interviewees talks about the impact of non-acceptance of criticism over care:

"It happened many times when colleagues are upset by criticism, for example, when you say to your colleague that your patient has called you 10 times. Why haven't you answered him/her back? Your colleague gets upset and thinks this advice is a sort of meddling. Well, here the patient will get offended and be in tension, and will cause tension for other patients and even for other colleagues". (P.8)

Discriminatory beliefs

According to the findings, discriminatory beliefs have the greatest deterrent effect on praxis. One of the discriminatory beliefs is related to ethnicity.

In one field note, you read a dialogue between two nurses about a patient:

"Nurse: the patient of bed No. ... You have to repeat things for him too much, you like to blow a fuse because of severe anger.

Other colleague: Where is the patient from?

Answer: the patient is from ……. city.

Other colleague: they are like this. They resist too much. They resist against the instructions that they receive"

Other discriminatory beliefs include beliefs about marginal population including, foreign nationals, addicts, prisoners, and the homeless people.

One of the interviewees says:

"I don't like addicts, I don't want to say I hate them, but well, one is reluctant to work for them. I don't know how to put it. It seems as if you don't like to work for them". (P.13)

The same participant described his feelings about the prisoners:

"When I was working in the hospital ... a lot of prisoners used to be taken to the hospital, they would get stabbed in jail, their liver would be torn, they would be brought to the ICU. I would always say to myself why those young patients who had accidents and needed ICU, had to stay on emergency beds, but these prisoners occupied these beds ... In fact, I was working for them with hatred ...".

Social status of the patient is also another form of discrimination.

One of the nurses said:

"It is very difficult to take care of a patient with a high position ... This caring must be carefully done, even if the patient needs the simplest treatment, again it will be difficult for us. Because we should always try to do everything carefully and in a clean manner". (P.5)

One of the nurses says about his beliefs about rural patients:

"Patients who are rural or less literate do some weird things, you have to teach them everything, they have never seen a bed before, they don't know how to bring up or down the bed…They come to the corridors, pass by and spit on the ground...". (P.6)

Other discriminatory beliefs include tendency or non-tendency of nurses to some patients. Most of the interviewees did not prefer patients with severe need for care who demand too much nursing work. One of the interviewees says:

"I don't like the patients with very low general health conditions, I like the patients who are not too old, who don't have too much trouble, and who are not complex". (P.19)

Based on the findings of the present study, nurses do not prefer aggressive patients or patients who do not give positive feedback to their care.

One of the interviewees says:

"Maybe it is not correct but ... always nurses, in my opinion, subconsciously, are attracted by polite patients. Nurses like to pay more attention to such people rather than a patient who is disrespectful and aggressive ...". (P.17)

Other discriminatory beliefs include tendency or non-tendency to certain diagnoses of diseases, especially contagious diseases such as AIDS and TB.

You can read one of the observation notes:

"When carrying the patient with tuberculosis to internal ward: the nurse who was sitting at the station, came forward and asked about the patient's diagnosis. The delivery nurse said: "TB". The recipient nurse took up her eyebrow filled with a sense of concern and fear. The delivery nurse who noticed her concern and fear said: "Don't worry, the culture is negative. The recipient nurse asked: "Are you sure? The delivery patient said: "yes".

Discussion

Praxis is contrary to theory and is the engagement of a nurse in the development of informal theories about certain clinical situations in which the nurse is drowned.[26] In fact, praxis arose in response to the elimination of the gap between the nursing language and nursing practice as an important step towards our shared collective ability to think about nursing.[7] Praxis is professional nursing practice to achieve goals including reflexivity to achieve social justice.[27] Thus, freedom is a fundamental and essential component of praxis that is a key component for achieving evolving social change, reflection on human existence, the ability to think independently, to live in the way desired. Freedom as an emancipatory context is only achieved when individuals have equal access to human rights and no culture or individual forms a group dominant over others to receive more rights.[27] Therefore, from the emancipatory point of view, all patients are equal, regardless of any ethical, racial, ethnic, or cultural attributes.[28] Nurses should respect patients' religious, personal, and cultural beliefs, and should try to speak to and listen to patients without any judgment, and make every effort to provide personalized and impartial care.[29] The findings of the present study indicated that, nurses with desirable and humanistic attributes consider the dignity of the patient and regard him/her as a human being. Participants noted that, patients with different cultural and religious beliefs are also respectable for

them, and even because the members of some religions minorities are supported more by the nurse, so that they do not feel lonely or isolated.

Effective nurse-patient communication with different age groups, from infants to the elderly facilitates praxis. This relationship requires nurse's awareness about patients' needs and identification with them. For example, if the nurse is aware of the need for emotional communication with the elderly, or of speaking logically with the middle-aged persons, this awareness is integrated with other patterns of knowing and contributes to the formation of praxis. Despite the importance of consideration of psychosocial needs in caring, especially in caring for the elderly, the findings of a study indicated that psychosocial needs are prioritized at a lower level than the physical needs of the elderly. The nurse-patient relationship, which includes the need for trust, respect, love, security, and belonging, is especially important when assessing the elderly living alone.[30]

The findings of the study showed that some of the nurses' characteristics such as compassion are facilitators of praxis in nursing practice. Application of ethics, emotions, compassion, and sympathy along with knowledge and wisdom are factors of human-friendly and holistic nursing care.[31] Compassion and sympathy should include empathy and sensitivity, respect and dignity, active listening and responsiveness, competency and cultural caring, attention to patient preferences and choices, striving to empower and support the patient.[32] Similar to the findings of the present study, a qualitative study found that compassion was one of the essential themes of caring in advanced holistic nursing practice.[9]

Caring, according to Watson, is a relationship with love, empathy, and forgiveness between the nurse and the patient.[3] Empathy, which is the ability to perceive others' emotions, [33] can mean putting oneself in place of another person, expressing emotions of another individual, and understanding the logic of those emotions, and related behaviors.[34] The findings of the present study also indicated that, nurses in many cases imagine themselves as the patient or his/her family and are assimilated to the patient or his/her family.

Awareness of weaknesses somehow refers to personal knowing, as one of the four fundamental patterns of knowing is achieved through self-discovery and discovery of others and through reflection, perception, and communication with what is known. Thus, the nurse achieves self-awareness and openness to herself/himself and others through participation in daily events, thinking, and understanding and communication with his/her own experiences.[4] Self-awareness is a continuous, purposeful, intrapersonal, interpersonal, relational, and contextual process, improves the therapeutic relationship between nurse and patient.[35] Similarly, the findings of an observational study found that interpersonal skills are the core skills of nursing that promote therapeutic relationships between the nurse and patient.[36]

In contrast, the findings indicated that some factors inhibit the formation of praxis in nursing practice. Prejudices and sometimes even discriminatory beliefs about patients are the most important barriers of praxis. One of the discriminatory beliefs of the nurses was the beliefs about the foreign nationals as well as the patients from different ethnicities that have a language different from the official language of the country. Most participants pointed to language barriers. In line with this finding, a qualitative study also points to problems arising from differences in patient-physician language. Participants in the mentioned study have described that, sometimes even relatives and friends who are beside the patient as a translator, cannot make the patient's intentions clear.[37] Sometimes, belonging of patient to specific groups can be the source of discrimination, as it was reported in one study, transgender/gender-nonconforming patients were discriminated in the health system. This discrimination is exacerbated if they belong to minority or marginalized ethnicities as well as blacks.[38] In order to clarify the importance of considering emancipatory view and applying praxis dealing with marginal population, a review study found that less than 0.16 of published articles in top-10 journals of nursing were related to the subject of marginal populations.[39]

Other discriminatory beliefs derived from the findings of the present study, are nurses' beliefs about homeless people as well as addicts. Most participants spoke of a hidden fear of homeless people and addicts because of their potential for communicable and dangerous diseases such as AIDS. The effects of discrimination increase when the two social problems of poverty and homelessness come beside addiction. As the results of a study indicated, the most discrimination by the health system was against alcoholics or drug addicts or mental patients (33%) and secondarily, homeless people (30%). The study noted that homelessness as a specific social marker results in more discrimination than ethnicity or race because the marginal life of homeless people is strongly linked to drug abuse and their psychological problems.[40]

Social status is another form of discrimination between patients that is addressed in this study. The findings of a study showed that low income and low socioeconomic status of patients can occur at the level of the insurance system and the overall health system and have negative effects on poor patients' access to primary health care.[41] According to the findings of the present study, patients with higher social status receive better care than patients with low or even average social status. Participants noted that patients with a higher social status received more respect for addressing and received more attention. Consistent with this finding, a study in Ghana also found that patients' satisfaction with caring was significantly higher among patients with higher education levels and higher incomes than other patients.[42] A study in Iran

found that, patients with lower economic, social, cultural, and educational status are more discriminated by nurses than those with average one.[43]

The findings of the present study indicate that nurses prefer to provide care for patients who appreciate the services of nurses and give positive feedback on the care received. According to the findings of a study, these positive feedbacks, including hand-shaking, caressing, verbal thanking, writing a letter of appreciation, etc. can have positive effects such as increasing motivation to continue working with dedication, love, effectiveness and efficiency.[44] However, the findings of the present study showed, positive feedback from some patients can lead to discrimination between other patients and them, so that, they might provide more service for them than other patients.

Among other discriminatory beliefs is that, nurses tend to care for younger patients who need less attention and less care. The participating nurses mentioned other characteristics of the patients including the patient's ability to move, the patient's weight, and the extent of their cooperation in self-care. Similar to this finding, in a study on nursing student biases, it was found that, more than half of participants had negative attitudes toward obese patients.[45] According to a literature review, nurses' negative attitudes toward elderly patients include attitudes about characteristics of the elderly and their care needs. These attitudes can include thinking of elderly patients as weak, incapacitated and inflexible people, who lack mental and cognitive abilities.[46]

The findings of this study indicate the negative impact of some occupational barriers on praxis. One of these barriers is the discrimination in the workplace by the superiors. Understanding the injustice in the workplace can cause conflict and dissatisfaction among colleagues to the extent that they decide to quit the workplace.[47] Interpersonal conflict among colleagues has a significant relationship with missed nursing care and has long-lasting effects on the provision of care, especially in the elderly caring section.[48] Other occupational barriers in this study include work overload and unwanted work shifts. It is generally said that the division of professional functions, organizational structure and workforce flow, resource limitation and the work environment are the source of organizational disagreements that put pressure on health care providers in complex clinical environment with high volume of patient care.[49]

Caring culture in a clinical setting is said to have a significant impact on professionalism in nursing [50] and promotes collaboration between members of the health group, their individual and group reinforcement and quality of care.[51] However, the findings of the present study indicated that if an improper care behavior is construed as a culture, other co-workers adjust their behavior to it and thus the proper care behavior is mocked. This ridicule prevents the repetition of proper and wise care or praxis.

It is notable that the abstract nature of praxis caused some problems for the nurses to perceive and answer the questions. Therefore, some more detailed explanations were provided to clarify the related concepts.

Conclusion

The purpose of the present study was to study the factors involved in nursing practice. The findings of the study indicated that human beliefs and values, effective nurse-patient communication and desirable and humanistic attributes are praxis facilitators. In contrast, negative thoughts, occupational barriers, prejudices, and discriminatory beliefs are praxis inhibitors in nursing practice. If we consider praxis as the simultaneous application of patterns of knowing alongside the effort for establishing social justice, emancipatory beliefs have the most facilitating effect and discriminatory beliefs have the greatest deterrent effect. Likewise, other factors that drive nurse practice toward social justice facilitate praxis, and factors contributing to varying degrees of discrimination and injustice, inhibit praxis. By identifying these factors, nurses can identify the barriers to social justice, remove them and improve their practice.

Based on the findings of the present study, the researchers suggest that praxis and its facilitators, especially social justice, be included in undergraduate, postgraduate and in-service training curricula. For future studies, the researchers suggest that an instrument be developed and validated to assess praxis facilitators and inhibitors in nursing practice.

Research Highlights

What is the current knowledge?
Nursing practice refers to the professional behavior of experienced nurses. Praxis refers to practical human behavior that can be artistic, ethical, or political, but its central meaning is the application of knowledge in practice. When four patterns of knowing including ethical, personal, empirical, and aesthetic patterns are integrated with emancipatory pattern, and the nursing practice is aimed at social justice, praxis and emancipation are achieved.

What is new here?
The findings of the study indicated that human beliefs and values, effective nurse-patient communication and desirable and humanistic attributes are praxis facilitators. In contrast, negative thoughts, occupational barriers, prejudices, and discriminatory beliefs are praxis inhibitors in nursing practice.

Authors' Contributions

FR, FJT: Conceptualization and methodology; FR, ANN: Supervision; FJT: Investigation and writing original draft; FR, ANN, FJT: Review and editing; FR, FJT: Data analysis; FR, ANN, FJT: Final approval of the article.

Conflict of Interests

There is no conflict of interest among the authors of this study.

Data Accessibility

The datasets are available from the corresponding author on reasonable request.

Ethical Issues

None to be declared.

Funding

Not applicable.

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