Applying the Art & Science of Human Caring
Applying
the Art and Science of
Human Caring
Applying
the Art and Science of
Human Caring

Jean Watson, Editor

Center for Human Caring

National League for Nursing Press • New York
Pub. No. 42-2647
# Contents

Foreword ......................................................................................... ix
Invited Preface ............................................................................. xi

*Leland R. Kaiser*

Editor's Preface ........................................................................... xiii

*Jean Watson*

Introduction .................................................................................. 1

*Jean Watson*

A Step-By-Step Guide on
How to Implement Caring Theory .............................................. 11

*Eileen Cappell*

The Denver Nursing Project in Human Caring .......................... 19

*Gina Astorino, Karen Hecomovich, Tracy Jacobs, Linda Laxson, Peggy Mauro, Ruth M. Neil, Sen Talley*

The Caring/Healing Relationship of
"Maintaining Authentic Caring" .................................................. 39

*Carol Montgomery*

Table 1: Caring/Healing Relationship .......................................... 42

Guidelines to Prevent Becoming
Involved in a Destructive Way ..................................................... 43

Case Management in the Caring-Healing Paradigm ................. 47

*Marlaine C. Smith*

Implementing Watson's Theory of Caring ................................. 53

*Jan Nyberg*

Caring for the Caregiver .............................................................. 63

*Janet F. Quinn*

Works by Jean Watson: A Bibliography ....................................... 73
Contributor’s List

Gina Astorino, MS, RN, is Clinical Specialist/Educator, Denver Nursing Project in Human Caring, Denver Colorado.

Karen Hecomovich, MS, RN, CS, is Psychiatric Clinical Nurse Specialist, Denver Nursing Project in Human Caring, Denver, Colorado.

Eileen Cappell, MScN, RN, is Director, Nursing Services, Baycrest Center for Geriatric Care, Toronto, Ontario, Canada.

Tracy Jacobs, BSN, RN, is Staff Nurse, Denver Nursing Project in Human Caring, Denver, Colorado.

Linda Laxson, BSN, RN, CIC, is Clinical Director, Denver Nursing Project in Human Caring, and Infection Control Coordinator, Denver Veterans Administration Medical Center, Denver, Colorado.

Peggy Mauro, RN, is Staff Nurse, Denver Nursing Project in Human Caring, Denver, Colorado.

Carol Montgomery, PhD, RN, CS, is Assistant Professor, University of Colorado Health Science Center, Denver, Colorado, and the author of Healing through Communication: The Practice of Caring.

Ruth M. Neil, PhD, RN, is Project Director, Denver Nursing Project in Human Caring, and Assistant Professor, University of Colorado School of Nursing, Denver, Colorado.

Jan Nyberg, PhD, RN, is Assistant Professor, University of Colorado, and Faculty Associate, Center for Human Caring, Denver, Colorado.

Janet F. Quinn, PhD, RN, FAAN, is Associate Professor and Senior Scholar, Center for Human Caring, University of Colorado Health Science Center, Denver, Colorado.

Sen Talley is Administrative and Community Coordinator, Denver Nursing Project in Human Caring, Denver, Colorado.

Marlaine C. Smith, PhD, RN, is Assistant Professor, University of Colorado School of Nursing, and Faculty Associate, Center for Human Caring, University of Colorado Health Science Center, Denver, Colorado.

Jean Watson, PhD, RN, FAAN, is Distinguished Professor of Nursing and Director, Center for Human Caring, University of Colorado Health Science Center, Denver, Colorado.
Foreword

This monograph offers a framework for implementing a successful, caring-healing philosophy and theory in nursing. It provides an expanded model of caring-healing and health by which to consider/re-consider advanced professional nursing practice for the next era.

The monograph, in conjunction with the NLN Video, “A Guide to Applying the Art and Science of Human Caring,” provides guidelines for the diffusion of nursing’s caring values, knowledge, and skills into community nursing centers and total quality care programs by balancing technological innovation and system wide re-design projects and reform activities.

Distinguished educator and researcher, Jean Watson, along with her Denver and international associates at the University of Colorado Center for Human Caring (CHC), draw upon their on-going work and offer invaluable, essential experience, advice, and information for putting caring philosophy and theory into professional nursing reform. The monograph highlights caring as nursing’s philosophical, moral, values-based context from which to interact and apply the caring-healing paradigm for advanced nursing practice.

The monograph also makes new connections between caring theory based practice, quality patient outcomes, care management, along with total quality indicators required for health care reform. Included are tips for nursing administrators and practicing nurses on how to use the theory’s 10 carative factors for assessing, charting, documentation, and developing programs on care management. The authors address such issues as why caring theory based practice; how to enter into the caring model; caring for the care giver; and approaches toward transforming relationships, environments, and patterns of care delivery at multiple levels.
By situating nursing within its own paradigm, this monograph elicits and demonstrates the special caring-healing-health contribution of nurses; contributions essential for innovative, progressive, reconstructive health care.

The authors featured in the monograph include University of Colorado Center for Human Caring faculty associates and international colleagues: Dr. Jean Watson, author of the theory of human caring, Founder and Director of the Center for Human Caring with its numerous caring theory based projects; Dr. Ruth Neil, Project Director for the Denver Nursing Project in Human Caring—a caring theory based Community Nursing Center which serves as an international clinical demonstration project; Dr. Janet F. Quinn, Senior Scholar in the Center, recognized worldwide for her clinical scholarship and practices within a caring-healing praxis model; Dr. Jan Nyberg, Faculty Associate and former “magnet hospital” Nursing Administrator, experienced in caring based re-design of nursing administrative hospital projects; Dr. Marlaine Smith, Faculty Associate and widely published nursing theory expert who is involved in care/caring management projects and researching advanced caring-healing modalities within a hospital setting; Dr. Carol Montgomery, CHC Faculty Associate, psychiatric and transpersonal psychology educator, master clinician, researcher of caring and spirituality, author of the important 1993 work Healing through Communication: The Practice of Caring, published by Sage; and Eileen Cappell, Nursing Faculty, University of Toronto and Director, Nursing Innovations Unit for the Canadian International Centre for Human Caring Clinical Affiliate Project on Caring Theory Based Practice, a Canadian Ministry of Health project at Baycrest Centre for Geriatric Care, Ontario, Canada.
New times require new models. Jean Watson's *Applying the Art and Science of Human Caring* is a model for patient care in the coming century. It provides a much needed framework for implementing caring and healing theory in nursing. However, it is much more than that. It is a guide for the entire healthcare field and for every healthcare professional interested in creating higher levels of personal, organizational, and community wellness.

For health professions steeped in the curing tradition, this publication is a breath of fresh air. It supplies the missing dimension in much of contemporary medical and nursing practice. The reader is taken on a marvelous journey into the realms of ontology, philosophy, ethics, morality, and spirituality. Yet the reader is not stranded in the higher realms. All of these multiple levels of doing, being, and knowing are translated back into the most basic approaches to patient care.

*Applying the Art and Science of Human Caring* is not something you just read and do. Advice is cheap to come by and books are plentiful in the marketplace. This publication actually helps the reader advance on a pathway of personal transformation. “Getting it” is more than reading it or seeing it. It is an inner alchemical process triggered by seed ideas and thoughtforms carefully planted by the authors throughout the work. I know these people. They walk their talk and if you study this work carefully so will you.

Although this publication will stimulate you at many levels, it is more than a collection of theories and neat ideas. The work is grounded in the authors' many years of clinical nursing practice. The ideas flow with fluid ease, but they were earned slowly and painfully with sweat and tears. These kinds of insights do not come easily. There is a price to be paid. Hopefully, if you read carefully and meditate upon the lessons discussed, your pathway to personal and professional transformation will be made easier.
The disease model has taken us on a long and successful journey. It can take us no further. The caring, healing model, like a booster on a multistage rocket, must now kick-in. The integration of the two stages will produce the lift off needed to propel nursing into the next century.

No amount of medical or nursing care will substantially improve the average health status or wellness of a human population. A new paradigm is needed that enables us to heal individuals, organization, and communities. We must now learn to prevent disease and potentiate people. Ultimately, nurses will redesign our human habitat. This publication points the way to these new levels of intervention.

Jean Watson and her international associates at the University of Colorado Center for Human Caring have taken the next step in the continuing saga of healthcare. It is your good fortune as the reader of this work to join them in an exciting adventure into outer and inner space. Sit back, relax, and prepare for warp speed.

*Leland R. Kaiser, PhD  
President, Kaiser & Associates  
Brighton, CO*
Editor’s Preface

This monograph is an invitation to practicing nurses, health administrators and clinicians everywhere—wherever you may be in the health care setting. Coupled with the video, “A Guide to Applying the Art and Science of Human Caring,” it is an invitation to engage in more mindful and alive practice of the caring-healing dimensions of our life’s work. Theory has entered recent nursing science and practice and is now at another turn in its relevance to health care reform initiatives. However, theory as theory often distances the practitioner from the concrete acts of practice and often the concrete world of practice seems atheoretical or too remote from the abstract ideals that theory embodies. In assessing the state of theory in nursing today, we see a shift from “theory based practice” to more “practice based theory.” Nevertheless, we can all learn from those who are interacting with theory in practice and action; whether that occurs from the inside out or the outside in. Those who are actually working with nursing theory are playing a large part in constructing the field of both practice and theory, and are impacting the disciplinary perspective that guides nursing’s evolution. In this monograph, you will encounter those of us who are selecting, bringing together, and synthesizing different theories or further developing any given one as exemplars for others who wish to translate abstract theory to actual alive, reflective, informed practice/praxis—practices that are serving as reforms for the individual practitioner as well as the system in which the practitioner works, and most importantly, for the public. Thus, this work is not a recipe nor panacea for all the maladies we face during this time of collapse of what we have known as the modern medical system; it does not provide prescriptions nor definitive answers that will repair the breakdown associated with routine, functional practices of modern nursing—outdated practices that reside within the established medical service paradigm.
EDITOR'S PREFACE

What this monograph provides is a window into another paradigm—a way of framing the way we see, a glimpse into another reality of what nursing might be, and ironically is already becoming. We see nursing within this caring-healing model emerging as courageous nursing practice reform initiatives in pockets all over the world. We want to share some of the essential components of the caring based paradigm and offer a road map on how it can be and is being translated into transformative practices and system reforms. My hope is that this monograph, along with the video, “A Guide to Applying the Art and Science of Human Caring,” will serve as a transitional bridge for those wanting to step beyond the confines of what is and into what might be, for transformed health care practices. The chapters that follow are directed toward those wanting to take those necessary steps—stepping into the caring-healing model for reform—learning from other nursing leaders who have already taken the plunge, and are living the experience.

I hope you will step into the process with us, cross the bridge, and be a part of what might be. For those who are not ready to cross the bridge, perhaps this work will help improve your commitment to steps along the way.

Jean Watson
Chapter 1

Introduction

Jean Watson

In my work to define and expand the possibilities for human caring in nursing, I have developed and put into practice a theory and philosophy based upon the act itself. Understanding the act of caring in its fullest sense, and within both professional and human contexts, is essential. In terms of nursing, the theory of human caring provides direction as a moral foundation for professional practice and commitment. It orients the practicing nurse toward a covenant that remains at the heart of the nursing profession: to develop with the other a trusting, caring-healing relationship that potentiates health and well-being, physical comfort, symptom management, pain control, and promotes meaning, growth, and harmony between provider and other.

Although the theory is not new to nursing, it is an attempt to find and deepen the language specific to the caring relationship and its many meanings. It allows for the need to continually rediscover what caring is and what it can become within the knowledge contexts particular to nursing. In addition, it places great value on the artistry of nursing practice, an artistry foundational to professional health and healing practices in and beyond nursing.
That nurses express and experience such artistry on a daily basis is a certainty. Yet, the biomedicalization and the technologizing of health care have marginalized that which makes nursing so important to nurses and others. Simply, we cannot be satisfied with a conception of nursing that reduces it, and its artistry, to functions, procedures, and tasks in the service of medical curing.

A caring-healing theoretical framework, on the other hand, consists of caring as both a moral and philosophical context, as well as a therapeutic stance from which to engage in clinical practice, education, and research.

But what of the theory? *Theory,* of course, stems from the Greek “Theoria,” which refers to the act of “seeing.” It is within “seeing,” then, that I think of my work as a theory—a way to see our reality within an ethical context that points toward a certain kind of practice based upon caring as foundational to the paradigm of the discipline and profession of nursing. The theory is not prescriptive—there is not one correct way to practice. It does, however, spotlight human dimensions of nursing practice that have been obscured, and have suffered thereby. When nursing loses any aspect of its ethical basis in caring, both nurses and their clients suffer. Thus, if nursing is going to be a committed and active partner with the public in its search for a greater understanding and enhancement of health generally, a revisioning is long overdue. Current efforts toward health care reform are perhaps the most publicized aspect of this revisioning. Less public but equally, or more, important is the reclamation by nurses of the phenomenon of human caring.

In many ways, a theory of caring, a philosophy, and an ethic of caring for our practice, education, and knowledge returns us to the heart of nursing, rooted in ancient traditions of service. The revisioning of human relational healing dimensions through caring is also a way to return to nursing’s finest motivations toward the community. In this light, Nightingale’s view of nursing, which has yet to be actualized, appeals to us again.

So my work on caring can be considered a philosophy and a theory, as well as an ethic, returning nursing to its most meaningful human foundation within the contemporary world enhanced as much by scientific breakthroughs as beset with political turmoil. We now know, for instance, or, to put it more accurately, have “rediscovered,” that mind-body medicine and the “soft” caring modalities affect longevity, meaningful living in the midst of suffering, and healing responses at the psychoneuroimmune level of an experiencing person.
INTRODUCTION

Still, it is the restoration of human values at all levels in the health care setting that we seek: to reintegrate the lost art of nursing; to advance and expand both old and new nursing arts that embrace all ways of knowing; and to pay special attention to the authentic presencing and being of the practicing nurse within an expanded view of science and the human science context.

As a starting point for theory and practice, caring involves the humanity of the nurse, expands to embrace the humanity of the other, and seeks to preserve the intersubjective human-to-human relation between nurse and other as a process of mutuality and trust. A transpersonal relationship is revealed that includes a search for wholeness, healing, integrity, and harmony.

Such an orientation moves beyond the given context of functional skills and technological competencies, and requires that nursing attend to competencies of use of self. Here, advanced caring modalities to deal with the broader human dimensions and subjective meanings within the health-illness continuum are invoked. Of course, not all nurses or systems of nursing will embrace this model. Some will continue to advance within a functional-task and/or a medical specialty curing framework. But those sympathetic to the theory of caring and those not will have to deal with the public's ever increasing demands for better and more humane health care services, however they do so.

Overview of the Theory

Caring is the heart of nursing and the ethical and philosophical foundation for our acts. As such, caring involves a deep level of commitment to patients, families, communities, societies, and to planet Earth.

First and foremost, caring is an ontology, a mode of being human. Professional caring is a special way of being in relation to self, other, and being in the world. It draws upon and calls for the full use and expression of self and one’s personal and professional modalities of expression as part of the finest art of nursing’s practices.

Within such a context, it is important to remember that the art and science of caring practices requires balanced attention to the doing, the knowing, and the being of nursing’s development. We must also remember that in the history of nursing focus has fallen more acutely on the doing, and in contemporary terms via medical-technical knowing, than on the being or knowing of caring. Only in more recent times have we begun to acknowledge that aspects of human “being” related to caring-healing relationships and practices are critical to health and quality of living, coping, growing, and dying.
By invoking the moral values context as foundational, certain other aspects arise as influential factors in nursing practice. First, one has to personally and professionally consider and reconsider what it means to be human. Here we reflect on how we treat self and other in relation to the integrity of mindbodyspirit and the human field. For example, do we view the human as a biological organism? Do we view self and other as subjectively whole? Do we accept the assertion that being evolves and changes through greater consciousness of self and its relation to the world? Do we acknowledge that embodiment in the here and now involves something more than the body physical, Rx care? Do we acknowledge that all of these questions gain greater meaning for nurses within the caring moment? And do we accept that the caring relationship for the nurse and other can become an existential turning point from which significant healing possibilities root and grow?

A positive answer to any or all of the above questions situates caring within an expanding view of human science. Acknowledging the integrity of mindbodyspirit and the human field, the theory restores caring as a special way of being human that requires specific consciousness and intentionality in relation to the preservation of dignity, humanity, and wholeness of self and other within the greater universe. As the theory restores to nursing a spiritual reverence toward life, humanity, and unknown mysteries, it also seeks to restore a sense of reverence to caring-healing relationships and practices.

In this way, the nurse caring relationship becomes a subject-to-subject, human-to-human process. It does not admit to an objectivist model that prescribes distancing, control, or manipulation as necessary tools for professional nursing. Rather, it sustains caring and wholeness through a range of caring-healing arts and modalities other than those offered by medical treatment functions. It allows nursing to come of age and mature within its ancient and contemporary paradigm of caring-healing and health.

The theory also calls for an integral caring consciousness within the moment care is given and accepted. The caring-healing consciousness of the nurse, combined with intentional, expressive caring arts/acts can thus potentiate healing and wholeness and lead to advanced nursing practices. Such advanced practices will allow for the reintegration of traditional and nontraditional healing modalities in pursuit of the fullest expression and practice of nursing yet possible. Here, the nurse will also gain enhanced self-expression as nurse and person.

Balance will be restored between nursing’s institutional medical-technological competencies and, what I call, its ontological caring competencies replete with advanced modalities and healing arts skills. Such is the kind of evolution in nursing that I have sought and will continue to seek. Evolution has always been the point. Different nurses can thus be at different points on the evolving continuum of practicing the caring-
healing arts as part of their advanced practice. Some may even enter into the model through more structured, focused attempts; for example, a system moving toward a theory based practice or more practice based theory.

For Systems Considering Entry into the Theory of Caring

For systems wishing to consider entry into the theory via a practice setting, grounding can occur in several ways, as listed below:

- Caring can be seen as a moral foundation and end in and of itself; the highest and deepest level of commitment to preserving integrity, wholeness of self-other, patients, families, communities, nature, and planet Earth in nursing.

- Caring requires attending to the subjective and intersubjective relationship of the nurse and other. The nurse will attempt to stay within the other's frame of reference to promote a mutual search toward meaning and wholeness of being, honoring diversity and the inner cultural life world of the other.

- Within the caring relationship, the nurse seeks to preserve the humanity, dignity, and integrity of self and other(s).

- The caring paradigm allows nursing to advance its practices by drawing upon the full legacy and more complete expression of ancient and contemporary practice modes from compassionate listening to competencies required by complex medical technologies, to advanced caring-healing derived from the arts and humanities.

Here, new levels of nursing competencies arise such as authenticity of being, ability to be authentically present to self and other in reflective caring sense, ability to center one's consciousness and intentionality to promote caring-healing outcomes and wholeness. Responsivity, mutuality, intersubjectivity, and the full engagement and expressivity of the nurse as appropriate to the caring needs of the other are paramount.

Transpersonal Caring Relationships

It is important to understand the transpersonal nature of the caring relationship. Originating in earlier work in psychology, as influenced by Rogers (1959), Pelletier (1978), Achtenberg (1985), and others, the concept captures much of what transpires in the theory of caring. More specifically, and for our purposes, it implies both a going beyond the self and a recognition that relationships are mutual and reciprocal. It also focuses our self-development and expression on deeper, more spiritual, even cosmic concerns that emanate from the personal and intersubjective in regard to the human community. Indeed, recently anthropologists and ecologists, as well as nurses and psychologists, use “transpersonal” to describe emerging directions in the different fields
of study and the growing interest in and awareness of changes that embrace the non-
physical, metaphysical, transcendent dimensions of relations at multiple levels of do-
ing, being, and knowing—allowing, in this way, all ways of knowing to be considered as
part of the human phenomena of interest and concern to nurses engaged in caring-
healing practices.

Grounding the Philosophy and Theory

While we consider, within caring philosophy and theory, the ontology of being caring
and all its lived/embodied implications, the skeletal structure and “ontic” dimensions
of the theory become manifest and grounded through the 10 Carative Factors that
include:

1. A humanistic-altruistic system of values.
2. The instilling of faith-hope.
3. Sensitivity to self and others.
5. Expressing positive and negative feelings.
7. Transpersonal teaching-learning.
8. Supportive, protective, and/or corrective mental, physical, societal, and spiritual
   environment.
9. Human needs assistance.
10. Existential-phenomenological-spiritual forces.

    Associated University Press)

These 10 carative factors provide a structure and guide for the theory. They also
present implications for how one interacts with its directions for practice. It is impor-
tant to understand, however, that they are not a prescription but a conceptual and
philosophical guide toward a caring-healing artistry of practice in a human-to-human
relationship irregardless of specifically medical prognoses and treatment demands.
The 10 carative factors can thus be used as an expressive tool and guide in the assess-
ment, charting, and full engagement of caring human dimensions of nursing practice.
In addition, the carative factors provide a framework from which to reflect on and critique the current state of caring-healing practices for an individual nurse, a nursing unit, an entire system of care, or a redesigned unit or system of caring in nursing, in or out of traditional institutions and community settings.

**Advanced Caring-Healing Modalities:**

**New Ontological Caring-Healing Competencies**

Within the caring model for advanced nursing practice, and within the best tradition of our "coming of age" as a profession, we must recall this salient fact: There are modalities of caring-healing arts that have been lost to nursing and replaced by advanced medical specializations and institutional management functions. Even if considered as nursing therapeutics, these must be developed anew.

To do so, we turn again to the caring-healing modalities outlined in this monograph, which include the intentional use and expression of auditory, visual, sensual, olfactory, tactile consciousness to potentiate wholeness, pain control, symptom management, comfort, integrity, dignity, release of emotions, and so forth "to put the person in the best condition by which nature can heal" (Dr. P. Updike, personal communication). These modalities can also be translated into more integrated, intentional use of poetry, music, sound, art, movement, color, light, shape, touch, and imagery. They can further be translated into actual skills such as therapeutic touch and/or massage, touch therapies, essential oils-aroma therapy, relaxation techniques, breath work, and so on.

That all of these modalities have been used across time, here and there, in whole or in part, among nursing’s caring-healing practices does not release us from the need to integrate them within a conceptual-philosophical framework that allows nursing to be directly accountable for its practices and knowledge development. Here, we take from the margin and move to the center in our efforts to establish advanced nursing practices within the context of health care reform.

**Language of Theory of Human Caring in Practice**

The above sections outline some of the seminal aspects of the theory of caring. If one chooses to use the work as a specific theory for practice application or guide to practice, however, then the language of the theory itself provides some additional structure and order by which to frame nursing actions.

Whereas modern nursing, within the medical services paradigm, concentrated on “technological competencies” (that conformed to the institutional model of functional task demands), the theory of human caring calls for “ontological caring competen-
cies” to balance, complement, and actually transform the modern medical framework into relevant advanced nursing practices. One approach toward attending to “ontological competencies” is to use the language of human caring theory to guide nursing practice values, decisions, actions, and evaluation of outcomes. The language of “carative factors” is integral to translating human caring theory and concepts of transpersonal caring into action. The application of the art and science of human caring ranges from individual nurse-other/nurse-client relationships within a caring moment, to its use as a guide to administrative system-wide practices among nursing units, to nursing center models, and to re-design projects both within institutions and the community settings. (For the original discussion of these factors, see Watson’s 1985 publication, Nursing the Philosophy and Science of Caring, and 1988 publication, Nursing: Human Science and Human Care.) Also, in the NLN video, “A Guide to Applying the Art and Science of Human Caring,” I have provided a verbal overview of all 10 of the carative factors. For our purposes here, they will be highlighted only with commentary on how they can and are being used in practice settings. The following chapters by nursing colleagues provide more explicit, concrete examples as to the use of carative factors.

Carative Factors and Their Use
This theory of human caring which calls forth both the art and science of nursing provides a set of related ideas and philosophically grounded concepts and values that one can interact with for practice relevance. The language of the theory is not meant to be a prescriptive set of applications. The theory is open to creative use in both general and specific ways. The following are examples of how the carative factors may be useful against the backdrop of the philosophical foundation for the theory.

- Provide consistent language for discussing nursing actions, assessing, charting, and evaluating patient care decisions, actions, and outcomes.
- Serve as a context for advancing nursing qua nursing practice, and for potentiating advanced nursing practice within its own paradigm.
- Serve as self or unit audit for critique; reflecting on practice; staying within the nursing paradigm; attending to “patient-centered” nursing priorities.
- Serve as caring indicators of nursing-sensitive priorities related to quality outcome measures that are nursing/patient-centered (rather than medical care centered).
- Serve as a value clarification guide for establishing nursing care priorities for individual patients and translating priorities and values into concrete action.
INTRODUCTION

- Serve as the nursing paradigm and philosophical foundation for demonstration projects related to the currently popular “patient-centered care” programs, modeled after the PlaneTree Project in California.

- Serve as a basis for Total Quality Management (TQM) approaches, which promote diffusion of values-based innovation as part of health care reform. Caring and caring indicators (based on the carative factors) become the value components that are added to the TQM Model.

- Serve as a basis for nursing-patient care data base for wide range of research, e.g., quality outcome research, specific patient conditions, different patient populations, settings, patient defined needs; develop more specificity of factors that correspond with different levels of nursing practice, advanced nursing therapeutics, advanced caring-healing modalities; serve as indicators to guide the teaching, practice, and research of “ontological competencies.”

- Serve as a basis to specify nursing caring practices as a form of primary therapy for selected patient populations, e.g., gerontology, chronically ill, persons with developmental disabilities, cancer care, care of terminally ill, “step down units,” and other high-demand nursing units and populations.

Conclusion

In closing, whether one chooses to use this theory as a philosophical guide to practice, a model to interact with to critique and reflect on practice, or as a specific theory toward transforming health care, the values and language of the theory serve as a foundation for redefining nursing within its own paradigm and caring ethos. Thus this work can be seen as a bridge toward action and transformation, providing voice, language, new meaning, value, and concrete action toward transforming not only nursing, but helping nursing to play a major role as mature partners in broad health care reform measures—shifting from the functional paradigm-in-crisis, toward an emerging model that is responsive to the evolving human consciousness and society’s new demands. This emerging consciousness and new public expectations are moving toward integrated mindbodyspirit approaches, caring-healing relationships, self-healing, self-care approaches, prevention, alleviation of vulnerability, preservation of wholeness, and focus on community based models of caring that offer accountability for quality outcomes and cost containment. While all of these changing dynamics and crises of paradigms offer somewhat overwhelming challenges, they also offer enormous opportunities for nursing during this shift between centuries, between world views, and between paradigms. I wish you personal and professional excitement, growth, and fulfillment as you enter into this model, at any point on the continuum. I invite you to
cultivate it, locate yourself and your patients and system within it, and then find your own way to sustain and live it—then you/we together become part of the transformative process at this critical turning point in nursing as we awaken and respond to the next age in human health history.

References


Chapter 2

A Step-By-Step Guide on How to Implement Caring Theory

Eileen Cappell

Introduction

Everett Rogers (1983) defines an innovation as “an idea, practice, or object that is perceived as new by an individual or organization. An innovation presents an individual or organization with new alternatives, with new means of solving problems” (p. xviii). Caring nursing theory is an innovation that helps nurses examine new ways of solving old problems both in quality of client care and in quality of nursing worklife.

While nurses are eager to embrace theory, especially caring theory, as the answer to some of the more pressing problems in health care, they are unsure how to begin. Nurses across the country are asking for specific guidance on how to choose the most appropriate theory, how to translate seemingly abstract ideas into a format that can be easily disseminated, understood, and put into practice, and how to keep the ideals of
caring theory "alive" despite the day-to-day realities of current practice settings. For the past three years I have been struggling to find the answers to questions such as these.

In this paper, I will guide you step by step as you begin the process of implementing caring nursing theory. As well as sharing my own experiences, I will be posing questions that we considered along the way. I suggest that you follow a similar process by using these questions as a guide for discussion and debate within your organization. By following this step-by-step process, I hope to be able to help you to avoid costly and time consuming errors on your way to successfully integrating caring nursing theory into your organization.

Understanding the Need for Innovation

The first step in diffusion of an innovation occurs when one or more individuals in an organization identify an important problem and then seek an innovation as one means of coping with the problem. The difference between how an organization's members perceive its performance, in comparison to what they feel it should be, is a strong impetus to search for an innovation (Rogers, 1983). It is important that you understand your motivation.

Q: What are some of the problems that are leading your organization to want to implement caring theory?

Q: What do you hope to achieve?

In our organization we felt that nursing theory would help nurses more clearly articulate and define the scope of their practice. We also felt it would help us look at specific nursing outcomes.

How Do You Pick the Most Appropriate Theory?

Once you understand why you want to introduce caring theory based practice, you can begin the process of conceptual matching in order to establish the fit between the problem, the innovation, and the organization. This stage is quite labor intensive. It is at this time that you should review several theorists' work. At my institution, eight theories were reviewed before Dr. Watson's theory was chosen to guide our nursing practice.
Q: Who do you plan to include in reviewing the various theories?

I suggest that there should be representation from all areas of nursing and from all levels of practice with the greatest emphasis being on those who will eventually use the theory in practice.

Q: What are some criteria you need to consider when assessing the suitability of each theory?

When defining these criteria be careful not to limit your discussion to how easy it would be to operationalize the theory. In addition to these considerations, it is important to pay a great deal of attention to finding a theory that is congruent with beliefs and values you already hold and one you would like to promote.

Here is an example from my own experience. Some of the values and beliefs discussed in Dr. Watson’s theory supported an abiding view of care held by my institution. Other values in her theory were ones we wanted to adopt and promote.

For example, Dr. Watson expresses high respect for life, and the power of humans to grow and change. We felt this was important in caring for elders because this value would empower us to see the potential for people to grow and change despite age and/or infirmity. Explicit adoption of this value would allow us as gerontological nurses to be hopeful, and to approach people with a sense of optimism and purpose. This optimism could then be transmitted to the people we care for as a way of combating the despair so many people experience in illness.

Q: In addition to the values and assumptions in the theory what else is important to consider?

Each theorist has a certain worldview and this worldview is expressed in the way the theorist defines the four metaparadigm concepts (nursing, person, health, and environment). For example, when you consider the concept of health, healthy is not often thought of in terms of the people that are old, sick, and in an institution. This contra-
diction poses difficulties for nurses working with patients. Health as defined by Watson is unity and harmony within the mind, the body, and the soul. This definition allows for “health within illness.” Defining health this way helps nurses see their care as active and purposeful toward achieving the goal of promoting health.

Ask everyone on your theory committee to describe what their worldview is by having them define each of these concepts. If people have trouble articulating these concepts, encourage them to find a poem or a piece of music or a swatch color which will help them express themselves. Encourage creativity and risk taking.

Once you have done this, ask yourselves the following questions: Which worldview seems most compatible with the most people? Is that good? Do you want a theory that is congruent with prevailing views of the metaparadigm or do you want to encourage a “paradigm shift”? Has your organization had previously successful experience with change? Or is change particularly painful and difficult for your agency? All of these must be considered when choosing a theory.

**Implementation**

Once you have chosen a theory, you enter the implementation phase. In this phase, the first step is to refine or modify the theory to fit the organization. In my organization, we geared our application of the theory to older people who live in our long-term care institution. Theory is meant to be lived and experienced. Modify the theory in the ways that will let you live a caring philosophy. In turn, by living caring theory, you will engage in a form of action research which will lead to enhancing our understanding and knowledge of caring theory.

It is also important at this stage to define the organizational unit that will have specific responsibility for theory implementation. For example, you may decide to appoint someone as a project coordinator to oversee the implementation.

The project coordinator’s role is to facilitate the process by explicating a critical path for implementation. This is a long-term project and should be planned as such. Too rapid an implementation can be problematic.

This would suggest that you need to stage the implementation over a period of time so that it can become imbedded in the organizational structure. One of the most important strategies in this stage is to ensure staff involvement and commitment.

Q: How can you best involve your staff?

However approach to this you decide to take, it is important that you model caring values to staff. You do this by ensuring that all participation is voluntary and you must remember to build in rewards and celebrations.
IMPLEMENTING CARING THEORY

For example, we asked interested units to have a majority of staff agree that they wanted to participate, then we asked them to submit a letter indicating their interest in becoming a pilot unit.

You then need to decide how you will help your staff learn about the theory.

Q: How do you think you should teach a caring theory?

Use innovative teaching methods. Explore alternatives such as poetry and music. Use interactive methods designed to encourage self-reflection and to increase self-awareness. It is very important that staff feel valued and cared for because then it is much easier for them to be with their patients and families of patients in a caring way.

Once you have given staff an initial introduction to the theory, they should meet on a regular basis under the guidance of an advanced practitioner who is using the theory in practice. These meetings need to occur for at least six months to help staff to learn how to integrate the theory into their practice.

Some of the possible areas of focus during these discussions might be how to use the carative factors to guide the establishment of a caring relationship. Explore alternative caring modalities such as therapeutic touch, gardening, and aesthetically enriched environments.

Implementation of caring theory should not be limited to caring occasions between nurses and clients. Rather, it should be used to help staff feel cared for as well, because this is foundational for being able to care for others.

As the changes in practice begin to occur, caring theory will move beyond the unit level to middle management, senior management, and other disciplines as well. You can help assure that this happens by letting all levels and disciplines in your organization know about the value of caring theory. Herald the arrival of caring theory and trumpet your successes.

Many of the approaches used during implementation are in keeping with Total Quality Management (TQM) such as recognizing staff as experts, celebrating success, viewing problems as opportunity, giving staff feedback on the whole project, and the valuing of staff’s role in the project and in the organization. By making explicit the connections between caring theory and management theory, you can facilitate buy-in to the project of senior administrative non-nursing staff.
Q: What changes will you want to make in documentation, performance appraisals, and job descriptions?

The answer to this question will vary greatly from organization to organization. However, I do suggest that this come later in the implementation process rather than sooner. It is not so important how your staff document, or on what forms they document, but rather what they document. What you should begin to see in documentation is evidence that nurses are learning to understand the meaning of the experience of the person for whom they are caring and details of caring interventions designed for that unique individual.

Another reason to leave forms to later in the implementation process is to avoid having staff latch on to very concrete issues such as documentation and assessment tools rather than encouraging them to grapple with the more difficult issue of changing their way of “being with” their patients. However, once you do begin to look at changing the forms and documentation that you do use, the carative factors can be used to shape your documentation.

The last stage in diffusion of an innovation is routinizing. At this stage, the innovation has become incorporated into the regular activities of the organization, and the innovation loses its separate identity. It is during this phase that there is the greatest danger of de-implementation. Just as it was essential to plan for the initial first two to three years of implementation, it is just as essential to plan on how to make this caring theory an integral part of the organization. Just as the initiatives to establish the project were designed to elicit staff involvement, the dismantling of the project must also be designed to elicit staff’s ongoing support and participation.

In providing for support and participation, it is important to develop the role of staff resource person. Over time theoretical expertise is being developed in staff so that they will be the ones to continue to drive the project forward. They will become the experts in caring theory based practice and they will begin to share this knowledge with others.

Staff who have experienced caring theory based practice say the following:

“It has given us a camaraderie—among staff—a closeness, sensitivity among ourselves.”
“We see the patient more as a person, not a patient—with unique needs and individual needs.”
“It has made a difference—with difficult patients. For example, we had a patient who was a Holocaust survivor and one of the penalties was to hold their urine for a long period of time. The patient was incontinent. Therefore, we tried to toilet train—this
reminded her of the concentration camp. We charted this and informed all staff not to toilet train. As a result, she became continent and, when she learned to trust us, didn’t request to go as frequently."

You can see that the implementation of caring theory requires enormous commitment on the part of nurses who are going to participate in this process. Yet this commitment is essential because caring theory promises to be a central and unifying force for nursing which in turn will lead to tremendous personal and professional and societal gains.

References
Chapter 3

The Denver Nursing Project in Human Caring

Gina Astorino, Karen Hecomovich, Tracy Jacobs, Linda Laxson, Peggy Mauro, Ruth M. Neil, and Sen Talley

Introduction

The Denver Nursing Project in Human Caring (the Caring Center) opened in 1988 as an outpatient, nurse-directed health care facility for clients living with HIV/AIDS. Since its inception, the Center's programs and services have been based on Watson's philosophy and science of human care nursing, creating both the challenge and opportunity to consider reflectively the meaning of true theory-based nursing practice. (See Appendix A.)
The Center’s Mission Statement guides all program and policy decisions at the Center. Written by Center staff and reviewed annually, the statement expresses beliefs and values concerning the nature of the human being, health and healing, and the contribution of caring relationships to human experience and optimum health. Developing the Mission Statement helped staff clarify individual and group values. An enlarged copy of the statement is displayed near the Center’s entrance, read by clients, students, and other visitors to the Center. (See Appendix B.)

Shared values and goals create a sound foundation for community. At the Caring Center, clients and staff have become partners in living out the Center’s mission. Such a process requires open, trusting relationships among clients and staff at individual as well as group levels. In turn, the community is a source of strength and healing for all participants.

Numerous strategies have evolved that support the actualization of authentic caring in the Caring Center environment. The sections that follow describe several of these. Each member of the Center staff has written a contribution related to her area of greatest interest. Karen Hecomovich presents a chronicle of factors that have enhanced the staff’s ability to work together in a way that nurtures our ability to care. Tracy Jacobs summarizes the key elements of the nursing care partnership program which has client empowerment as a central goal. Client education, an essential ingredient of empowerment, is described by Gina Astorino.

Because of its broad definition of health and healing, the Center consistently makes alternative therapies and experiences available. These are discussed in sections written by Peggy Mauro and Sen Talley.

Finally, careful attention has been given to documentation and evaluation of the Center’s programs and services. Linda Laxson describes charting which incorporates the carative factors and contributes to continual quality improvement. Ruth M. Neil comments on outcomes evaluation activities.

Learning to Work Together in a Way That Nurtures our Ability to Care

When we first started working together at The Denver Nursing Project, we did not just sit down and decide that our ways of working together were going to be different from other settings we had known. But over time, the unique combination of our setting and ourselves has contributed to a very special and satisfying team experience. Key components we’ve identified include the following:
We all value our spirituality, and though we may use different language to describe our belief systems, we do believe our work has a meaning beyond the concrete here and now. Although we continue to “make it up as we go along,” we are now able to articulate what we were not able to then—that caring is not a set of behaviors that can be listed but rather a way of “being” in the world that corresponds to a way of “being” in the workplace.

We know how lucky we are in that we experience support and validation for one another and for our practice. We know that we need that. Our work cannot be accomplished in isolation. Most of us know that the only time we’ve really made an impact was when we were willing to become involved with our patients and their families beyond the “emotional distancing boundaries” that we all learned were necessary and “professional.” While we all have appropriate individual coping skills, we recognize that the emotional demands of caring for others requires that we care for ourselves and support one another in the work environment in a very special way. We believe that this team support is important enough that it can and must be expressed as a health issue.

We recognize that because we work with clients who are living with a life threatening illness we have the potential to become “burned out” by exposure to repeated and sustained loss. It is for this reason that we value our support in the work environment not only from the clients with whom we share our losses but by each other. We are able to cry with our clients, to reveal our own wounds and vulnerabilities, thereby making us more human and trustworthy. We approach our clients in partnership, with no authority and no judgement. Our focus is not on curing or fixing but upon healing. We understand that healing almost always occurs in relationship. In that relationship we grow and change with our clients.

We know that caring for ourselves, having the same compassion for ourselves that we have for our clients, is important to our continued ability to be of service. We know that if we want to enjoy other wonderful things in our lives, we must leave room for them. Finding a balance between caring for others and caring for self (and being able to integrate the two) can be challenging. We recognize that, as caregivers, we are by nature other focused and vulnerable to self-care deficits.

We are aware of the environment as something that we enjoy attending to because we know that we are skilled in shaping the environment to facilitate and support healing. Light in the form of lamps (rather than overhead fluorescent), music, and flowers all contribute to a homelike and nurturing environment.
The staff and the interrelationships that the staff enjoys with colleagues are also part of the environment. As I stated earlier, it is not a set of behaviors but the way we are that creates the atmosphere. Because we believe that we are all interconnected, that our consciousness is not separate but integral with all consciousness, our intention, focus, and being centered is important. We no longer look at the environment as being “out there”—for our patients, our colleagues, or our communities. Our environment is also within us, within and around our energy fields. We are inseparable from our environment.

Very early on we recognized it as imperative to develop a sense of community amongst ourselves if we were going to be able to succeed in working with this very challenging population. Many (if not all) of us had come from leadership roles in previous work settings. As a result, initial conflicts occurred—everyone tried to lead. As we made the decision to enjoy our shared commitment to the project, to abandon our concern with individual egos, and to respect and celebrate our differences, we developed a sense of community. We thus embraced the values of cooperation and egalitarianism vs. the more traditional values of competition, power, and winning. We were then able to evolve into a non-hierarchical, more horizontal or circular “management style.”

Decision making occurs jointly. Staff meetings occur weekly, with an open agenda where everyone has input. Somewhere along the line we recognized that everything is “perspective dependent,” and that our definition of maturity is having a “high tolerance for ambiguity.”

We made a commitment to open authentic communication among ourselves. We know that if one person has an issue with another, the only way that can be resolved is by going to that person. We know that the difference between “gossip” and other communication is in the intent. We believe that there is a contagion of caring that can occur in the environment (just as there can be a contagion of hostility!). Clients notice and tell us when things are “out of sync,” and we know that if we are not coming from a place of centeredness, individually or collectively, we need to understand why it is and do something about it. When it comes to direct communication with each other, even though we know that our dream is not always our reality, we have learned that in behaving like the dream is reality, it may become so. We have a simultaneous wish, need, and fear of mutual honesty—and are learning to trust that speaking up to our coworkers will not sever ties, just strengthen them.

We believe that responsible people have a way of organizing themselves so that the work of the system does get done. (For example, when we set about the task of writing this article, individual staff members volunteered to write the section that was of special interest to them.) Responsibility for completion of various projects rotates and people are able to use their talents where their interests occur and where they, as
individuals, “shine.” The fact that we are able to self-schedule our time acknowledges that we will be responsible for unit coverage, that our staff are balancing career and home, that time is important, and that we have other things going on in our lives that sustain us.

As a team, we are committed to continued growth—and recognize that team process is a day-to-day experience, not something that takes place in one hour or one day of inservice. As with any human endeavor, the process is imperfect and unpredictable. Sometimes the process is carefully structured and deliberate, at other/most times it is relaxed and spontaneous. “Down time” can be a way of caring for one another, of giving and receiving support “on the spot or at the moment,” or simply of having fun.

Because our unit is small, and our work is specialized, it is with relative ease that we regularly and consciously affirm a continued commitment to purpose. The relative autonomy with which our unit functions allows us the luxury of being able to self-correct quickly when things go wrong.

We make time to replenish ourselves by creating times away. In those times, we reconnect with our inner voice and renew our energy. Some of us find spending time in nature a great way to put our lives and our work into perspective. And as we use this reflective time—because there’s no such thing as doing nothing!—we will be renewing ourselves and perhaps seeing that little bit of light that will let us know “what we are doing here anyway” and developing a realistic viewpoint of what we can do: where we can have an impact in this challenging work and where we can’t.

Finally, we have learned to value our intuition—to work centered, focused, present, and aware. We listen and attend to the “wise old person within” that tells us what is true for us now, how to act in an unusual situation, what we need, and when we need it.

Karen Hecomovich

What is the Nursing Care Partnership?

A full description of the Nursing Care Partnership program at Denver Nursing Partnership in Human Caring (DNPHC) is available in Schroeder and Maeve (1992). The following information summarized its key characteristics.

The program is

- A mutually accepted, reciprocal agreement that both partners openly acknowledge and identify needs as the relationship evolves.
• An avenue for the nurse to foster client independence in his or her own health care by helping the client identify internal and external resources and offering information about how to negotiate health care systems.

The nursing care partner is
• A person to help problem solve.
• An advocate during crisis.

The goals of the Nursing Care Partnership are
• Client empowerment.
• Nurse empowerment.
• DNPHC empowerment.
• Supporting agency empowerment.

Expected client outcomes from the partnership stipulate that the
• Client will feel better able to identify needs and utilize appropriate resources.
• Client will have better decision-making and negotiating skills.
• Client will feel better able to care for self.
• Client will feel his or her quality of life has improved.

The partnership process involves an
• Initial interview with a nurse who provides information about the center.
• Client is encouraged to “get to know” the DNPHC and its staff and then to choose whom he or she would like to have as a care partner.
• Client and nurse mutually establish a freely chosen relationship.
• Client and nurse negotiate their roles in the partnership with the understanding that these roles are flexible and variable depending on the situation.

Tracy Jacobs

Education Approach

“Education is the second mission of the DNPHC. Education is the foundation for competent care of others as well as care of oneself. Clients and staff continue to share openly their knowledge and experience as greater understanding develops about the spectrum of HIV-induced health changes. DNPHC staff and clients also serve as re-
source persons for various education programs in the community. In addition to client and family education, training and observational programs for students and professionals from nursing and other health-related disciplines are provided at the Center” (words from the Mission Statement, 6-8-93).

The characteristics of our education approach are manifold. They are

- An integral part of nursing care in that we take advantage of the “teaching moment.”
- A response to the felt need on part of the client (i.e., education is provided when needed and accepted, it is not forced)
- Presented authentically.
- Tailored to individual need and ability.
- Realistic and appropriate for each participant (e.g., will provide home-like setting to teach home IV therapy).
- To provide information on a wide variety of healing and health promoting modalities that may not necessarily be focused on the traditional medical model.
- To provide individual informal education and classes/workshops.

The goal of our education mission is

- Client empowerment.
- Self-care, independence.
- Informed decision making.

The education curriculum is

- A comprehensive curriculum covering topics that are related to living with HIV disease.
- A modular, self-paced, selective use system.
- Consists of written materials, audiovisuals, audiocassettes, bulletin board presentations, etc.

Gina Astorino
Complementary Healing Options at DNPHC

Information about and provision of a variety of non-traditional healing options contribute to the uniqueness of DNPHC. It can be a very rewarding experience for both clients and staff to utilize holistic modalities to enhance the healing process by helping the client draw on inner resources to enhance quality of life while dealing with the challenges brought on by the illness process.

Complementary healing options which are or have been available include a variety of body-centered therapies, nutrition counselling, meditation, and activities to encourage creative expression such as art therapy (painting, clay work, collage-making, etc.), writing (especially poetry), and journaling. The benefits derived are quite diverse, but ultimately give the participant the opportunity to have a consciousness awakening that enables growth and healing on many levels.

Body-centered therapies which have been beneficial for HIV/AIDS clients include massage, Reiki, Therapeutic Touch, reflexology, and Jin Shin acupressure. Clients report relaxation, reduced stress, and pain reduction following treatments. Some of the outcomes of the nutrition counselling include increased energy, confidence that one's diet is appropriate for symptoms being experienced, elimination of toxins from the body, avoidance of foods that may be harmful for an immunocompromised individual, and an overall increased sense of well-being. Activities which encourage creative expression have helped clients gain both self-knowledge and increased understanding of others as they share and discuss their art or writing.

One client, who was often homeless, found poetry-writing to be his way of telling of his life experiences. The poems, like the one below, became the basis for his frequent visits to the Center for counselling and support.

Oh, look how it's snowing
The sleet, the frost, and the cold to me
is all glowing.
I can hardly see,
but I'm not blind.
I have prayed for cooler days,
and now that it's snowing,
this must be my time.
I need a cup of hot coffee
and a meal that will stick to my ribs
for now I feel like an alley cat
that has been locked up in the "fridge."
My teeth are hurting
and I can hardly take a bite.
I wouldn’t call myself homeless
but, “God—where am I going to sleep tonight?”
It is so cold, I can hardly hold my breath
I refuse to get drunk to keep warm
because I don’t want to freeze to death.
I could build me a snowman and
play with him like the days of old
but I almost swear, the way I’m rubbing my hands
the snow knows I’m cold.

The self-healing which clients experience by participating in these therapies and activities helps them feel empowered, as well as supported, by the practitioners who provide the services. The fact that many of the therapists volunteer their services contributes to the overall environment of caring and community at the center.

Peggy Mauro

Client Advisory Committee and
Paid and Volunteer Work Programs

The Denver Nursing Project in Human Caring (The Caring Center) has three primary missions: fostering professional health care practices based on research findings; educating clients and their families, nursing students, and professionals, as well as students and professionals from other health-related disciplines; and, our top priority, facilitating high quality health care to HIV-positive clients, their lovers, friends, families, and designated others who make up their support systems.

This nurse-directed, outpatient community health center offers a broad range of services and opportunities for its clients utilizing Watson’s science of human caring. This philosophy, and the Caring Center, espouse the belief that healing (as opposed to curing) involves the whole person—all physical, mental, emotional, spiritual, and social aspects—and that each person has the inner resources, strengths, and knowledge to facilitate his or her own healing. It is the commitment of each staff person to foster the client’s self-acceptance, self-love, and self-empowerment in order that each may accomplish what is necessary for his or her own well being.

Each of the Center’s missions and goals are accomplished and enhanced through the participation of clients. One of the very first clients collected a group of other interested clients and organized the first Client Advisory Committee. The role of this volunteer committee was, and still is, to serve as a liaison between the staff and the clientele at large. The Committee generates suggestions and ideas for meaningful Center programs and conveys suggestions for improvement or issues of dissatisfaction.
from the greater client group, in addition to coordinating their own special projects. The Committee is comprised of five primary members and up to five alternate members, all of whom serve an eight-month term following election by the greater client body.

The Client Advisory Committee has been involved in many of their own activities including organizing floats for parades, coordinating Thanksgiving luncheons, honoring other clients and non-client individuals and groups for extraordinary contributions to the Center, and bringing concerns of the larger client body to the attention of staff. Of particular note was the development of the Client Emergency Fund. The Committee established written guidelines and maintains full responsibility for fundraising and approving expenditures (loans and grants to other clients) from the Fund.

The Client Employment Program provides another opportunity for clients to become involved in the Center. A specific grant was solicited by pay clients for such activities as cleaning the Center, providing office assistance, publishing Positive Attitudes (the client newsletter), and speaking at educational events with (and often without) staff to further knowledge of HIV/AIDS. Participation in the Client Employment Program enhances self-esteem, extends the clients' focus beyond HIV/AIDS and, at the same time, supplements their often meager incomes.

It has seemed to this author (a non-nurse) that Watson's carative factors were developed as guidelines for nurses to facilitate healing and caring. At the Caring Center, however, not only do staff utilize the carative factors with positive outcomes, but it is also apparent that many of the clients have, through participation and observation, adopted these ways of being as their own.

The members of the Client Advisory Committee receive great satisfaction of receiving through giving—volunteering on this Committee very often results in new and meaningful relationships with other clients. The committee process allows them insight into their own personal ways of being and they develop a greater sensitivity to themselves and their fellow clients as relationships develop.

There are a number of clients who participate formally in the Center's mission of education by speaking at classes, seminars, and group meetings with and without staff members. These clients share their personal experiences in living with HIV/AIDS and their knowledge for the growth and benefit of their "students." Clients sharing this information with nursing and medical students, practitioners in rural communities, and other health care professionals is yet another way of bringing meaning to their own lives and facilitation of self-actualization.
Many of the clients are extraordinarily well informed about this disease and have personal insight into the effects of a variety of opportunistic infections and ways they can be handled. Clients continually act as resources for one another and develop not only transpersonal teaching-learning relationships, but also helping-trusting relationships which foster creative problem solving and a supportive environment for one another.

Acting as resources for one another also extends to emotional support. Throughout any day, and especially at the weekly Friday luncheon, clients can be heard being helpful to each other—sharing their personal experiences, philosophies and beliefs in order to help one another through difficult situations with families, friends, partners, caregivers, health issues, and life in general. The existential, phenomenological, spiritual forces of the one reach out, support, and help the other.

There is an energy, a spirit, that permeates the Caring Center. It emanates from the core of each person. It is expressed in the commonality of goals and the respect for the multitude of ways to accomplish those goals. All of us, staff and clients alike, are at the Center to facilitate healing and growth. Each person crossing the threshold has his or her own level of awareness of that and his or her own way of going about personal healing and growth, and ways of interacting with others that impact as well.

The Center works. It works because a group of committed, caring individuals have come together with a specific intention. It works because Watson’s carative factors are effective. And it works because there is a present and tangible higher force that guides each of us with love and caring.

_Sen Talley_

**Charting within the Caring Framework**

*Background Information*

Charting in the traditional health care setting tends to be fragmented and focused on specific body systems where physical ailments occur. This fragmentation is compounded by the many disciplines providing service-specific documentation. The DNPHC's focus, however, is on optimal health for the individual and we believe that health and well being are multidimensional—including physical, emotional, mental, spiritual and social components. Charting is therefore designed to reflect the multidimensional aspect of the individual as well as the complex nature of HIV infection. We have found we can do this most completely by using a narrative entry format.
The practicality of designing written “nursing care plans” has been very limited in this setting due to the unpredictable and often dramatic life changes repeatedly experienced by persons living with HIV/AIDS. Instead, we use a present and future focus in each entry. Thus, documentation incorporates both the immediate nurse-client interaction and future planning. This is accomplished by labeling the final portion of each narrative entry as “Future Focus” (FF). Future Focus refers to particular unresolved issues the nurse and clients are working on and/or concerns the nurse has which need follow-up before/during the client’s next visit to the center. Thus, the FF functions as an on-going, regularly updated nursing care plan.

The Carative Factors (CFs) are used in charting to provide a useful reminder to us daily, but in a reflective rather than predictive way. We do not see the carative factors as mutually exclusive or easily definable. The priority of one over others is very much influenced by both the individual client’s particular situation and the nurse-client interaction at a particular time. The manner in which the CFs are useful to us is in reviewing them after each charting entry and, from the narrative description of the client encounter, deciding and documenting which of the CFs are best exemplified. The corresponding CF number is then noted in the chart page margin. In addition to the 10 CFs identified by Jean Watson, we have created an eleventh entitled “medically supportive nursing.” We believe this allows us to accurately reflect the technical treatment as well as the emotional/supportive interventions that occurred during the interaction.

Charting at DNPHC includes a combination of narrative, procedure focused and flow sheet documentation. Charting obligations include documentation of all:

- Introductory Interviews.
- Medically supportive nursing care.
- Significant nurse-client interaction.
- Referrals.
- Client Education.

The Chart

The client record at DNPHC consists of a simple folder with designated basic information. The left side of the folder is a demographic “face sheet.” This information is usually obtained during an introductory interview and is entered into a computerized data base from which a set of index cards is generated for quick and easy use by nurs-
ing and support staff. The lower part of this lists the Carative Factors for easy reference by all persons charting. Under this sheet is a “check list” page used for documentation of client education.

The right side of the record consists of progress note documentation and may appear in one of several formats:

- **Narrative account of the nurse-client interaction**
  - Most common progress note
  - Uses present and future focus format

- **Flow sheets**
  - Standardized to include necessary information for treatment
  - Used to document specific treatments such as blood transfusions

- **Stamp for Aerosolized Pentamidine**
  - Standardized to include necessary information for treatment
  - Stamped onto progress note

**Quality Improvement**

All nurses participate in chart audits biannually. Charts are randomly selected for review, with each nurse completing the “Chart Review Check List” for approximately six charts. Results are tallied and shared with all staff. The information is used for:

- A basis for clarification.
- Improved consistency of information recorded.
- Use and understanding of the Carative Factors.
- Decisions regarding modification of expectations/standards.

*Linda Laxson*

**Outcome Evaluation Activities**

Numerous methods have been used to document and evaluate outcomes of the overall program as well as individual caring activities at DNPHC. Central to caring theory is the belief that the definition of a “positive outcome” must incorporate the client’s values and wishes. Therefore, DNPHC has consistently invited open client input and involvement, both on an individual and group level. Open forums, attended by all interested staff and clients, are held quarterly. Regular communication between staff and clients at the bi-monthly meetings of the Client Advisory Committee encourages
mutual commitment to upholding the Center’s mission. The open and trusting environment makes it possible to revise the correct programs or policies that aren’t working, through joint staff-client problem solving and planning.

The steady increase in use of the program throughout its history, in itself, documents that clients’ needs are being met and there is satisfaction with services. Questionnaires and interviews are used periodically to evaluate specific aspects of the program (e.g., the Nursing Care Partnership program, cost-effectiveness, etc.). Focus group methodology (Schroeder & Neil, 1992) was used as an effective “total program evaluation” in 1990 and resulted in the formation of the Nursing Care Partnership program.

A form of unsolicited outcome evaluation has come in recognition from outside organizations and groups. DNPHC has received six separate awards for excellence in services to the HIV/AIDS community.

The appreciation expressed by clients who use DNPHC (and their families and friends) continues to be the most satisfying and rewarding documentation of positive outcome. Many such sentiments were expressed in a videotape which tells the Center story. The videotape as well as letters of support which have accompanied grant applications comprise a permanent record of such evaluations.

Finally, DNPHC has completed extensive research to validate its cost effectiveness. Articles by Bronikowski (1993) and Schroeder (1993) describe methods used by reach conclusions concerning dollars saved by and for the sponsoring institutions because of their cooperative sponsorship of the Center.

Ruth M. Neil
Appendix A

CARING CENTER
The Denver Nursing Project in Human Caring

Words from the Mission Statement

The DNPHC Staff, through establishment of authentic caring relationships with the clients, assist and encourage them in self-acceptance, self-love, and self-empowerment. The staff belief is that the healing process is fostered by the understanding, love, and concern of those who care.

History

The Denver Nursing Project in Human Caring (DNPHC) opened in July, 1988, as an out-patient center for clients with HIV Infection/AIDS. Since that time, the center has hosted more than 21,000 (as of August, 1993) client visits and currently has more than 325 active clients. Sponsorship of DNPHC has been shared by three Denver hospitals (Veterans, University, and Denver General) and the University of Colorado School of Nursing/Center for Human Caring. Persons eligible to be clients of the center are HIV-infected individuals whose medical care for their HIV disease is based in one of the three sponsoring hospitals. The services and programs available at DNPHC are totally nurse-directed, with effort dedicated toward responding to current client needs and interests.
Services and Programs

DNPHC is located in Building 5 on the Veterans Hospital grounds (11th and Bellaire). Hours: 10 a.m.–3 p.m. (Monday–Thursday) and 8:00 a.m.–3 p.m. (Friday). The center provides numerous educational and support services (both individual and group); alternative healing modalities such as massage, therapeutic touch, and art therapy; aerobics classes; dental screenings; free Friday lunches; and opportunity for clients to be with friends and caring professionals in a positive environment. Medically-supportive services (blood transfusions, IV fluids, pentamidine treatment, etc.) are also available.

Special emphasis is placed on opportunities for meaningful client involvement through the Client Advisory Committee and through volunteer and paid work available at the center. Clients are responsible for production of the newsletter and participate in educational efforts of the center.

The center has been recognized by the AIDS Lobby for Better Living, the U.S. Department of Health and Human Services (Region VIII), Sigma Theta Tau, the Annual Rocky Mountain Regional Conference on HIV Disease, and the 31st Annual Excellence in Government Awards Program for the quality of its services and programs.

The Nursing Center as a Model in the Health Care System

DNPHC began receiving funding in July, 1990 from a grant awarded by the Division of Health and Human Services, Division of Nursing. The purpose is to evaluate the effectiveness of a nursing center (in terms of consumer satisfaction as well as long-term economic feasibility). Because of the current concern with health policy and economics throughout the nation, the center maintains communication with individuals across the country who are involved with decisions about provision of health services—in addition to networking with others involved with AIDS/HIV care.
The Denver Nursing Project in Human Caring (Caring Center) is a nurse-directed outpatient community health center offering a broad range of programs and services for persons affected by HIV/AIDS.

Mission Statement

The first mission and top priority of The Denver Nursing Project in Human Caring is facilitation of high quality health care of HIV-positive clients and their lovers, friends, families, and designated others who make up their support systems. Such health care is based on respect for each person and belief that health and well being are multidimensional—including physical, emotional, mental, spiritual, and the social components. Every person is unique and has the right and responsibility to make informed choices concerning health. Each also possesses inner resources and strengths to meet health challenges. Through establishment of authentic caring relationships, the DNPHC staff and clients encourage self-acceptance, self-love, and self-empowerment. The staff belief is that the healing process is fostered by the understanding, love, and concern of those who care.

Education is the second mission of the DNPHC. Education is the foundation for competent care of others as well as care of oneself. Clients and staff continue to share openly their knowledge and experience as greater understanding develops about the spectrum of HIV-induced health changes. DNPHC staff and clients also serve as resource persons for various education programs in the community. In addition to client and family education, training and observational programs for students and professionals from nursing and other health-related disciplines are provided at the Center.
The third mission of the DNPHC is to foster professional health care practices based on research findings. This includes staying abreast of the professional literature, participating in research conferences, initiating nursing research, and cooperating with other disciplines and agencies as appropriate in the conduct of research. DNPHC is also committed to demonstrating and disseminating information regarding the cost-effectiveness of the nursing center model.

Nursing practices carried out at the DNPHC are based on Jean Watson's theory of Human Care Nursing. This provides opportunity for ongoing validation of the theory as well as basis for research questions.

Selected References


1. As caregivers we have been socialized to believe that “getting involved” with patients is unprofessional because it threatens the objective, value-neutral stance that is idealized by medicine. As a result many caregivers tend to suppress their own caring instincts. Caring theory can help nurses articulate and claim legitimacy for the complex and deep personal relationships that sustain us and give meaning to the work that we do.

2. Caregivers can, however, be misled into destructive ego-centered entanglements in the name of “caring.” In order to maintain authentic caring, we need to transcend our own ego to find a greater meaning and significance to our involvement with clients, one that goes beyond the superficial self to the core of being or the spirit within the person.

3. This “spiritual transcendence” is what allows us to move beyond judgement and care for individuals whom we might otherwise want to avoid.
4. Another way to avoid the wrong kind of “over-involvement” is to always strive to do the “least possible” when helping another person. Whenever we do too much we always take away some of the other person’s own potential. Instead, we remain in the background, facilitating or mobilizing the client’s own resources.

5. Because authentic caring empowers clients in this way, it never promotes unnecessary dependency or over-treatment, and is ultimately the most cost-effective method of helping.

6. Caring is a unique expression of the authenticity of each person in a relationship. There are no theories that can prescribe “correct” caring behaviors. When we experience a “caring occasion,” we are able to give full authority to the experience and allow the expression of compassion in whatever form is appropriate to that moment. Sometimes caring involves being forceful or angry. What distinguishes a caring confrontation from an abuse of power is that the confrontation is used as a way to express concern. In other words we do whatever we need to do to stay involved with the client. In some cases this may necessitate setting limits on behaviors that are making it impossible for us to care.

7. Sometimes we need distance, but when that happens we distance from the pathology rather than from the human person.

8. In order to avoid becoming consumed by a client’s pathology, hopelessness, or despair, we need to have access to a broader perspective that comes from our knowledge base, life experience, and experiences with other clients that serve as a source of hope and optimism. So, instead of maintaining therapeutic objectivity, we strive to achieve a therapeutic perspective.

9. As caregivers we are routinely confronted by situations of human breakdown, violence, and loss that assault our human sensibilities. As a result, we need to find our own source of personal and spiritual sustenance through counseling, therapeutic touch, meditation, and other spiritual practices that help to restore our own sense of peace.

10. Nursing and other health professions contain both caring and curing functions. Curing involves a sense of mastery by the clinician that is satisfying to the ego. Knowledge, expertise, and power belong to the clinician and the technology that is used to solve or remove the problem. This model is very appropriate to certain situations, for example, when responding to a medical emergency. However, in a caring model these curing functions are utilized in the context of a caring relationship and in the service of alleviating vulnerability rather than as an end unto themselves (see Table 1).
11. It’s important to keep in mind that, unlike curing, caring is a social creation not an individual achievement. Therefore, we need to think of ourselves as part of a larger team or network when providing care. Otherwise we might be seduced into an over-inflated sense of our own importance.

12. When working with clients in tragic or deplorable circumstances, our urge to help might cause us to take their life on as though it were our own. It helps to remember that we can never live another person’s experience or pain, nor would that be helpful even if we could. Our ultimate responsibility is to respond with compassion and helpfulness. I like to think of myself as one person they meet by the side of the road during their journey through life. I can make a difference, but I can never take away or replace their particular journey. (See Appendix A.)
### Table 1
Caring/Healing Relationship

<table>
<thead>
<tr>
<th>Curing</th>
<th>Caring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking over and fixing the problem.</td>
<td>Mobilizing client’s own resources for solving problem.</td>
</tr>
<tr>
<td>The clinician and his/her skills are in the foreground. They are the subject of the experience, while the client is the object.</td>
<td>Clinician in the background allowing the client to be the subject of the experience.</td>
</tr>
<tr>
<td>Clinician feels mastery/ego satisfaction (swelled head).</td>
<td>Clinician transcends ego (swelled heart).</td>
</tr>
<tr>
<td>Clinician becomes very involved in problem or pathology. Limits involvement with person.</td>
<td>Clinician becomes very involved with human center of the person. Limits involvement with pathology.</td>
</tr>
<tr>
<td>Independent of context.</td>
<td>Dependent upon context.</td>
</tr>
<tr>
<td>Goal is to control outcome.</td>
<td>Goal is to suspend control and participate in process.</td>
</tr>
<tr>
<td>Knowledge/expertise belong to clinical.</td>
<td>Authority is derived from the client’s experience and the intersubjective knowledge that is cocreated by the relationship.</td>
</tr>
<tr>
<td>Values rationality. Emotions subjugated by intellect.</td>
<td>Intellect and rationality are used in the service of heart-felt emotions.</td>
</tr>
<tr>
<td>Patient is passive recipient dependent on clinician.</td>
<td>Client is the active subject in control of own treatment.</td>
</tr>
</tbody>
</table>
Appendix A

Guidelines to Prevent Becoming Involved in a Destructive Way

What is it about this person that I am overinvolved with? For example, am I fascinated with the pathology or the symptoms? Do I identify with the problem?

The problem with these questions is that if you answer "yes," it does not necessarily indicate the wrong kind of involvement. For example, identification with a client is not a problem unless it is a destructive identification. Those who are most at risk might answer "no," as they are probably unaware of the needs that are driving the relationship with the client.

Is something about this client's personality or situation getting me "heated up"?

This is okay and can provide motivation for advocacy. The danger arises when we get caught up in principle at the expense of the client by making the client a "cause." Another danger is that this may be our battle, although we may not be aware of it and may think that it is the client's need.
Is my ego getting caught up in this situation? Will this case prove my abilities or worth as a clinician? Have I, as a helper, become the focus of this experience rather than the client? Do I think I'm the only one who can help?

It's hard to admit when we get our egos caught up in our work. One caregiver explained that she will get a swelled heart rather than a swelled head when she has a caring experience.

Can I stand back and look at this situation from a variety of perspectives? Can I hear the team’s point of view, the family’s?

If we become too immersed in the client’s inner world without an alternative perspective, we will no longer be a resource for that person.

Might I be unwittingly using this relationship to work out some pain from my own personal history?

While helping others with similar problems can be a very healing practice, it requires that we have healed ourselves. For this reason, and many others, many people in the human service fields find counseling, psychotherapy, or other healing work helpful.

Am I acting as “The Lone Ranger,” rather than trying to mobilize a team response?

Successful caregivers will see themselves as part of a team even if they have to create one from community/client resources.

Am I empowering this person by doing the very least possible for the person so that I don’t take away any of the client’s potential?

This may be difficult because it means allowing yourself to watch someone struggle to solve problems instead of just taking over yourself and doing it for the person.

Do I believe in the inherent competence of this client? Do I feel a sense of hope for the client?

Every client has strengths and inner resources that have not yet been mobilized. If we become immersed in the client’s own sense of despair and helplessness, then we will probably diminish them and create the client’s dependency on us and on the system.

Have I utilized all existing resources on behalf of this client? Have I created some if there aren’t any?

Remember that when caring, you strive to be like a conductor of an orchestra, bringing all the resources to life, rather than being the main resource yourself.
Do I have a preconceived idea of what I would like the outcome to be for this client?

While we all have to be professionally accountable for outcomes, to take this on as though we really know what the best outcome for this person should be is arrogant. While we do the best we can, successful caregivers strive just to make a difference for the client, no matter how small it might seem, rather than to try to control the client or what happens to the client.

Am I avoiding my own life by becoming so caught up with this client or with my work in general?

Sometimes, when we are in a personal crisis, it can be helpful to temporarily lose ourselves in work, but to allow work to become part of a pattern of avoidance is the antithesis of caring.

Is there a sense of harmony, or a beautiful feeling, even in the face of tragic circumstance, or do I feel emotionally drained without a sense of meaning?

This is probably the most challenging question, for which there is no easy answer. You should always strive to make sense out of what you are exposed to and make use of all the spiritual, philosophical, and psychological resources that can help you do this. If it is just too much, then it is okay to back off emotionally and distance yourself in whatever way you can.
Case Management in the Caring-Healing Paradigm

Marlaine C. Smith

Case management is a current buzzword in health care delivery circles. It refers to a structure of care delivery characterized by coordinating care within or across continua by a designated provider who relates with the client-family, multiple caregivers, agency representatives, and resource-support staff. Bower (1992) states that the goal of case management is “to integrate, coordinate, and advocate for individuals, families, and groups requiring extensive services. The ultimate goal is to achieve planned care outcomes by brokering services across the health care continuum” (p. 3). Case management is not a new idea in the delivery of health care. The traditional family physician who knew the family well and intervened as a trusted confidant in times of crisis was a case manager. Public health nurses from the time of the Henry Street Settlement practiced case management. These nurses “carried caseloads” of vulnerable families who they “followed” over time. The nurse established a long-standing relationship with “her families,” and as primary care provider referred clients to other professionals and agencies that might promote a holistic conception of health. With
burgeoning health care costs and the need to contain these costs, case management has been viewed as a process to ensure appropriate, coordinated, and cost-effective care. Medical case management has been instituted by third party payers for potentially high cost claims to oversee the use of resources. So in the 1990s case management has been more closely associated with cost containment than with its roots characterized by values of caring, advocacy, and the primacy of the nurse-family relationship. The purpose of this chapter is to reclaim and reframe case management within a caring-healing paradigm of nursing.

Care Management in the Caring-Healing Paradigm Is Based on Principles of Choice, Advocacy, Relationship, and Empowerment.

The term case management, in itself, violates the foundational beliefs of a caring-healing paradigm. It implies a dehumanizing perspective (case) of making decisions about or for another (management). It may be necessary to use the term care management in place of case management, and to clearly define these words for greater clarity. Management can be conceptualized as mobilizing human and material resources that are essential for growth and transformation. Care can be defined as the relationship and activities that facilitate health, healing, and quality of life. Using these definitions, care management is more consistent with the values of this paradigm than case management.

The first principle of care management within a caring-healing paradigm is choice. In care management human freedom is honored. Clients and families choose their own way. The nurse collaborates with clients as they chart their course, and the nurse navigates these choices through the turbulent waters of various systems. Choices may be limited by resources. When confronted with these situations, the nurse explores options with the client and family. The nurse case manager does not make decisions for the client; the client and family make informed decisions for themselves. These choices are facilitated through exploring the meaning of the situation and the meaning assigned to the outcomes imagined in each of the options. The nurse engages the client and the family in this exploration until they have arrived at the choice that is most consistent with their values.

The second principle, advocacy, relates to choice. The nurse brings the client’s wishes and desires to the table when the client or family is not able to bring them. The nurse becomes the voice for family choices with the multiple providers and agencies that are involved across the care continuum. The nurse case manager interprets the client’s perspective to others on the team and champions that perspective in interdisciplinary or interagency conferences. The ANA’s “Nursing’s Agenda for Health Care Reform” (1991) acknowledges this quality of care management. “Case management will be re-
quired for those with continuing health care needs. Case management will reduce the fragmentation of the present system, promote consumers’ active participation in decisions about their health, and create an advocate on their behalf” (p. 3).

The third principle of care management is relationship. Relationship is primary to care management. The nurse care manager knows the client and family and they know and trust her/him. The nurse sustains this relationship through viewing contact as ongoing, not defined by episodes of crisis or illness. The family contacts the nurse with questions or concerns that are health-related. The nurse’s commitment is to the client-family, not the setting or agency. The nurse is present with the client-family over time attending to the quest for health, healing and quality of life.

The final principle is empowerment. This principle describes the shifting of designated power in health decision making to the client-family. The care manager does not “do for” the client, but helps to demystify the system so that the client-family can do for themselves. Empowerment is not the giving of power; it is awakening to the inherent power of intentions, choices, will, and energy that is often diminished by the health care system and providers. The nurse care manager supports the transformation of the health care system from a provider-centered to a client and family-centered model. The nurse care manager supports the client in learning to assert wishes and choices, to explore options, and to enact will. In this way the metaphor of “gatekeeper” gives way to one of “keygiver.” The client has the key to accessing and choosing among available options.

**Nursing Case Management Is Guided by Nursing Theory**

Case management is a structure of care delivery and not the substance of nursing practice. Like team nursing, primary nursing, and primary care, case management is a “vehicle for practicing professional nursing” (Newman, Lamb, & Michaels, 1991, p. 405) but not the practice in and of itself. Care management, on the other hand, is a structure that by its nature decreases fragmentation of care and enhances the client’s ability to negotiate the complexities and dehumanizing experiences that characterize interfacing with multiple bureaucratic systems. Newman (1990) identified levels of practice in nursing where the highest level of advanced nursing practice was realized in the practice structure of case management. Perhaps this structure affords the greatest potential for developing a truly professional practice in nursing. The case management structure is fleshed out by the philosophic and theoretic base for nursing practice. A nurse can practice care management, then, guided by any number of theoretic perspectives. “Practice from a nursing perspective at the most general level encompasses being with the other in a caring relationship that facilitates health, healing and the quality of life” (Smith, 1993, p. 8). In case management, this practice focus can
easily be eroded or superseded by an *exclusive* focus on the medical and financial goals of cure and cost-containment. When this happens case management is no longer nursing care management; it becomes a delivery structure for medical care or financial management. The nurse practicing as a care manager needs to define the practice from a nursing perspective, that is, one focused on caring, health, and healing. Furthermore, the nurse engages in a practice consistent with selected nursing philosophies, models, or theories that are most congruent with personal values and beliefs.

Two well-defined nursing theory-based models of case management have been described in the nursing literature. Both of these models are based on theories within a caring-healing paradigm. The first was developed at Carondelet St. Mary’s Hospital and Health Center in Tucson, Arizona. The theoretic base for this model was developed as scholar-practitioners reflected on the practice and its fit with Newman’s (1986) theory of health as expanding consciousness. The practice was framed in terms of Newman’s concepts of facilitating transformation at critical choice points as clients recognize patterns and make decisions related to changing themselves and their lives. In this model the client, not the nurse, directs the flow of decisions. The nurse facilitates the process of examining patterns and choices. The nurse who relates with the client over time engages with the client over a care continuum. The second model is the care partnership program at the Caring Center, a nurse-administered outpatient facility for persons living with HIV infections (Schroeder & Maeve, 1992). In this model, Watson’s (1985) theory of human caring was chosen as the nursing philosophy and theory that underpins nursing practice at the center. These values are made explicit in nursing practice that fosters healing and wholeness through love and a deep respect for human dignity and freedom. Watson’s carative factors serve as a non-prescriptive guide for addressing client concerns. The care partnership model is an exemplar for care management in the caring-healing paradigm.

**Goals Related to Caring-Health-Healing and Cost-Effectiveness Are Not Necessarily Mutually Exclusive**

In a world where all resources (not only health care) are dwindling and precious, cost-effectiveness is a goal that is worthy of our attention. Nurses, as all other health care providers, are now enrolled in the effort to control escalating health care costs. Bringing costs under control benefits all of us. “Most nurses have recognized they can no longer practice in a traditional cost-unconscious manner and remain members of a viable profession. It is apparent that documentation of cost-effectiveness of nursing care is an essential priority, or nursing may be replaced by other health care professionals better able to respond to a competitive market” (Schroeder, 1993, p. 4). Nursing care management can address the goals of quality and cost-effectiveness. “This
attention to both quality and cost is attained through giving voice to client concerns and choices, establishing an ongoing relationship with the client and family, coordinating care with other providers, and facilitating awareness of cost-effective care modalities” (Smith, 1993, p. 8).

As mentioned previously, case managers are often placed in the frontlines of cost-control by third-party payers. In these situations the ethical/moral question confronted by nurses becomes, “Who is the client?” Banja (1991) states that “the ethical dilemma for the case manager will frequently consist of determining whose agenda deserves the most consideration when they clash. In other words, whose version of what is best or proper ought to prevail when those versions conflict and you can’t satisfy everybody” (Banja, 1991, p. 78). This ethicist states that the patient or health consumer is the ultimate focus of concern and acknowledges that the nurse as moral agent is often in conflict because of employment by a payer or hospital whose goal is cost containment. There are situations when the client-family’s desires for quality of life are clearly congruent with cost-effectiveness. For example, most of our health care dollars are spent paying for advanced technology and heroic treatment during the last three weeks of life. A shift in focus needs to occur. It is a shift from cure at almost any cost to providing love and support in the final days, protecting the dignity and humanity of the dying, and honoring the wishes for quality of living in dying. Clearly, this shift in focus can meet the goals of cost-effectiveness and caring-healing.

The nursing focus on health promotion and healing is cost-effective. Nurse case managers practicing from a caring-healing paradigm view the client as the authority on her or his own health. Clients review their choices, make decisions, and chart a self-designed course facilitated by the care manager. Options for health promotion/healing such as massage, imagery, art therapy, and therapeutic touch are as legitimate within the caring-healing paradigm as experimental pharmaceuticals and surgical procedures are in the medical paradigm, and they are by far less expensive. Indeed, cost analyses conducted on the Caring Center have indicated an estimated savings of over a million dollars in two years (Schroeder, 1993). Evaluation studies on the Carondelet-St. Mary’s model have also supported the cost-effectiveness of this caring-healing model of case management (Ethridge & Lamb, 1989).

Nursing care management enacted within a human caring perspective can facilitate health and healing. The principles of choice, advocacy, relationship, and empowerment are essential to perspective on care management. Nursing care management is a structure of care delivery that is defined by the nursing theoretic approach utilized. Nursing care management may be central to achieving the outcomes of access, cost, and quality in a reformed health care system.
References


Chapter 6

Implementing Watson's Theory of Caring

Jan Nyberg

Introduction

In this text, I will describe how certain organizational characteristics can be structured to enhance the implementation of Watson's theory of human caring. The well-known systems framework of structure-process-outcome will be used.

Structure

Diminishing the Bureaucracy

The bureaucracy was described in the early 1900s as the “ideal organizational theory” (Weber, 1978). The goal of the bureaucracy was to increase the work output of a group of people. By structuring the work in an efficient manner, greater numbers of goods or services could be produced.
The bureaucratic approach to organizing stresses hierarchical chains of command, standardized rules and procedures, and specialized workers. In nursing, bureaucracy encouraged functional work assignment (e.g., medication nurse, bath nurse, treatment nurse) and assignment of responsibility to layers of managers.

As a result of such bureaucratization in nursing, individual nurses were prevented from coming to know and being responsible for a particular patient, a context antithetical to Watson’s caring theory which focuses on relationships as vehicles for healing. To implement the caring theory, the organization should be structured in a way that encourages strong relationships between nurses and patients. Significant here are primary nursing models that require the nurse to know and respect each patient’s personality and needs. Simply, the idea is to get away from assembly-line care where different nurses do different things to patients. Rather, nursing can become more whole-task or craftsman-like in structure. One nurse commits to one patient, actually provides as much of the nursing care as possible, and accepts responsibility for designing and implementing the nursing care for the patient throughout their need for care. In one instance at our facility, the nurses were given business cards that could be given to patients to formalize their care relationship. The patient feels less like a “number” or “diagnosis,” and the nurse is provided the opportunity and autonomy to construct each patient’s care much as an artist crafts a sculpture.

The nurse administrator who wishes to implement Watson’s caring theory should try to diminish the bureaucracy for patients and for nurses. To do so, get to know as many nurses as possible and relate to them as equal partners in nursing. Open staff meetings can assist administrators and nurses to share their perspectives and problem solve together. Nurse managers should be expected to treat their staff with respect. Nurses should consistently hear that their work is important and no one should be made to feel like a cog in the bureaucratic wheel.

Creating New Organization Models

Many current organization theorists have described new organizational models that are more “people oriented” and flexible to changes in the environment. These organizations are trying to be “centers of excellence” (Peters & Waterman, 1982) or “learning organizations” (Senge, 1990).

Such models are important to nursing. Change is constant and often turbulent in the healthcare industry. Procedure books and policies often are out-dated before they can be implemented. Technology changes the whole context of how patients are cared
for. New organization models must emphasize autonomy, flexibility, and relationships which allow nurses and patients to find meaning in their health care experiences. This can be done by work teams, quality circles, and multidisciplinary committees.

Governance structure such as participative management, shared governance, and self-governance can be very useful in the caring organization. As nurses become more autonomous, they also become more responsible. The organization creates a sharing, care environment where nurses consider individual patient’s needs and managers consider individual nurse needs. Issues such as work structure, equipment needs, job evaluation, and quality management are shared by staff and managers. The goal of organization becomes facilitating meaningful patient care and meaningful work for nurses.

Implementing Caring Factors

Watson has defined 10 carative factors which can be wed in the structure of the organization. They are not a list of skills but rather factors which contribute to caring relationships for nurses. They describe caring as a way of being, not how to do things. Implementing the caring factors can help move nursing from a context promoting and protecting bureaucratic skills to a context promoting and advancing professional goals. By using the factors in job descriptions and performance evaluations, the nurses can see that caring is a very important part of their work. The factors can also be used in standards of care, acuity systems, documentation forms, and quality assurance tools. When nurses find the caring factors in each factor of their work, a strong message is delivered about the importance of caring.

Administrative Structures

The goal of an organization structure is to identify who does what under whose control. Structures which facilitate caring theory are “flat”—have few layers of management control. Power is vested in the first-line employee—those who actually deal with patients. Managers are expected to help staff, not boss them. Nurses at all levels in the organization see themselves as colleagues—each with an equally important role in facilitating patient care.

Middle managers, such as assistant directors of nursing, are minimized so that the nurse executives and staff nurses have contact with and respect for each other’s roles.

Flexibility and creativity should be encouraged in an organization implementing a caring theory. Nurses should feel free to use new nursing treatments such as massage, music therapy, and therapeutic touch. The organization of tomorrow is not yet formulated today. It will evolve as nurses and managers explore new ways of structuring the caring organization.
Several questions to help you determine your organizational path are listed below:

1. Are your private philosophy and values compatible with Watson’s theory of caring?
2. What are some ways you could diminish the bureaucracy in your workplace?
3. Are you familiar with newer models of care that would better “fit” with caring theory?
4. Could the caring factors be used to encourage nurses to be caring in their work?

**Process**

*Relationships* are the most valuable commodity in an organization implementing Watson’s theory. Nursing skills are requisite with the caring relationships. But nurses are not just evaluated on whether they can perform skills. They are evaluated on how they perform them in the relationships of their job.

Watson’s work on transpersonal caring should be learned by every nurse. They can then become aware that caring is a two-way relationship where both people are profoundly affected. Teaching communication or caring interactions can be done by emphasizing:

1. **Self-worth**—nurses must learn to appreciate their own self and attend to their own needs to learn and grow.
2. **Commitment**—nurses must see their work as more than a job where they do their tasks and leave. Teaching nurses about commitment means treating them like professionals and expecting them to commit to their patients throughout their health or illness episode. Such things as taking care of the patient’s whole needs, recognizing the importance of their families and significant others, and being willing to “buck the system” if needed to get patients’ needs met are of paramount importance. Patient assignment should be made so that one nurse takes care of a patient repeatedly. As the relationship between the nurse and patient grows, so does the commitment.
3. **Openness**—nurses should be encouraged to be open to patients’ communications. Nurses should learn to be comfortable with silence and to accept positive and negative feedback constructively.
4. **Prioritize**—nurses are very busy at work, and they sometimes feel that they do not have time to care. Part of prioritizing has to do with reserving time for caring communication. In addition, nurses need to be assured that caring can be a priority without a lot of time. Every interaction with the patient is a priority time for caring.
5. Potential—it is necessary for caring nurses to have the basic attitude that all people have potential to learn and grow, and the nurses are responsible to assess needs for growth and then address the needs in partnership with the patient.

One excellent way to teach nurses about caring is through story telling. If you ask nurses to tell about a caring moment for them in nursing, they almost always can share beautiful stories. As they share, the story telling itself can become a caring moment. Nurses are aware of caring; they know what it is inherently. But the process of implementing Watson’s theory of caring is one that gives nurses a better understanding, teaches them a language to express their caring, and gives them a new voice to explain this essence of nursing: caring.

Education

Another important process in implementing caring is to teach nurses about new modalities of care that nurses are learning to use in patient care. They can learn a new appreciation of the aesthetics and sensory experience of the patient. Using therapeutic touch, imaging, music, art, or massage allows nurses to find their own best way to nursing patients. Stressing relaxation, taste and smell, and lighting changes may put the patient in a better healing mode. While the process of implementing Watson’s theory of care will require traditional classes, the teaching itself must be caring—a gently flow and sharing which opens up new understandings of ourselves and our surroundings.

Other Processes

Besides educational classes, other processes can help implement caring, including: consultation, conferencing, patient rounds, discharge planning sessions, and working with student nurses. The patient’s needs should guide the nurses’ caring activities.

Management Caring

The process of implementing Watson’s theory of caring requires the efforts of management as well as staff nurses. Leaders need to examine closely whether or not they exhibit caring in their interactions with nurses and others. The framework of self-worth, commitment, openness, prioritizing, and potential are just as applicable to managers and administrators as they are to staff. The only real difference is that most of the manager’s interactions will be with nurses and other health care professionals instead of patients. But administrators must care for nurses as we expect nurses to care for patients. Are we really good listeners? Do we look for transpersonal caring and caring moments in our own hectic days? Do we make caring a priority and do we believe in
the potential of staff to grow? As nurse administrators must change the organizational structure to facilitate a caring model, so must they change the processes of how work gets done; with the priority on caring. Several questions to help you in the management of caring are listed below:

1. Do you view relationships as an important part in the healing process?
2. What education or caring do you think is important for nurses?
3. Do you believe that learning and implementing caring in your own life is important?

Outcomes

Outcomes are the ultimate reality of whether any theory really works. The outcomes for an organization implementing Watson's theory of caring will be very different from the bureaucratic goal of economic efficiency.

Measures of an organization's effectiveness can range from a healthy bottom line to satisfaction of patients and employees. Many studies have been done on nurse job satisfaction. Measures such as organizational survival, salary and benefits, relationship to supervisor, and adequate staff and supplies are important to nurses. But the primary measure of effective outcomes for most nurses is this: "Did the patient get excellent care." Kramer and Schmalenberg (1982) wrote that in 12 "magnet hospitals" (hospitals known for excellence in nursing) "a high level of performance by RNs is inseparable from high quality patient care" (p. 40). Why is high quality care so important to nurses? Nurses want adequate pay and good supervisors, but nothing matters as much as the outcome of excellent nursing care.

Peters and Waterman (1982), in *In Search of Excellence*, wrote that the best companies develop a unique culture based on a few values that absolutely drive the system. Implementing Watson's caring theory says "our number one value is caring relationships"—relationships which enhance life for both the patient and nurse.

Nurses implementing a caring theory are, indeed, "searching for excellence," for themselves and their patients. Caring theory informs them that excellence is helping a patient grow. Excellence is the satisfaction of a mutually fulfilling caring experience, be it with a patient or with another nurse. It is defining a value system, tracking caring factors, learning about relationships, and knowing the satisfaction of connecting with another human being. Caring is more than a theory. It becomes the structure, process, and outcome of excellence in nursing care. It becomes a lived-theory which is, after all, the ultimate goal for all of us in nursing. Several questions to help you in understanding caring outcomes are listed below.
1. How would your organization be different if you implemented Watson's caring theory?

2. What could you do to encourage caring outcomes?

3. What are the ways you could measure outputs related to caring?

Summary

So, what would an effective unit where caring theory is implemented look like? First, the caring unit would have one primary goal: excellent care of patients. To achieve this, the nurses would need to understand the uniqueness of each patient and prepare themselves to offer nursing care in a way that puts the patient first. The nurse would consider the patient's characteristics and health state and plan care that would help the patient grow—sometimes to better health, sometimes to better coping, and sometimes to a peaceful death.

The unit would be aesthetically pleasing. Experts on color, light, and decorating would be consulted, and the environment may include special music and art. Nurses would be open to use alternative healing modalities such as therapeutic touch, massage, relaxation techniques, visual imaging, and so forth. They would contribute to the physician's medical caring approach, but medicine would not be the only goal. It would be viewed as one way to contribute to the well-being of the patient. Nurses would no longer wait for the doctor's orders and do what they were told. The nurse would realize that not all experiences in health care are positive for patients, but she or he would be committed to staying with the patient through good and bad times; willing to hear good and bad things from the patient. Nurses would become active partners with patients through caring relationships, and care would be organized around the mutually defined patient care goals.

Nurses on a caring unit would treat other nurses differently as well. Positive energy would be extended from nurse to nurse so that a supportive community would be created that would lead to growth for nurses—one helping another, and another helping one.

The “boss” on the unit wouldn’t be a boss at all, but rather a facilitator whose goal is to help nurses achieve positive caring relationships with patients. All of the nurses would study caring theory, and the result would be a community of caring where patients and nurses could feel the energy and satisfaction of caring.

The nurse manager models caring in her own interactions with doctors, nurses, and other health care providers. She would be responsible for integrating the organizational goals with the nursing goals. She would stress the need for good stewardship.
financially recognizing that costs are a concern for patients and for our society. She would seek adequate resources to provide caring nursing care, but she would also try to find ways to minimize costs and change the system to meet changing patient needs. She would not keep financial restraints centered on her own actions, but bring nurses to a level of financial understanding so that everyone is a part of a cost-efficient care environment. She would see herself as a partner with her nursing colleagues: someone who gathers and disseminates information, who collaborates with nurses to set unit goals, and who evaluates the system for needed improvements. When discord occurs between patients, nurses, doctors or others, the nurse manager will be a mediator. She will encourage people to communicate directly with persons they disagree with in order to minimize gossip and back-biting. She would attend to her own growth and needs in order to be able to attend to the growth and needs of the staff. The nurse manager would have the responsibility of understanding and interpreting the organizational goals and environment as they relate to the nurses and patients on the caring unit. She would also be active in the health care system outside the organization so she can find new ideas and can influence health care as a whole.

Caring Theory in the Future

Drastic changes are coming fast in health care, so the question becomes “how do we use caring theory in the future?” The pessimist might say “we will never be able to afford caring—it takes too much time.” Another answers that “we won’t be able to do without it!” Although our new health care system will bring new challenges, I am hopeful about nursing’s future. The new system, no doubt, will have wonderful opportunities for nurses to try new roles in nontraditional settings. Still, I wonder about the majority of nurses who work in traditional hospital settings. They already feel overworked and unappreciated. Will their new responsibilities drive them to the brink of despair?

I believe that implementing a caring theory can make all the difference in how nurses perceive and do their jobs. Caring relationships can be an anchor in this time of change.

One fundamental reality about caring is that no one can make you do it or take it away from you. Another essential fact is that caring doesn’t necessarily take time. Caring can occur in an instant, and having a caring relationship will cut down on time because it strives to meet the patients’ needs efficiently. A nurse who has a caring relationship with a patient needs less time to care for him or her than a nurse who is a stranger—who has to get to know the patient well enough to treat him or her effectively and efficiently. And the nurse using caring theory will be much more satisfied with his or her work (as the patient will be with his or her care). Caring requires time to get to know the patient and may call attention to patient’s needs not otherwise uncovered. The greatest danger to caring from an economic point of view is that, if nurses
feel themselves to be overworked, they also get frustrated. By then, it's hard to be caring. But if the nurse believes in caring as fundamental to nursing, the nurse will use every opportunity (whether one minute or one hour) to use a caring philosophy with a patient.

Another fundamental characteristic about caring is that it spreads. When one nurse is caring regardless of circumstances, others may be able to do the same. Another very important source of caring originates from nurse leaders and administrators. If they are committed to caring, two things need to happen: first, the nurse administrator must work hard to obtain adequate organizational resources to allow for caring; second, the nurse administrator must set the standard for caring by making it a part of her or his own work. Nurse executives are very busy today; they probably feel as overworked as the nurses. But prioritizing time to find opportunities for caring can change the whole feeling of an organization.

I know health care costs will be a major problem for some time to come. But I also know that caring nursing care is what keeps a health care organization from being nothing more than a business. As nurses learn to take Watson at her word—that nurses have a responsibility to society to keep caring alive—they will answer emerging problems with caring solutions.

References

Chapter 7

Caring for the Caregiver

Janet F. Quinn

Introduction

This paper is written for nursing clinicians. It describes an approach to caring for the caregiver which derives from nearly 17 years of clinical practice, teaching, and research in the nursing intervention of Therapeutic Touch, and from working with practicing nurses in a program called “Caring for the Caregiver,” which is offered throughout the world by the Center for Human Caring at the University of Colorado Health Sciences Center School of Nursing. I’ll begin with a metaphor.

When you fly on an airplane you receive a set of instructions designed to teach you how to survive various situations. One of these situations is the instance of a change in cabin pressure and the instruction goes something like this: “In the event of a sudden change in cabin pressure a yellow oxygen mask will drop down in front of you... if you are traveling with someone who needs assistance, adjust your own mask first and then assist the other person with an additional mask.” Of course, this makes perfectly good sense—what good will you be to the other person if you lose consciousness from oxygen deprivation because you’ve either neglected to put on a mask or given yours away?
I believe that the challenge for anyone practicing nursing, literally traveling with many others who need assistance, is precisely the same—to maintain one’s own breath or “inspiration,” one’s own wholeness, vitality, and life energy before, and even as we engage in, helping others. In addition, caring for ourselves, remaining full of vital energy, allows not only our patients but all who come in contact with us to drink from and be nourished by a deep well of abundance, rather than struggling to drain the last drop out of an already empty cup.

There are many, many ways to take care of ourselves. Good nutrition, regular exercise, rest and relaxation, pursuing interests which are meaningful to us, meditation, journaling, and many other activities are now so frequently discussed as to seem common sense. Yet all of these activities, all of these approaches to caring for ourselves have one thing in common, namely, they are things we do away from our actual work. We eat properly, exercise, rest, and so forth, so we can recover from and prepare for the stresses of our work. While any or all of these strategies may be useful, they do not help us to care for ourselves as we are working; in the very moments when we are engaged in our caring and healing interactions. The purpose of this paper is to describe such an approach to caring for the caregiver.

**The Need to Care**

Benner and Wrubel (1989) hold “that caring and interdependence are the ultimate goals of adult development. To care and feel cared for promotes personal and societal health. Caring is the most basic human way of being in the world” (p. 368). Fewer and fewer opportunities for such an exchange exist in a health care system which is increasingly high tech and low touch, yet this desire to care in a healing and compassionate context is what draws most nurses into nursing to begin with. In fact, if this is not the larger part of the motivation which one brings to the pursuit of nursing as a profession, I would suggest that she or he will never be a truly excellent nurse, despite any degree of competence in the technical skills involved.

When the need to care is frustrated, prevented, or ignored, there is a serious price to pay. Repeatedly in my work with nurses, they tell me that it is not caring too much which has drained them or caused “burnout”; rather, it is not being permitted to care in the systems in which they work. This situation is strikingly similar to one which can occur in the role of the shaman, the healer or medicine person; a role nearly as old as human consciousness itself.

In shamanic traditions across every human culture, there are many ways in which one discerns that they are “called” to be a healer. In this context, to be “called” means to come into contact with one’s deepest wisdom, one’s sense of purpose or meaning in life. Frequently the call comes in a prophetic dream; the healer-to-be dreams that he
or she is called to be a medicine person for the community. The dream includes the
details of where the apprentice healer can find a teacher, when the journey is to com­
ence, and how long the training period will be. Of course, free will remains, and so
the dreamer can awaken and either follow the call or go on with life as it was. Yet the
ego’s will and the heart’s desire are not always in agreement, and if free will blocks the
call of the heart to become a healer, the story goes, serious or even fatal illness will
ensue. This illness can be physical or it can be mental, such that the person can appear
quite psychotic. This “psychosis” has been named a “Shamanic crisis” and is, I believe,
essentially the manifestation of inner despair and turmoil created by the failure to
follow the call of one’s heart.

When we enter nursing because we are following our call to care, then not caring, or
acting in ways which are actually personal overinvolvement and not true caring, will
become unhealthy for us. If we are paying attention to our intuitive self-awareness and
our tendency towards wholeness, we will begin to identify that our work is literally
making us sick, and ultimately, to remain healthy, we will leave. To prevent this from
happening it is important to learn how to care for one’s self through caring in healthy
ways for one’s patients. We need to solve the apparent paradox that to be healthy we
must care without becoming overinvolved.

Actualizing the Need to Care:
Unconditional Love and Compassion

A modern approach to healing which derives from the ancient practice of the laying­
on of hands, Therapeutic Touch, was introduced by Dolores Krieger, a Professor of
Nursing at New York University (Krieger, 1979). Since that time, both the research
and nursing practice of Therapeutic Touch have grown dramatically. Therapeutic Touch
is now practiced by nurses throughout the United States and internationally.

At the core of the Therapeutic Touch process is the intent of the practitioner to help
the recipient, that is, the practitioner attempts to focus completely on the well being of
the recipient in an act of unconditional love and compassion. For this reason, Therapeu­
tic Touch has been called a “healing meditation” (Krieger, Peper, & Ancoli, 1979).
I have observed consistently that the use of Therapeutic Touch in nursing practice
seems to be as beneficial to the nurse as it is to the patient at many different levels, and
several research studies support this observation (Lionberger, 1985; Heidt, 1991). Why
should this be so? What is it about doing Therapeutic Touch that is so beneficial to
nurses?
I believe that the answer to this question is complex, but can be explored beginning with one single element: The practice of Therapeutic Touch demands that the practitioner begin every treatment with centering in love and compassion, and from this center making the intent to be an instrument for helping and healing. In this way, using Therapeutic Touch allows for the full actualization of the deeply human motivation to care; to connect; to respond to human suffering with unconditional love and compassion without attachment to the outcome of the treatment. Let's explore these characteristics of Therapeutic Touch more fully and then discuss how they may be applied to caring for one's self during all nursing practice—whether or not one ever chooses to practice Therapeutic Touch per se.

**Centers**

At the start of a Therapeutic Touch session the nurse centers, that is, turns his or her attention inward, reaching a calm, relaxed, and open state of consciousness. In this state of consciousness, the Therapeutic Touch practitioner then consciously formulates the intent to be an instrument for helping or healing and focuses on wholeness and balance in the recipient. This process on the part of the Therapeutic Touch practitioner may be thought of as a repatterning of his or her own energy field in the direction of expanded consciousness, a consciousness experienced as unified, harmonious, peaceful, and ordered. Being in such a state of consciousness is not only helpful to the patient, but extremely helpful to the nurse. In nurse theorist Margaret Newman’s conceptual framework, expansion of consciousness is equivalent to health/healing (Newman, 1986, 1990). Thus, the repatterning of consciousness which can occur during Therapeutic Touch may be viewed as movement toward health for both the nurse and the patient.

**Becoming an Instrument for Healing**

The word _heal_ derives from the word _haelan_, which means to be or to become whole. Wholeness in this context means more than the intactness of physical structure and functioning. Rather, wholeness may be thought of as a dynamic process of being in right relationship at all the levels of the human experience—body, mind, emotion, and spirit (Quinn, 1989). Harmony and balance, ease and a sense of rightness, characterize the healing process. Facilitating the healing process through caring is the unique focus of nursing (Quinn, 1989; Watson, 1988). This differs significantly from the focus of medicine, which is the removal of signs and symptoms of disease, and which we know as curing.
A basic requirement for those who wish to facilitate the emergence of healing through Therapeutic Touch (or any nursing intervention) is to recognize the source of the healing. All healing, indeed, all curing, is ultimately the work of the patient—the “one-healing.” We may assist in this process, we may help to remove the obstructions to healing or curing, but we cannot heal or cure anyone. The inner wisdom of the patient, that tendency toward healing and wholeness, will always use the resources and energy we provide (or help him or her access) in a mysterious way which is unique to each individual. Given these assumptions, it is very clear that one cannot predict what the outcome of any given treatment will be—whether the treatment is Therapeutic Touch or medication or surgery. Because of this, during Therapeutic Touch, we center in compassion, make the intention to be an instrument for healing, direct energy for that purpose, and then let go of any expectations for or attachments to the outcome, trusting the natural healing process to do its work.

“Caring from Center” as Caring for the Caregiver

In the centered state of consciousness, we can open to the qualities of unconditional love and compassion and allow ourselves to be nourished and healed by them. When we center in the present moment, in love and compassion, we are able to step out of our own worries, anxieties, fears, and concerns, and completely focus our intention on being an instrument for healing. From this place of centeredness, fullness, and abundance we reach out to our patients with love and compassion. This reaching out in love and compassion, without attachments to the outcome, is what we mean by becoming an instrument for healing. For as Watson (1988), citing de Chardin, reminds us, “care and love are the most universal, the most tremendous, and the most mysterious of cosmic forces; they comprise the primal and universal energy” (p. 32). The nurse in a centered state of consciousness accesses this energy and it becomes available to him or her as well as to the patient. “Caring from center” constitutes a form of transcendence—a caring which comes from that place within the nurse which is deeply intimate yet beyond personal ego and can connect with the other in compassion, without demands for particular outcomes. In so doing, the nurse is nurtured and energized by caring, which becomes a connection to something larger than the personal self. To complete the analogy with which this chapter began, “caring from center” is the equivalent of placing an oxygen mask over your own face first, before trying to assist someone else.

Centering need not be limited to its use in Therapeutic Touch. “Caring from center” is an extremely meaningful and self-caring way of responding to the stresses inherent in all of our work as nurses. If we can learn to notice stress responses in our bodies related to specific situations, we can use those responses as cues or invitations to shift
consciousness, and to choose to enter a centered state of consciousness in the precise moment in which the stressor is being experienced. This is an approach which radically shifts the focus of the nurse into a self-caring, self-healing focus, out of which creative responses to the stressor may be imagined and employed. When centered, the actual nature of the “stressor” or the energy demand being made on us may be more fully perceived and responded to with increased clarity and choice, just as the passenger on the airplane will be able to think and act more efficiently with proper oxygenation.

In a centered state, the nurse also decreases his or her reactivity and thereby increases the possibility for creative actions which serve the nurse-self and others more fully. The choice to enter a centered, healing state of consciousness in the face of environmental stressors is an empowering one and is the opposite of denial, avoidance, or repression. Centering calls for a dynamic opening up and expansion of consciousness, whereas denial, avoidance, or repression may be thought of as contractions of consciousness. This expansion of consciousness does not “turn off” our humanity; it does not guarantee that we will not experience sorrow or grief or pain in the presence of human struggle or suffering. Rather, it gives us a way of being with that person and with our own humanity with such openness that we are not drained by the experience. We can be touched deeply by the suffering which we are interacting with, and then we can let it go, because to hold onto it does not serve either the patient or the caregiver.

It is this shift, out of reactivity and helplessness in the face of clinical demands and human suffering to empowerment, choice, and action in the same contexts which is so helpful in caring for ourselves. This approach to caring consists of three ways of being—which will now be summarized with some suggestions for accessing them.

**Be Centered**

Before each interaction with a patient or a family member, or anytime during the day when you notice that you are feeling “stressed” or drained, center yourself. There are many approaches to centering—find a way which is useful to you to bring your awareness to the present moment. Perhaps begin by noticing your breath, and allow all other thoughts—ruminations about the past or fears, hopes, dreams for the future—dissolve or float by like clouds passing above you on a breezy day. Allow your total attention to turn inward, focusing on your breath. Take a deep breath in, and a very deep exhale out; imagine as you breathe in that there is a stream of energy entering your bodymindspirit from the top of your head; as you breathe out, draw this energy through you and down into your legs and out your feet, grounding you in the earth; imagine yourself as a tree—open and interacting, being nourished by the sunlight which you draw into yourself, while being firmly grounded and rooted; if you find your mind wandering, simply turn your attention back to your breath, and to centering yourself.
Be an Instrument

From this centered and grounded place, make the conscious intention to be an instrument for healing/wholeness. Imagine that a healing energy, or unconditional love, is moving through you, filling your whole being, and then overflowing out towards the person or people you are with. Use whatever symbols or feelings are meaningful to you to create this sense of energy moving through you—some people think of a beautiful stream of light coming through the top of their head; others imagine a waterfall or a river, or perhaps a very gentle stream if we are concerned about giving “too much” energy. Still others think of a person or a pet for which they have unconditional love. Use whatever symbols are meaningful to you, but do be sure to maintain the intention to be an instrument—a conduit or transmitter of this healing energy—not the generator. Remember that you want to allow this energy to overflow through you—not drain out from you. When we forget to open to the universal healing energy, this “most mysterious of primal forces,” or to the environmental energy field, or to whatever we choose to think of as the source of that energy, we become drained very quickly like a bathtub that starts out full and then has the plug pulled. Remaining centered and taking in energy as we give it out is like turning on the faucet in the bathtub at the same time that you pull the plug—there’s always more energy coming and you can actually end up with more than you started with. If you are a transmitter for healing energy, an instrument, rather than becoming the source, caring can leave you feeling energized and full—like the water filling the bathtub when the faucet is wide open—fresh and freely flowing.

Be Open to the Outcome

We cannot predict or control the outcome of any person’s life process. The complexity of factors and events and interactions which are part of the evolving life process for any single person is unfathomable, let alone controllable, in spite of our desires that this not be so. And while we will usually have a preference for an outcome, based on our data collection and our best clinical judgement, it is not useful to insist on or cling to that preference. When we do this, insist that the outcome of our care be a certain way, we have become overinvolved; we are not caring, but are imposing our agenda onto the patient rather than facilitating their unique process—and this can lead to exhaustion on the nurse part as well as inhibiting the patient’s healing. To be a facilitator of healing, we bring the best we have to offer to the care of our patients, and then we let go of our attachment to the outcome of that care. Our satisfaction comes from having done our best and from having connected with this other human being in love.
Summary

Learning to care from the center, to be an instrument, and to be open, rather than attached to outcomes, takes practice. And even with practice, there will be times when nursing will feel draining. There will be times when, for our own reasons, we will avoid relationship, or we will become overinvolved, or we will take on the patient's suffering as our own instead of remaining centered. Experience teaches us how these choices affect us, and even then, we might choose these kinds of involvements. There is no judgement here, no inherently right and wrong way of caring. What is important is that we have choice; that we are not being in either non-caring/avoidant or overinvolved/enmeshed ways because we do not know any other way of engaging with the human experience.

There are ways to care, to be deeply connected to another human being, to be with that person, in love and compassion, which are as nourishing and caring of us as for the one cared for. There are ways to solve the apparent paradox of "caring without getting too involved." One of these ways is "caring from center." It is helpful to practice centering at times when one is not feeling pressured or tense, in order to be able to access this state of consciousness when it is needed. Remember that we are taught about those oxygen masks before we need to use them—not in the midst of the crisis. Although learning this way of being takes patience and effort, I believe that in the long run, our work as nurses will be infinitely more satisfying and healthy if we have learned to care for ourselves while caring for those we are traveling with.

References


Chapter 8

Works by Jean Watson:  
A Bibliography

**Books**


CHAPTERS AND MONOGRAPHS


JOURNAL ARTICLES


*Refereed journal publications.

**Abstracts and Other Publications**


Watson, J. (1981, April 14). The need to clarify faculty governance. *Silver and Gold Record* (p. 2), University of Colorado publication.


BIBLIOGRAPHY


UNPUBLISHED MANUSCRIPTS

AUDIOVISUAL OR MEDIA PRODUCTIONS
Watson, J. (1974). Interview of patient with progressive-permanent threat to steady state maintenance—Mr. J. (Audiotape). University of Colorado School of Nursing Learning Resource Laboratory, Denver, CO.


Watson, J. (1981, Fall). A phenomenological approach to person (Videotape). University of Colorado Health Sciences Center Educational Resources Production, Denver, CO.


Applying the Art and
Applying the Art & Science of Human Caring

Advanced nursing practice will occupy a key position in resolving the current health care crisis. As nursing evolves, health care professionals need to reevaluate the theories which have informed and guided them, insuring that these meet the needs of the changing profession. Nurses must regain the aspects of the caring-healing arts—the holistic, integrated approaches—which have been replaced by advanced medical specializations and institutional management functions. As nursing moves forward, nurses must shift their concern from function and procedure to embrace "ontological caring."

In this essential companion resource to the video A Guide to Applying the Art and Science of Human Caring: A Consultation with Jean Watson and Colleagues, Jean Watson concentrates on putting her theory into practice, incorporating a new and viable definition of caring that is professional, moral, and human. A caring framework should be the heart of nursing as it shifts from "theory-based practice" to "practice-based theory." This resource is invaluable for anyone seeking to implement a caring model into practice.