Research Evaluation

## Sociology and Nursing Practice

There are various contributory factors in nursing care and the healthcare outcome of a patient; for example, a patient is an individual with family, economic and social factors that influence the health of the patient. Therefore, these overarching factors in the social realm have a direct correlation to quality patient care and health outcomes.

Sociology is the study of human social life, and this approach in nursing looks at the practice from a sociological perspective. This is because nursing is increasingly undertaken within a social context rather than in isolation. New approaches are considering the impact of nursing that is carried out with the direct involvement of the family, and the community, and these new strategies are increasing the healthcare outcomes and improving the quality of care (Earle & Green, 2016). Such an approach, referred to as “holistic care,” takes care of the patient within a sociological realm that enhances the overall well-being of the patient and involves the critical patient stakeholders. Sociology, in such a context, helps the nursing practitioners to understand the patients’ holistic needs and their families because it helps in perceiving patients in the context of their society. Therefore, understanding sociology and how it plays in a context of a patient can improve patient care and the overall nursing practice.

Sociology can enhance the quality of patient care and, consequently, the nursing practice through enabling the nursing practice to understand individual patients’ social contexts, which provides significant insight into how they experience the world, specifically their experiences of health care provision (Cooke, 1993). Thus it allows nurses to reflect on their actions towards patients in light of the different social backgrounds and taking into consideration what is important to them and viewing the world from their perspectives. Sociology is critical to this because individuals from different social backgrounds see the world differently and may need different caring skills and practices. In this regard, therefore, it is imperative for nurses to have sociological knowledge so as to enhance the quality of patient care, which is a primary aim of nursing practice.

Finally, within a particular community, patients remain in an environment that contributes to their adverse health outcomes. Through sociology, nurses can gain a greater understanding of various individuals and the numerous factors that contribute to their ill health. Understanding the social factors from which the adverse clinical outcomes arise and how different groups are affected in various ways, nurses develop more comprehensive knowledge of the lifestyles of the different social groups (Cooke, 1993). Consequently, the nurses can advise better patient changes that they can implement within their environment to improve health and healthcare. Moreover, sociology provides the nurses practice with the knowledge, which allows them to develop a critical understanding of what threatens people’s health within their social contexts and providing strategies for improvement. Therefore, sociology is imperative to nursing practice because it leads to the development of preventative care practices that are crucial to improving public health.

In conclusion, sociology enhances the quality of nursing practice through developing new nursing approaches that involve the sociological factors in care, facilitating an insight into individuals’ social settings, which influences their perspectives on care, and understanding societal conditions that negatively or positively impact care.

# References

Cooke, H. (1993). Why teach sociology? *Nurse Education Today*, 210-216.

Earle, S., & Green, B. (2016). Sociology for nurses. In E. Denny, S. Earle, & A. Hewison, *Why should nurses study sociology?* (pp. 28-38). Melbourne: Polity.

## Social Models of Health Highlighting the Limitations of Biomedical Models

The biomedical model of health focuses or emphasises diagnosing and treating individuals separate from their living or lifestyle conditions whilst ignoring the reasons for the illness (Barbour, 1997). The social model of health has highlighted the limitations of the biomedical model because it addresses the broader influences on health (cultural, social, environmental and economic conditions) rather than disease and injury, and it leads to a direct effect on reducing occurrences of adverse health care results.

The social model of health has highlighted the limitations of the biomedical model because it leads to access to health care. The biomedical model of health is based only on the obvious need to classify and treat an illness and diseases, which have been the focus on this model, which has also resulted from conventions on clinical thinking, which have focussed on ways of naming and treating what is seen (Germov, 2009). It is a means of simplifying healthcare. Therefore, using the model, healthcare has been out of reach for those that cannot access healthcare. The social model, however, acts to enable all people to have healthcare access because it looks to eliminate the social factors that negatively impact access to health care; for example, the cultural and language barriers, and the economic and the geographical factors.

The biomedical model of health places emphasis on diagnosis and treatment as the sole means of healthcare management, but, as recent research has shown, this approach to healthcare eliminates a fundamental aspect of caring that has a long-lasting effect on the quality of care. Healthcare should be in the context of the environment in which the patient resides to increase healthcare outcomes and improve the quality of attention (Germov, 2009). The social model of health incorporates all stakeholders (individuals with a shared interest) that have an influence over the social and the environmental determinants to address the healthcare positively adequately.

The social model of health has highlighted the weakness of the biomedical model, which fails to treat some conditions. For example, cancer treatment is not always successful through the biomedical model even though there are advances in the field. However, through addressing the broader factors that predispose people to the diseases, such as lifestyle, or diet – there will be a significant reduction in the condition (Barbour, 1997). For example, consumption of processed meat has an important influence on cancer rates. Therefore, if people can be educated to substitute processed meat and lead better lifestyle, cancer rates will be reduced. Finally, a limitation of the biomedical model of health that has been highlighted by the social model is the considerable burden that it has on the healthcare system whereas the social model attempts to prevent some of the burdens (Germov, 2009).

The social model of health has highlighted the limitations of the biomedical model through increasing access to healthcare, improving the outcome of health, and finding new approaches to managing conditions that the biomedical model has failed to treat. Furthermore, the social model of health has reduced the burden on healthcare.

# References

Barbour, A. (1997). The limitations of the medical model. In A. Barbour, *Caring for patients: A critique of the medical model* (pp. 1-5). Palo Alto: Stanford University Press.

Germov, J. (2009). Health sociology and the social model of health. In J. Germov, *Imagining Health Problems as Social Issues* (pp. 5-22). Melbourne: Oxford University Press.

## Racism and the provision of adequate nursing care

The provision of a quality and adequate nursing practice has been one of the primary goals of the healthcare. However, the achievement of this goal continues to be inhibited by challenges such as racism.

For example, antipathy, ignoring, disengagement, avoidance, disgust and rejection of care in healthcare exemplify some of the manifestation of racism within the context of Australian health system. This treatment leads to disproportionate care, which can be defined as ‘racialised care,’ which is highlighted in the persistent differences in the health of the people (Trueman, Mills, & Usher, 2011). Furthermore, the disproportionate care is evidenced by a majority of the minority populations. Therefore, racism does inhibit the provision of adequate and quality nursing care.

Racism in health care provision is seen through attitudes, ideas and behaviour, which significantly affect the nurse’s ability to give appropriate nursing care. For example, the indigenous aboriginal population in Australia has continuously experienced racialised care since colonisation, and this disproportionate care has resulted in the differences and lower levels of their access to care. The healthcare system -- and the sentiment is shared amongst the nursing personnel -- has labelled them as lacking in morality, restraint and civilising social skills. Such thoughts have persisted and are remembered the Aboriginal populations’ raise issues that are health related in nature (Trueman, Mills, & Usher, 2011). It has been noted that the healthcare providers that are not of indigenous origin tend to forget the terrible consequences of colonisation, poverty and the inherent bureaucracy of medical service, which denies them access to adequate care whilst generalising the held views of Aboriginality. The held view enacted by nurses continues to cast aboriginals in a negative fashion and inadvertently leads to disproportionate care. In this sense, the thoughts, views and the notions of particular groups of people affect a nurse’s ability to offer adequate nursing care.

Secondly, a study research, observing midwives who came into contact with women of Asian origin, highlights how the behaviour of these nurses led to an inadequate care system. The study argues that the categorisation of patients, coupled with the often and commonly used stereotypes that were used to make assumptions about what a particular woman is, was likely to want or prefer during labour and delivery (Bowler, 1993). This practice of using categorisation led to the formation, transmission and the acceptance of stereotypes views of particular groups of people. For example, Asian women were stereotyped as being difficult. The consequence of the stereotype is that a patient is likely to suffer the effects of a particular negative stereotype. People of colour, such as blacks and the minority indigenous population, were particularly vulnerable to the stereotype because the colour of their skin makes it easy for the nursing staff to recognise them and to negatively assign them to an already ‘negatively categorised’ group. These negative categorisations and stereotypes thus affect the quality and the adequacy of nursing care because it already assigns the quality of care to be offered to individuals even before they are assessed.

Racism seen through various aspects continues to hamper the provision of adequate care because it has led to disproportionate care, and it is seen through nurses’ behaviour, attitude, ideas, stereotypes and categorisation, which negatively influence a nurse’s practicing ability.

# References

Bowler, I. (1993). 'They're not the same as us': Midwives' stereotypes of South Asian descent maternity patients. *Sociology of Health & Illness*, 157-178.

Trueman, S. W., Mills, J., & Usher, K. (2011). Racism in contemporary Australian nursing. *Aboriginal and Islander Health Worker Journal, 35*(5), 19-21.

## Economic inequality and good health

Certain healthcare factors are characteristics of a general population; for example, poor clinical outcomes are associated with individuals and families that face economic hardship or lower economic abilities. Furthermore, more illnesses and diseases tend to strike more poor people than the economically well-off. Thus economic inequality is a threat to good health.

Various research studies were done to understand the inequality existing in the access of healthcare between the economically able and those who are not able. The results show that poor individuals with health challenges are only half as likely to seek medical attention as individuals with a high income (Reuss, 2001). Furthermore, the research studies indicate that people and families living in low-income areas are more than twice likely to be hospitalised for a health issue that could have been effectively treated with a timely medical intervention or outpatient care, compared with individuals and families living in high-income areas. The inequality in economic ability influences access to healthcare, making it a major stumbling block to healthcare access.

Secondly, low income and little economic ability have predisposed certain groups of people to live in areas with dangerous environmental conditions and hazardous occupational surroundings that exacerbate poor health conditions. For example, individuals and families with economic hardships tend to live in areas with poor social facilities, poor sanitation, and in a congested environment, which perpetuate poor health outcomes. Moreover, poor economic families and individuals have characteristic lifestyle choices that negatively impact their health outcomes (Leeder, 2003). This is seen in cases where the poor are likely to hospitalise for asthma, which is directly linked to the quality of air, and poor men are almost six times more likely, as high-income men have elevated blood lead levels, which directly reflect the workplace environmental hazards. Educational levels, which are other indicators of one’s economic ability, play a part because the less education someone has, the more he or she is likely to drink or smoke heavily (Leeder, 2003). Such factors have a direct correlation to one’s health. Such factors are seen amongst the indigenous Aboriginals and the Torres Strait Islanders who, due to their poor economic conditions, have poor health outcomes.

Finally, the diseases of affluence, such as heart diseases that are associated with high-fat diets and high calories, lack of exercise and physical activity, are prevalent amongst the economically challenged in wealthy countries. Whilst noting the effects and the role of behavioural risk factors, there is a need to look at the greater impact that the economic access has on access to health.

Therefore, economic inequality is a threat to good health because it is directly correlated to healthcare access, directly influences the living conditions of a person and leads to lifestyle choices that affect the overall health of a person.

References

Leeder, S. R. (2003). Achieving equity in the Australian healthcare system\*. *MJA*, 475-478.

Reuss, A. (2001, June 1). *Cause of death: Inequality*. Retrieved from Third World Traveler: http://www.thirdworldtraveler.com/Health/Cause\_Death\_Inequality.html