Global Advances in Human Caring Literacy
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Global Advances in Human Caring Literacy

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Editors
To my husband, Bill, and my children, Erica, Christopher, Stephen, and Holly, who are the greatest joys in my life.

—Susan M. Lee

To my wife, Sarita, and my precious daughter, Vanessa, who bring joy and love to life; to my nurse mom, Carol, for guiding me to join her beloved profession; and to my friends and colleagues, especially Nataly and Joan, for helping us advance Caring Science throughout South America.

—Patrick A. Palmieri

To all nurses worldwide, who are offering human caring to humanity, contributing to healing and peace.

—Jean Watson
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Foreword

“The life we want is not merely the one we have chosen and made. It is the one we must be choosing and making.”

—Wendell Berry

Choosing to live with intention, awareness, compassion, and mindfulness is an ongoing journey. The decision to live by design rather than by default is a deeply personal one. Yet the decision to grow in this way also has important effects on others as well, especially if we engage in the work of healing and health. In this inspiring book, Drs. Lee, Palmieri, and Watson call upon international Caritas Scholars to expand the ideas of Caring Science to an evolving consciousness of Critical Caritas Literacy. The authors write from their unique perspectives ranging from pedagogy, leadership, inquiry, and praxis, to peace and the healing arts. The writing comes from vulnerable personal and professional growth points, inviting us to share the path in meaningful and inspiring ways. What ensues is a vivid demonstration of the aliveness of Caring Science as a theoretical perspective that actively informs, motivates, coalesces, frames, gives voice to, and amplifies the science and delivery of caring. Caring Science and Caritas Literacy take on the forward-leaning energy of a fluid, evolving, personal-yet-social movement, urging connection with our personal and professional caring core.

This work is an invitation to remember our deep belonging, connecting with self and others in loving kindness with generosity of spirit, rooted in the ethic of human caring. It is this awareness of dynamic self that enables us to more effectively connect with others, be they patients, colleagues, students, or unknown people across the planet. The nature of this work is, first of all, personal, requiring self-awareness and a spirit of disciplined curiosity, willing to become even while becoming ever more observant and compassionate with the process of becoming. The work invites cocreation at every level, from concrete to more abstract, novice to sage, academic to direct care, personal to professional. The work inspires us to reach toward a higher intention for our science, our praxis, and indeed for our very lives, individually and collectively.

The authors engage us to enter or continue in this work with expansive open minds, actively reflecting on how the ideas and experiences shared can be woven
into our own lives and work. There is candid acknowledgment of the tension that often exists between the aspirational inner world and the very real demands of care settings in terms of technology, time pressures, and task-orientation. It is in this space and tension that the power of the work can fully come to life. By being aware of and present with the gap between the way things are and the way they might hopefully become, we are more apt to genuinely connect afresh with that which drew us to caring work.

There is a sense in these pages of the ability to enthusiastically begin again and again and again in creatively conscious ways as we take part in a global vision for peace and well-being. There is promise that theory, specifically Caring Science, can and does animate patient-centered care delivery, science, and professional/personal growth. My experience in reading the authors’ work is that it made me want to grow-seek-be-learn-become in unabashedly more caring, peaceful, and compassionate directions. May your reading and reflection create even more peace and compassion in your life, and thus in the lives of those you touch and for the planet. For the world needs and deserves peace and compassion now more than ever.

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Preface


Watson’s Theory of Human Caring/Caring Science is the foundation for this book. Thus, the original scholarship on Caring Science/Theory of Human Caring/Caritas serves as a guide for this collected work. Caring Science Theory and 10 Caritas Processes have provided a philosophical, ethical, intellectual treatise and blueprint for nursing’s evolving disciplinary/professional matrix.

As discussed in the diverse chapters, others interact with the original work in Caring Science Theory at different levels of concreteness or abstractness. The caring theory has been, and is being, used as a guide for educational curricula, clinical practice models, methods for research and inquiry, social–political programs, and humane policies, as well as administrative directions for transforming nursing and health care delivery.

This work posits a value’s explicit moral foundation and takes a specific position with respect to the centrality of human caring, “Caritas” and love as an ethic and ontology, as well as a critical scholarly starting point for nursing’s existence, broad societal mission, and the basis for further advancement for global caring–healing knowledge and practices. Nevertheless, its use and evolution are dependent on “critical, reflective scholarly practices that must be continuously questioned and critiqued in order to remain dynamic, flexible, and endlessly self-revising and emergent” (Watson, n.d.).

This first series collection of global scholarship in Human Caring Science/Caritas is designed to go beyond Watson’s original scholarship and offers a new narrative of “living theory” from the inside out—each author finding his or her own unique way to Caritas Literacy and Caring Science. This collection of diverse perspectives from around the world serves as a historic work for our time, seeking to uncover an evolving consciousness of human caring for nursing and our world as exposed through each author’s own personal awakening and from his or her own country and culture.

It is offered as a living exemplar for nursing students, faculty, practitioners, staff, and any and all health professionals who long for insights toward another
deep way of purposive being/becoming Caritas in their lives, work, and career trajectories.

The book reveals the global evolving consciousness of each author toward Caritas (love and compassionate service) as a personal journey, transcending differences and uniting in human caring. Each author demonstrates, through his or her personal story, how a worldview of Caring Science and the Theory of Human Caring/Caritas led (and can lead) to new directions for self, system, society, and our world. In some instances, authors depict living exemplars of projects and possibilities that have unfolded in unique ways in their lifeworld. For example, Chapter 17 reveals activities that are guided by caring relations, transcending politics and embedded historic conflicts between Israelis and Palestinians, living caring relations at the grassroots level.

This collected work seen as a whole helps us to grasp how assertive leadership and evolving scholarship in Caring Science, human caring programs, and projects are, ultimately, contributing to world peace.

Finally, this book offers a refreshing dialogue and exposition of Caritas and love of humanity as a forum of living scholarship, demonstrated through experts in the Theory of Human Caring/Caring Science.

Jean Watson

REFERENCE

CHAPTER FIVE

The Use of Simulation to Strengthen Humanistic Practice Among Nursing Students in the Canton of Vaud (Switzerland)

Philippe Delmas, Otilia Froger, Muriel Harduin, Sandra Gaillard-Desmedt, and Coraline Stormacq

Simulation in the field of nursing education tends to focus primarily on the acquisition of clinical skills, often of a technical nature, without necessarily taking account of the uniqueness of individuals or the caring relationship. This phenomenon is all the truer in certain French-language countries where nursing is an emergent discipline. The challenge facing teaching staff remains, therefore, to construct simulation scenarios in which the caring relationship between the student and the standardized patient represents the focal point of the simulation session. The aim of this chapter is to share the story of a Swiss team of teachers from an institution with a long history of advocating disciplinary thought and their experience introducing a simulation activity to strengthen humanistic practice among nursing students.
OBJECTIVES

The objectives of this chapter are to:

• Describe the history and pedagogical evolution of a pioneering institution (La Source School of Nursing Science) in the development of nursing thought in Europe

• Identify the factors that triggered the decision by certain teachers to apply Dr. Watson’s (2008, 2012) Theory of Human Caring as the foundation for developing a simulation activity

• Share the experience of a team of teachers in the construction and conduct of a simulation activity aimed at strengthening the caring attitudes and behaviors of nursing students

HISTORY AND PEDAGOGICAL EVOLUTION OF NURSING SCIENCE IN EUROPE

It does not seem appropriate to expound on the integration of a nursing theory in clinical practice in French-speaking Europe without talking about the development of nursing as a discipline in Europe. In fact, the development and teaching of nursing theories often remain embryonic and depend on the particular will of institutions or groups of people. In this context, integrating Dr. Jean Watson’s theoretical approach in the curriculum through practice simulation can be considered a giant step forward in undergraduate teaching methods and constitutes for our teaching staff a clear commitment to Caring Science. This progress was made possible by various factors, such as the history of the La Source School of Nursing Science and the implementation of the Bologna agreements (Council of Europe, 1999), that deserve to be highlighted for paving the way for the universitization of the nursing profession, the development of a network of French-speaking researchers interested in caring, and, lastly and above all, Dr. Watson’s visits to La Source to conduct various colloquia. These visits, in particular, allowed members of the teaching staff to raise their own awareness of the fact that caring is at the core of nursing. Consequently, in order to gain a firmer grasp of the European issues related to the development of nursing science, these various factors will be covered in the following sections.

LA SOURCE: AT THE CROSSROADS OF THE HISTORY OF NURSING THOUGHT IN THE FRENCH-SPEAKING WORLD

The history of the nursing profession and of its educational institutions has long been the preserve of the English-speaking world, which, owing to various factors such as its school system (Delmas, Sylvain, Lazure, Boudier, & Shinn, 2006),
continues to be a major locus of disciplinary reflection and development. This notwithstanding, there are certain institutions in the French-speaking world, such as La Source in Lausanne, whose history and present commitment regarding the education and training of nurses have been and remain pioneers in the development of nursing thought.

Under the aegis of Valérie de Gasparin, La Source admitted its first cohort of students in 1859. It became the first international school to deliver nurse training from a purely lay perspective, 1 year before the inauguration of Florence Nightingale's school. Indeed, de Gasparin defended the idea that being a nurse was before all else a profession, just like being a teacher, and that this required a formal place where nursing could be taught outside of all religious denominations (Francillon, 2008). From its inception, the training centered on three essential points—theory, practice, and community care—and aimed to meet the needs of communities (Francillon, 2008). The community care approach remains one of the school’s hallmarks, which might explain why it has been an important place of reflection on the development of nursing competencies in connection with public and community health. Despite the renewed desire by successive administrators to raise the level of nurse training, it was only with the European reform of higher education that the countries concerned committed to the Bologna Process (1999), whose mission was to harmonize the architecture of the European system of higher learning.

THE BOLOGNA AGREEMENTS: THE LATE UNIVERSITIZATION OF THE NURSING PROFESSION IN FRENCH-SPEAKING EUROPE

The shift from vocational training to university education for nurses began in Europe around 2005 in different ways. The policy in French-speaking Switzerland was to reconsider the entire undergraduate curriculum with the emphasis placed on teaching nursing as a discipline. The first PhD holders in nursing science were recruited at the same time as the education reform was implemented, in order to raise the existing level of education through the significant contribution they would make with the knowledge they possessed of the field. It would be remiss of us if we did not talk about La Source’s decades-old pedagogical culture, beginning with didactic conferences (Vienneau, 2005), before embracing socioconstructivist approaches (Vienneau, 2005); these consider learning a joint construct where individuals develop their knowledge through interactions with others. This allows for the development of narrative-based pedagogical approaches where students get the chance to reassess lived situations in a group mode and to question and share the meaning and purpose of nursing care. As pointed out by Scheckel and Ironside (2006), these approaches fostered the emergence of certain clinical concerns, which brought to light a broad array of patients’ needs that would have remained unexplored under standard traditional approaches.
In recent years, expert patients living with a particular health situation have been recruited as teaching partners to help illustrate the theoretical concepts that students learn in class. These narrative activities allow them not only to develop the self-insight that enhances the capacity for knowing oneself and others but also to penetrate, with the teacher’s help, someone else’s world in order to gain a better understanding of what they are going through. Thus, despite its short history as a university establishment, La Source has never ceased placing the human being at the heart of its concerns, and humanist values have informed its teaching processes and content for decades. In this context, it was not surprising that Dr. Watson’s (2008, 2012) Theory of Human Caring was very well received by, and even had a rallying effect on, a large portion of the teaching staff. In this connection, teaching regarding the helping relationship has been the focus of special attention on the part of the teaching staff at La Source in recent years, owing not only to changes in theoretical fundamentals flowing from exposure to continuous professional training but also to the development of international ties with the United States. The fundamentals underlying teaching of the relationship had for years remained those derived from the works of Rogers (1957). Then, contacts were established with Peplau, which led to teaching the subject based on her four phases of the interpersonal relationship: orientation, identification, exploitation, and resolution (Peplau, 1952). Continued exchanges between the teaching staff at La Source and Peplau, as well as her visit to the school, served both to enrich what and how students were taught and to stimulate teachers in their reflections, which led to the recognition that the interpersonal relationship was central to teaching and practicing nursing care.

DR. WATSON’S VISIT TO LA SOURCE: AN EYE-OPENING AWARENESS RAISER

More recently, partnerships were created between researchers in Quebec (Drs. Cara and O’Reilly) and at La Source (Dr. Delmas) to set up a research program centered on the evaluation of an educational intervention based on the concepts of Dr. Watson’s (2008, 2012) Theory of Human Caring intended for nurses working with rehabilitation and hemodialysis patients (O’Reilly, Cara, & Delmas, in press). Contacts were established between Drs. Watson, O’Reilly, and Delmas in order to organize a conference at La Source titled, Le caring dans tous ses états: point de vue de différents acteurs (Caring in All Its Dimensions: From the Actors’ Point of View). The aim of this event was twofold: (a) confront and compare different perspectives and knowledge of the concept of caring, including from clinical, pedagogical, management, and philosophical angles; and (b) illustrate how the caring approach had contributed to strengthen humanist clinical practices among health professionals. Getting Dr. Watson to host the conference proved a real challenge for the staff at La Source. It was also a dream come true, as it gave them the
chance to bask for a few hours in the light of an internationally renowned theorist. In her first conference at La Source, Watson placed a heavy emphasis on explaining how her theory and its concepts evolved over time and on describing the new forms of Caring Science evidence-based methods, models, and practices from the field (Watson, 2014). Certain words pronounced by Dr. Watson struck a particular chord among the teaching staff, especially the quote cited in the introduction. These words were one of the factors that prompted us to construct a simulation activity that would put into perspective the relevance for nursing students to deploy the concepts of Dr. Watson’s (2008, 2012) Theory of Human Caring in order to foster the development of a caring–healing relationship with patients. Moreover, according to Meleis (1997), the choice of a nursing theory allows strengthening the clinical practice of nurses and, a fortiori, of students by providing a structure and language that makes it possible to describe and explain clinical phenomena, to guide the action of nurses and, thus, to differentiate their practice. The various themes covered by Dr. Watson in the course of her conference at La Source bolstered the conviction among teachers that caring is at the core of the nursing profession and that “teaching caring becomes the moral imperative of nursing educators” (Bevis & Watson, 2000, p. 183).

■ APPLYING WATSON’S THEORY OF HUMAN CARING

RELEVANCE OF THE THEORY TO THE SIMULATION ACTIVITY

The objective that the group of teachers hoped to achieve was to create an opportunity for nursing students to gain awareness, through nursing simulation, of the added benefits of developing a caring relationship with patients. The choice of Dr. Watson’s (2008, 2012) Theory of Human Caring rested on various elements, including the fact that, according to Dr. Watson (2012), caring was at the core of nursing and nurses were vectors of caring for the patient. Under this approach, nurses and students can create a caring–healing environment through the use of intentional presence and caring connection (Herbst, 2012). According to Cara and O’Reilly (2008), the practice of caring seems to allow nurses to develop a value-based humanist relationship in order to alleviate human suffering and promote their dignity (Cara, 2010). To guide this practice, Dr. Watson (2008, 2012) proposed deploying 10 carative factors (CFs), whose operational application facilitates their understanding in clinical situations faced by students. Dr. Watson (1979, 1985, 1988b) has paid special attention to the development and refinement of these CFs. The factors provide a structure for studying and understanding nursing as a science of caring. Dr. Watson (2013) pointed out the relevance of the term carative, as opposed to curative, in order to help students mark the difference between nursing and medicine, whose primary aim is to cure the patient’s disease. This element of differentiation and the CFs were, on the one hand, very
useful for the development of the simulation teaching sequence and, on the other, very helpful to students, who were able to put words to their intentions, attitudes, and behaviors and, more broadly, to their vision of nursing. More specifically, there are 10 CFs in Dr. Watson’s (2008, 2012) Theory of Human Caring: (a) the formation of a humanistic–altruism system of values; (b) the instillation of faith–hope; (c) the cultivation of sensitivity to one’s self and to others; (d) the development of a helping–trust relationship; (e) the promotion and acceptance of the expression of positive and negative feelings; (f) the systematic use of the scientific problem-solving method for decision making; (g) the promotion of interpersonal teaching–learning; (h) the provision of a supportive, protective, and (or) corrective mental, physical, sociocultural, and spiritual environment; (i) assistance with the gratification of human needs; and (j) the allowance for existential-phenomenological forces. According to Tomey and Alligood (2002), these factors propose clear guidelines for nurse–patient interactions. As pointed out by Dr. Watson (2013), the first three factors establish the philosophical foundation for the science of caring. These were the factors primarily that the teaching staff took into account in constructing the simulation scenario because it appeared important to give students the opportunity, over the course of a short simulated practice activity, to shift their perspective in order to be able to grasp the human complexity of the cared-for person. Finally, certain Quebec researchers (Drs. Cara and O’Reilly) proposed a series of French documents mainly focused on the description and operationalization of the 10 CFs, which made it easier for French-speaking students to grasp the key concepts of Dr. Watson’s (2008, 2012) Theory of Human Caring.

The choice of a simulation activity as a teaching sequence to permit the integration of professional caring in nursing was a real challenge. Indeed, Eggenberger, Keller, and Lynn (2008) pointed out that most simulation scenarios were developed in order to strengthen the students’ technical skills, and thus at times reduced the quality of the nurse–patient relationship to principles of courtesy and propriety. Therefore, in the course of high-fidelity simulations, students tend to focus mostly on the acquisition of individual or group technical skills in hypertechnical care settings, thus giving a backseat to the more complex and sophisticated aspect of nursing’s focus, that is, as underlined by Hills and Watson (2011): “people and inner meaning, perceptions, feelings, and the complex, relational, experiential, contextual aspect of health and healing” (p. 10). According to Eggenberger et al. (2008), students can thus become technically competent without necessarily coming into contact with patients as persons. This state of affairs can, according to Roach (2002), lead to “competence without compassion,” which, in turn, can give rise to brutal and inhumane relationships between nurses and patients and culminate in a biocidic relationship between the two (Halldorsdottir, 1991). Consequently, it seemed particularly relevant to offer students a simulation activity that would allow incorporating professional caring in nursing simulation in order to strengthen the bioactive, if not biogenic, relationship (Halldorsdottir, 1991), or at the very least to refocus the attention of students on care centered on people rather than disease.
Building a Simulation Scenario Incorporating the Caring Science Perspective

A simulation scenario is a clinical situation that must resemble clinical reality as much as possible. Some authors (Eggenberger et al., 2008; Webster, 2013) have proposed constructing and evaluating scenarios that place the emphasis on relational aspects of nursing care. Some scenarios have been constructed specifically on the basis of the concepts of Dr. Watson’s (2008, 2012) Theory of Human Caring (Winland-Brown, Garnett, Weiss, & Newman, 2013). These authors have recommended using standardized patients because, according to Webster, Seldomridge, and Rockelli (2012), interactions between students and these patients allow the former to deploy their relational competencies in a secure environment. Thus, students invited to take part in a simulation activity can immerse themselves in a caring environment and interact with standardized patients previously trained by teachers. Within the context of this project, the situation chosen as a clinical vignette and acted out by a standardized patient involved Chantal, a 33-year-old woman living with Crohn’s disease who, after emergency hospitalization for an abscess, underwent surgery. Chantal was fitted with an ileostomy bag for a period of 3 months. The situation proposed to students was to meet Chantal on the third postoperative day in order to perform ostomy care. On that day, Chantal was sad. She said she was depressed and withdrawn.

The scenario was constructed on the basis of this clinical situation using a graphic algorithm that determined the attitudes and behaviors of the standardized patient according to the students’ attitudes and behaviors. The teachers’ intention was to give students the chance to apply caring attitudes and behaviors, such as listening, presence, respect, honesty, trust, humility, hope, and courage, in the course of their interactions with the standardized patient. Accordingly, if students in the course of the simulation centered their practice on humanist attitudes and behaviors, such as relating to Chantal as a person and not merely a patient whose bandage needed changing, paying attention to what she was living rather than to her disease, and showing respect, compassion, and listening while taking account of her needs and desires—the more the standardized patient expressed her needs, anxieties, and fears and would seek to give meaning to her experience. Conversely, in the case where students display dehumanizing attitudes and behaviors—such as focusing on her disease and technicalities (insisting on dressing the stoma as prescribed by the physician), interrupting Chantal on a regular basis, minimizing and/or generalizing her situation by treating her lived experience as normal, and giving their own advice instead of helping the person find a solution that made sense to her—the standardized patient would adopt an attitude of nonopenness, diminish if interactions with the students were not ceased, and express feelings of anger, frustration, and sadness. It is important to note that the standardized patient was expected to offer cues in the form of feelings, attitudes, and behaviors aimed at inviting students to meet her needs and relate to her on a more human level.

1 An alias.
level when they strayed from a person-centered practice in the course of the scenario.

Once finalized, the scenario was assessed in terms of fidelity (Beydon, Dureil, & Steib, 2013), including environmental fidelity, equipment fidelity, psychological fidelity, and temporal fidelity (Jeffries, 2005, 2007, 2011). The opinions of various content and process experts were solicited. In addition, the two possible assertions of the scenario were pretested with the standardized patient and teachers. Thus, once certain aspects of fidelity had been verified, some minor adjustments were made. At this point, the scenario met the standards for simulated practice.

A SIMULATION ACTIVITY TO STRENGTHEN CARING ATTITUDES AND BEHAVIORS

DESCRIPTION OF THE DIFFERENT STAGES OF THE SIMULATION ACTIVITY

Jeffries (2005, 2007) and Demaurex and Vu (2013) have proposed that simulation sessions should be conducted according to four stages: briefing, implementation, debriefing, and conclusion. At each stage, different aspects must be taken into account, including objectives and planning, fidelity/realism, level of complexity, participant support, and debriefing structure. In addition, the teachers at La Source demonstrated creativity by initiating complementary periods of prepreparation, which included reflective practice exercises for students prior to the simulation session.

PREPARING STUDENTS TO EXPERIENCE A CARING RELATIONSHIP

In order to facilitate the sharing of experiences during the simulation session, 1 week prior to the activity, second-year undergraduate students were invited to complete reflective practice exercises in which they had to write down a significant care or personal situation that they had experienced and reassess it from the perspective of Watson’s (2008, 2012) Theory of Human Caring. To guide them in this analysis, the teachers proposed that they relate the highlights of their professional or personal experience to the 10 CFs. To facilitate this exercise, the teachers provided them with the French-language version (EIIP-70; Cossette, Cara, Ricard, & Pepin, 2005) of the Caring Nurse–Patient Interaction Scale (CNPI-70), which describes caring attitudes and behaviors in relation to the 10 CFs proposed by Dr. Watson (1979, 1988a). This instrument was meant to help students self-assess how often they expressed caring attitudes/behaviors in the course of their professional or personal experience. Furthermore, the students were encouraged to develop their self-insight by completing mindfulness exercises that were accessible online. As a result, during the briefing period with the students, which is described in the following text, a discussion could
be had between them and the teachers regarding their understanding of the 10 CFs in relation to their experiences. Though such a reflective stage prior to scenario implementation has not been developed much within the context of traditional simulation-based learning, it appeared indispensable to the teaching staff for creating a caring environment and contributing to the development of a caring practice, which was one of the objectives of the simulation activity.

### Briefing

This is a key moment prior to the implementation stage where teachers and students meet in the simulation environment. The teachers’ ultimate objective here is to create a climate of trust, security, and sharing, which are essential elements of an environment conducive to the development of transpersonal relationships. In order to foster this caring environment, students were invited to complete mindfulness exercises. These lasted 5 minutes and were intended to help students sharpen their self-insight and, therefore, to be better prepared to meet a person in a human-to-human relationship. Self-centeredness is a key element for students to be able to identify their own thoughts and emotions and to adopt the right disposition for observing them without being tempted to downplay them or to brush them away. In short, the students were prepared for the purpose of scrutinizing their own thoughts, feelings, and sensations. Then, the teachers revisited the significant situations encountered by the students in the course of clinical practicums and facilitated the process of tying the experiences described and lived by the students in practice settings together with the CFs deployed. This moment of sharing allowed the students to gain a better grasp of the importance of caring attitudes and behaviors in daily practice as the foundation of the sort of humanistic care that each and every member of humanity should be entitled to. At the end of this period of exchange came the moment of briefing immediately before the simulated practice. This stage served to contextualize the meeting for the participants. It consisted primarily of reading out the clinical vignette to introduce the simulation scenario (Demaurex & Vu, 2013), which, in our case, was Chantal’s situation. Other elements were added by the teachers, such as an analysis of Chantal’s situation in the light of how she might experience it and how the students might develop their listening, presence, and respect in her regard, as well as instill hope. This preparation before the meeting served to awaken in the students a knowledge of self and others as caring. Then, each teacher accompanying a group of 10 students solicited one student to play the role of the nurse who is to meet Chantal to deliver postoperative care.

### Implementation: Encountering Chantal

The encounter between the student and Chantal constituted the core of this simulated practice. During the analysis of the different simulated practice sequences by the teachers, a certain degree of homogeneity in how the interactions between the students and Chantal unfolded over time appears. Indeed, in the early
moments of the encounter, most of the students called upon the scientific and theoretical knowledge required for Chantal’s postoperative clinical management in order to address her pharmacological and physiological needs (vital signs measurement, pain assessment, information). From the point of view of the fundamental patterns of knowing described by Carper (1978), it can be hypothesized that the students deployed knowledge derived primarily from empirical patterns of knowing. Then, the students developed a more subjective analysis of the situation and swung back and forth between a narrower and a wider viewpoint. This was akin to the alternating rhythms described by Mayeroff (1971), which, according to Boykin and Schoenhofer (2013), provide an approach to applying caring empirical knowledge. Simultaneously, the students focused on the inherent meaning of the situation experienced by Chantal through an authentic presence and acceptance of the other person as a human being living a particular health situation. They established a relationship of trust with Chantal, in which it was possible for both persons to voice feelings, lived experiences, and doubts without being judged by the other. In other words, the students very quickly applied caring personal knowledge (Boykin & Schoenhofer, 2013) in order to establish a therapeutic relationship that allowed Chantal to find meaning in the experience she was living. Finally, throughout the encounter with Chantal, the teachers underscored that, in the course of these interactions, the students reinforced their engagement to care for Chantal and their respect for her right to self-determination, which bears witness to a certain ethical stance on the part of the students and, by the same token, to the deployment of ethical knowledge (Carper, 1978).

Debriefing

Debriefing took place right after the simulated practice. It is seen as a reflective thought session that allows the students to evaluate their actions, decisions, mode of communication, and capacity to deal with the unexpected in a secure universe where mistakes are permitted (Dieckmann, Reddersen, Zieger, & Rall, 2008; Haskvitz & Koop, 2004; Jeffries, 2005; Mort & Donahue, 2004). In our case, the teacher, the students who observed the simulated practice, the student who took part in the simulated practice, and the standardized patient came together to share their experience and understanding of the situation. In order to facilitate dialogue and evaluation among the different parties, the teacher organized the debriefing session into the following three phases as recommended by Savoldelli and Boet (2013): reaction (expressing of emotions), analysis (setting in motion the reflective process), and summary (brief recap to close the session). During the reaction phase, the teacher again used the mindfulness exercises to help participants focus on the present and examine their thoughts and feelings without judging. The aim here was to help participants awaken to experience and gain a higher degree of mindfulness. During the analysis phase, the teacher asked the participants to identify, using the French-language version (EIIP-70; Cossette et al., 2005) of the CNPI-70, the caring attitudes and behaviors deployed by the student in the
course of the simulated practice and those that they would recommend adopting were they to care for Chantal. Based on the results obtained by the participants, the teacher next asked them to compare and share their points of view beginning with the self-evaluation of the student who played the role of the nurse. The precise descriptors provided by the EIIP-70/CNPI-70 facilitated the reflective process and the organization of one’s thoughts at the time of sharing. Thus, confronting and comparing points of view allowed gaining a better grasp of the nature of the interactions that the student implemented in the course of the simulated practice from the perspective of the 10 CFs. The capacity to put words to and make connections between theory and practice allowed the students to acquire a deeper appreciation for the uniqueness of nursing care. Moreover, the standardized patient added considerably to the quality of the debriefing by sharing her feelings and her own perception of the quality of the relationship with the student. This open dialogue allowed all the participants to better understand the impact that the caring attitudes and behaviors, deployed by a nurse, can have on the quality of life of a vulnerable person. The teacher closed this debriefing phase with a series of questions concerning how the simulation session might be improved.

■ CONCLUSION

Though often employed to learn clinical skills of a technical nature, simulation appears relevant to facilitate the integration of concepts derived from a nursing theory such as Watson’s (2008, 2012) Theory of Human Caring. As discussed by Eggenberger et al. (2008), simulation activities are rarely reported in the field of Caring Science, but these need to be developed. Indeed, practical experimentation in a secure setting allows students to make the connection between theory and practice. This is a key method to help nursing students integrate complex phenomena into clinical practice. In this context, simulation plays a major role. Finally, the acquisition of a distinct vocabulary by nursing students through simulation activities is another important outcome worth highlighting. This allows naming elements of analysis and intervention in a distinct manner, thus differentiating the specific contribution of nursing care to the health of patients and, more broadly, to that of the population. Finally, facilitating the integration of Dr. Watson’s (2008, 2012) Theory of Human Caring in the students’ curriculum also constitutes a political act, equipping nursing students with a body of knowledge, know-how, and interpersonal skills that is specific to them, thereby giving visibility to their care acts and, by extension, to their profession. It has never been more urgent for each profession to identify the value proposition for the health of populations than in today’s global economy where the dominant discourse is centered on rationality and profit. This is why it is an ethical and philosophical imperative that caring be recognized as the nursing profession that has the most to offer in the way of added value.
REFERENCES


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CHAPTER NINE

Relational Caring Inquiry: The Added Value of Caring Ontology in Nursing Research

Chantal Cara, Louise O’Reilly, and Sylvain Brousseau

CARITAS QUOTE

Developing knowledge of caring cannot be assumed; it is a philosophical-ethical-epistemic endeavor that requires on-going explication and development of theory, philosophy, and ethics, along with diverse methods of caring inquiry that inform caring-healing practices. (Watson & Smith, 2002, p. 456)

This chapter describes the journey involved in the creation of a research method, the Relational Caring Inquiry (RCI), developed by Dr. Cara, now a Distinguished Caring Science Scholar, Watson Caring Science Institute. This method was based on Husserlian phenomenology as well as a caring ontology. The elements of human caring literacy, especially Watson’s work, informed this research method. The chapter also explores the shared venture by Drs. O’Reilly and Brousseau in utilizing this approach. In this way, the chapter exemplifies the creation and utilization of a theory-guided method of inquiry and shares our perspective regarding the added value of human caring ontology within research.
OBJECTIVES

The objectives of this chapter are to:

• Describe our personal journey within human caring literacy, specifically the creation of a research method and the shared venture of utilizing this approach within nursing research

• Demonstrate a theory-guided research methodology, based on caring ontology

• Discuss the meaning of being and becoming a caring researcher based on a human caring ontology.

JOURNEY TO CARING SCIENCES AND CARITAS

In the following section, we present three personal stories that evoke the reasons beneath our choice to develop and use a phenomenological method, the Relational Caring Inquiry (RCI), to perform research within the discipline of nursing.

Dr. Cara was fortunate to be Dr. Jean Watson’s doctoral student from 1991 to 1997 at the University of Colorado. Hence, being mentored by this great leader and inspired by her work over the years, she considered caring as the essence of nursing, not only within clinical practice but also fundamental to the research realm of nursing. Caring Science invited her to see what matters the most as being in relation with another human being and exploring the meaning of people’s lived experiences. Of course, humanistic values have always played an important part in her life; however, Caring Science allowed Dr. Cara to put words on those inner beliefs, thus expending her consciousness toward her own moral ideal of being and becoming a caring nurse within her professional journey as a nurse researcher, teacher, and scholar. As early as 1985, Dr. Watson suggested the exploration of paradigm-transcending methods to study human caring and other phenomenon in nursing. Consequently, Dr. Watson’s recommendation was illuminating in the development of a phenomenological method: the RCI (Cara, 1997, 1999). This research method was enlightened by the works of additional authors (Buber, 1970; Gadow, 1994; Husserl, 1970; Ray, 1991a, 1991b). Husserlian phenomenology primarily guides the data analysis and interpretation process, while Caring Science literacy provides a noteworthy ontology, since it assists the researcher in performing nursing research as a relational human process. Therefore, the ontology of caring allows this method to remain relational, dialogical, and transformative (Cara, 1997, 1999, 2002).

After several years of caring for patients and families, Dr. O’Reilly realized that the most significant nursing interventions were oriented on “being with” the person, a notion at the very heart of Watson’s transpersonal caring relationship. To explore and better understand this relational understudied phenomenon, she
achieved a doctorate at the Université de Montréal under Dr. Cara’s supervision. She explored the meaning and contribution of the experience of “being with” the cared-for person, from the rehabilitation nurses’ perspective (O’Reilly, 2007; O’Reilly & Cara, 2010). Later, she also studied the same phenomenon, but this time from the rehabilitation patients’ perspective (O’Reilly, Cara, Avoine, & Brousseau, 2011).

To study these eminently relational phenomena, Dr. O’Reilly selected the RCI, due to the caring ontological foundation, inviting us to see research as a relational process between the researcher and the research participants, and between the researcher and the *verbatim*. From Dr. O’Reilly’s standpoint, a human caring ontology makes phenomenology more coherent and relevant to study nursing’s phenomena of interest, such as those related to caring.

As for Dr. Brousseau, he observed for a decade that novice nurses refused to work in management as turnover was increasing. Inspired by Dr. Watson’s work, he started a doctorate in nursing administration to study the meaning of nurse managers’ quality of work life experience. Under Dr. Cara’s supervision, Dr. Brousseau chose the RCI for its caring ontology, however, within a mixed methods research design, along with a quantitative methodology. With the RCI, he developed relational skills, essential in research, such as an authentic presence and continual respect for participants during interviews, allowing him to discover, without judgment, their lived experiences and co-create rich and meaningful narratives. Also, Dr. Brousseau acknowledged the added value of RCI within a mixed methods research design to provide meaningful solutions to problems experienced, for example, in nursing management (Brousseau, 2015; Brousseau, Cara, & Blais, 2016).

**KEY ELEMENTS OF CARING SCIENCE AND CARITAS**

In the following section, we review a selection of important Caring Science tenets acting as a keystone for the RCI’s creation and utilization.

**RELEVANCE OF CREATING A NEW NURSING RESEARCH METHOD**

In her works, Watson (1988, 2012) argued that:

> The methodologies that are relevant for studying my theory can be classified generally as qualitative-naturalistic-phenomenological field and interpretive, expressive methods of inquiry or a combined qualitative-quantitative inquiry versus a quantitative rationalistic method of inquiry as the exclusive method. . . . Nurses are encouraged to create new approaches that are appropriate for the phenomena under study. However, it is important to point out that these and other methods are in need of further development and practice. (2012, p. 94)
Dr. Watson’s work was, therefore, inspirational to the development of a new method. Dr. Cara felt the need to expand phenomenology in order to enhance the research participants’ contribution to the research findings. Informed by the Husserlian phenomenological process of analysis and interpretation, similarities exist between the RCI (Cara, 1997, 2002) and other phenomenological methods. Nevertheless, the caring ontology guided Dr. Cara to invite each participant for a second interview, allowing to reciprocate the story, analysis, and interpretation with the research participants, in order to seek, through a relational dialogue, a negotiation pertaining to the final meanings of their story. Also, it promotes the participants’ contribution to provide new insights in regard to the phenomenon, going beyond a mere description of facts about people’s experience, empowering them to share their ideas on how to improve problems or challenges regarding the phenomenon under study. Hence, the co-created meanings illustrate the contribution of both the researcher and the research participants through the relational dialogue (Cara, 1997, 2002).

A CARING ONTOLOGY WITHIN NURSING RESEARCH

Hills and Watson (2011) stated the importance of an ontology of caring:

Caring Science provides this deep underpinning for a scientific-philosophical-moral context from which to explore, describe, and research human caring-healing phenomena as integral to our humanity. As the disciplinary foundation for nursing, Caring Science clarifies for the profession, and the professional, the question of ontology, that is, what is our worldview of reality? What is the nature of Being and Becoming human in relation to the larger infinite universal field of life itself? (p. 13)

If caring ought to be the core of nursing (Hills & Watson, 2011; Watson, 1988, 1999, 2012), we trust that it should permeate the entire profession, including the research realm (Cara, 1997). In other words, caring should prevail in the nurse researcher’s relationship with her research participants, not only in her relationship with her patients. Dr. Cara’s research ontological perspective was enlightened by Caring Science literacy.

Underscoring an ontology of caring for nursing research, the research becomes a relational human process (Cara, 1997). This implies the researcher must “be with” the participants while sharing their meaning and experience regarding the phenomenon under study, honoring their voice throughout the research to remain “true” to their perceptions, beliefs, meanings, and stories pertaining to their lived experience. Hence, research participants are not considered mere subjects (or objects) to be scrutinized and fragmented; rather, the researcher aims to preserve their uniqueness, wholeness, and human dignity (Cara, 1997). In other words, we believe human caring literacy can provide an ontological basis for human inquiry in nursing in order to better relate “to” and “with” the world.
INVITED CONTRIBUTION OF RESEARCH PARTICIPANTS TO KNOWLEDGE DEVELOPMENT

Watson (2005) proclaimed the following assumptions in regard to Caring Science:

An ontological assumption of oneness, wholeness, unity, relatedness, and connectedness. An epistemological assumption that there are multiple ways of knowing, not only the physical sense data, but through tapping into our deep humanity our caring-healing relationship with self, Other, Nature, one’s inner belief, accessing the infinity of life force of the universe, opening to something greater than oneself. . . . Caring science is grounded in a relational ontology of unity within the universe, which in turn informs the epistemology. (pp. 28–29)

Dr. Watson’s assumptions are relevant to the RCI to focus on the relational caring process unfolding during the interview between the researcher and the participant. Therefore, human caring literacy leads the nurse researcher to consider the research participants as collaborators, contributors, or again, as experts in regard to the phenomenon under study, inviting a co-creation of meanings. According to O’Reilly (2007), the co-creation of meaning is largely induced by the authenticity within the dialogue being RCI’s central element. In the absence of authentic dialogue, the participant’s story will not be a co-creation associated with Buber’s “I-Thou” relationship, but rather linked to Buber’s “I-It” relationship (Cara, 1997; O’Reilly, 2007). In other words, without such dialogue, the researcher might not consider the research participants as contributors to knowledge development. Consequently, within the relational caring process, both the researcher and the participant have something to contribute to the phenomenon under study. Nevertheless, neither one holds the “absolute truth” (Cara, 1997). Moreover, Watson (2012) explained that a “caring moment” corresponds to a sacred space where two individuals can connect, interchange their perspectives, and come to a shared decision. In research, being informed by human caring ontology leads the researcher to create a “research caring moment.” Hence, the unfolding within this “research caring moment” contributes to each person’s transformation: a transformation of personal growth, insights, and consciousness, for both the researcher and the participants, as well as expanding knowledge in nursing, in regard to the phenomenon under study.

CARING THEORY IN OUR WORK

The following section first discusses the operationalization of the caring ontology deployed within the RCI (Figure 9.1). Also, the process of the RCI, which represents the circular phases of this method, is described (Figure 9.2).
OPERATIONALIZATION OF THE CARING ONTOLOGY

For Husserl (1970), father of the phenomenological movement, phenomenology was a theory of knowledge, an “epistemology” rather than an “ontology.” Thus, Husserl’s work conveyed an epistemological perspective to nursing research rather than an ontological perspective (Cara, 1997, 2002). Therefore, a caring ontology can contribute, for the researcher, to enhance each participant’s subjectivity and relation to the phenomenon through advocacy, openness, commitment, competence, authenticity, compassion, presence, and methodological rigor (Cara, 1997; see right part of Figure 9.1).

In addition, this ontology facilitates dialogue, mutuality, relationship, and negotiation between the researcher and the participant, hence inviting a co-creation of meanings (see middle section of Figure 9.1).

These aforementioned caring attributes (see right section of Figure 9.1) are essential to the RCI method. For instance, the role of advocacy is revealed through protecting research participants’ human rights, respecting their confidentiality, and preserving the integrity of their stories. Watson (2014) also indicated that “moral justice framed within a sacred unitary worldview connects human-to-human caring with deep attention to both moral and social justice, including personal/professional action toward peace in our world” (p. 64). In the context of nursing research, however, we suppose the nurse researcher’s advocacy would enhance human dignity at the participant level, thus protecting participants from being used as mere objects or providers of data.

As for the researcher’s openness, it is imperative to encourage the participants’ real stories and voices to be heard (Cara, 1997, 2002). Through Caritas Process #8, “Create a healing environment for the physical and spiritual self which respects human dignity,” along with #5, “Allowing for expression of positive and negative feelings—authentically listening to another person’s story,” Watson (2007) emphasized the need for providing an environment filled with openness, trust, and support for people to allow them to feel comfortable in sharing their experiences with, in our case, the researcher. Openness makes it possible for the researcher to be entirely present and sensitive to the nuances in the participant’s story as well as to ask clarifying questions, which could lead to a deeper understanding of the participant’s experience (Cara, 1997, 2002).

For their parts, the researcher’s commitment, along with the researcher’s competence and methodological rigor, can be perceived as the cornerstones of quality research. Such attributes are exemplified within the method’s philosophical foundation, the methodological process, as well as the validation and scientific rigor required in a study.

Dr. Cara (1997) also considered authenticity to be a relevant attribute for the researcher, as it remains an important attitude within human caring literacy, as the latter “seeks to create authentic, egalitarian, human-to-human relationships” (Hills & Watson, 2011, p. 17). Also, her fifth Caritas Process suggested that “authentically listening to another person’s story” (Sitzman & Watson, 2014,
p. 21) encourages her or his expression of feelings, in this case, the research participant. We believe that the greater the commitment of the researcher to establish the relationship and the dialogue with the participants, the more the findings will provide practical and experiential knowledge.

Dr. Cara (1997, 2002) considered compassion relevant while gathering the participant's stories, as lived and experienced. Without compassion, the researcher might not be open to the participants' stories. Indeed, as Watson (2003) stated, "listening with compassion and an open heart, without interrupting" is essential to grasp another person's story (p. 201). Watson explained that "Expressed compassion and caring is not only the word that is spoken or the eye that sees, leading to action. The gaze itself is an expression... welcoming, receiving, affirming" (2003, p. 200). In other words, the researcher's physical stance or attitude should also be taken into account during the interview.

As for the last attribute, presence, Dr. Cara (1997) recommended being present to both the participant's story and the data throughout the entire research process. In her phenomenological method titled Caring Inquiry, Ray (1991a) also emphasized the importance of the researcher's presence. Husserl's (1970) first phase of his phenomenological reduction, named bracketing, also concerned the notion of presence, as Watson (2012) explained:

Husserl's ideal of phenomenology involved a different attitude: it involved placing within brackets the existential historical aspect of experience and concentrating on the essence or the ideal types exemplified by the experiences that we either have or are able to conceive of ourselves as having. Phenomenology studies such essences and clarifies the various relationships between them.... Human phenomena (such as

![Figure 9.1](image-url)
caring, caring moments . . . are not object-like; they cannot be inspected or studied in the manner of objects. They have to do with the “how” rather than the “what.” (p. 95)

Indeed, in order to be present to the participants and their stories, “bracketing” appears relevant to acknowledge both our own values and our own theoretical beliefs (Cara, 1997). Ultimately, we believe that the researcher’s presence can help to share oneself, be authentic, and be open to the participants’ stories. Indeed, Watson (2003) reminded us that “one’s human presence never leaves one unaffected” (p. 200). In fact, according to Buber (1970), both persons must experience mutuality of presence, within an I–Thou relationship, in order for a genuine dialogue to take place:

For inmost growth of the self is not accomplished, as people like to suppose today, in man’s relation to himself, but in the relation between the one and the other, between men, that is, pre-eminently in the mutuality of making present—in the making present of another self and in the knowledge that one is made present in his own self by the other—together with the mutuality of acceptance, of affirmation and confrontation. (p. 70)

In brief, all these caring attributes assist the researcher ontologically to establish a relationship with each participant, in order to initiate a relational dialogue. Concretely, this relational dialogue takes shape in the participant’s story, as well as the co-created meanings (or final findings; Cara, 1997; see also the middle section of Figure 9.1). More precisely, a relational caring ontology invites the researcher to understand the phenomenon with openness, consciousness, and humanness. It encourages both dialogue and mutuality between the researcher and the participants, hence sharing each individual’s uniqueness, perspective, meaning, and creativity (see the left section of Figure 9.1). The co-created stories will become richer, reflecting participants’ reality, while revealing the essential structures and essences of the phenomenon, thus contributing to new epistemology (Cara, 1997).

THE PROCESS OF THE RCI

The following section outlines the process of the RCI (Cara, 1997, 1999, 2002; O’Reilly & Cara, 2014; Figure 9.2).

Phase 1: Acknowledging the Researcher’s Worldview

This phase, inspired from Husserl’s (1970) notion of bracketing, corresponds to the acknowledgement of the researcher’s values, context, and assumptions related to the phenomenon, in order to understand that one’s background and underpinnings influence one’s interpretations throughout the study (Cara, 1997; O’Reilly & Cara, 2014). We believe that such procedures promote listening to and honoring the participants’ story. This is consistent with Dr. Watson’s fifth Caritas Process (Sitzman & Watson, 2014).
Phase 2: Seeking Participants

This step is concerned with advocacy and ethical responsibility as well as the selection of the participants. Besides the usual ethical procedures and assuring that confidentiality will be respected, each participant is asked to sign a written consent for both the audio-taped interviews (a minimum of two interviews will take place), along with its field notes (Cara, 1997). A resource should also be provided in case the participant would need to talk with someone after the interview (O’Reilly & Cara, 2014). As for the participants’ selection, Lincoln and Guba (1985) recommended to remain open to a variation of exemplars in order to maximize the data collection. Benner (1994) suggested recruiting until the researcher reaches “redundancy.”

Phase 3: Being Present to Participants’ Stories

This phase coincides with the interviewing moment. During the interview, the following open-ended question (first research question) is shared with each participant: *What is your meaning regarding [the phenomenon under study]?” The participants are asked to answer the question in the form of a story about a personal experience and to share it with the researcher: *Could you tell me a story about
**IV: DIVERSE FORMS OF CARITAS INQUIRY**

**Phase 4: Discovering the Essence of the Participants’ Stories**

Being inspired by Husserl’s (1970) approach, this step relates to the analysis and interpretation of each participant’s story in order to uncover its essence (Cara, 1997, 2002; O’Reilly & Cara, 2014). First, the researcher has to proceed with the transcription of each interview, then its transformation into a summarized story, which is followed by an analysis and interpretation aimed to seek the essence of the participants’ lived experience (Cara, 1997; O’Reilly & Cara, 2014).

**Phase 5: Reciprocating the Participants’ Stories**

This phase endeavors to achieve mutuality between the researcher and each participant by helping them to clarify and expand their meaning pertaining to the phenomenon. In fact, being informed by a relational caring ontology, we believe that additional interviews encourage participants to validate and co-create findings. Thus, before the second meeting, a copy of the summarized story and its analysis are sent to each participant in order to provide any appropriate changes during the second interview (Cara, 1997; O’Reilly & Cara, 2014). Allowing them time to reflect can enhance a deeper understanding of their own perceptions. We believe that it is fundamental to share the analysis and interpretation process with the participant, in order to promote a relational dialogue (RCI’s sixth phase) within the RCI (Cara, 1997).

**Phase 6: Relational Caring Process**

This step targets the last interview and is characterized by the relational dialogue between the participants and the researcher (Cara, 1997; O’Reilly & Cara, 2014). Through this dialogue, the researcher seeks the participants’ perceptions about the data analysis and interpretation (validation of the summarized story and its analysis) and solicits discussion and negotiation in order to foster a co-creation of meanings pertaining to the phenomenon for each participant (Cara, 1997; O’Reilly & Cara, 2014). During this phase, the researcher is also inviting the participant’s advanced reflection or vision on how to improve or solve problems in regard to the phenomenon: *Could you share your perceptions on how we can promote* [the phenomenon]? Watson (2011) specified that “Caring accepts and holds safe space (sacred space) for people to seek their own wholeness of being and becoming, not only now but in the future, evolving towards wholeness, greater complexity and connectedness.
with the deep self, the soul and the higher self” (p. 103). In doing so, the researcher facilitates the participant’s contribution to knowledge development (Cara, 1997). Indeed, Cara (1997) mentioned,

One of the goals of the Relational Caring Inquiry is to be transformative. . . . During the relational caring process such transformation occurred through the dialogue and allowed for co-created meanings to develop. Empowering research participants to share their perspectives can facilitate their contribution of new knowledge on how to improve the phenomenon under study. (pp. 73–74)

Once again, an analysis and interpretation of the second interview’s dialogue is realized by the researcher and sent to the participant for feedback. At the end of this phase, the researcher expresses her gratitude for the participant’s contribution. Watson (2005) also acknowledged the importance of gratitude in a given moment, as it is “transforming in itself” (p. 117).

Phase 7: Elucidating the Essence of the Phenomenon

This phase corresponds to the global analysis and interpretation of all participants’ stories in order to elucidate the essence or essential structures of the phenomenon. To access the essence, Cara (1997) was inspired by Husserl’s (1970) eidetic reduction, which corresponds to go beyond each particular individual’s story toward the emergence of the universal meaning (or essential structures) of the phenomenon under study. To accomplish the eidetic reduction, free or imaginary variation is used to facilitate data agglomeration (Reeder, 1991). It consists of questioning the place of each element within a group of data to allow the emergence of the universal essence of the phenomenon under study as co-created meanings (Cara, 1997; O’Reilly & Cara, 2014; Figures 9.1 and 9.2).

# CONCLUSION

This chapter highlighted the elements of human caring literacy, especially Watson’s work, as fundamental to the development and utilization of a research method, the RCI (Cara, 1997, 1999, 2002; O’Reilly & Cara, 2014). We uphold the necessity for a reconciliation with the core of nursing, the ontology of caring, within research. If caring is a way of being, then should nurse researchers also be informed by this ontology? We need to value the caring presence and relationships, without embarrassment, while being a nurse researcher. It is essential to raise our awareness in broadening our view of nursing research, so as not to exclude the human caring literacy as a way of knowing, being, doing, and becoming a caring nurse researcher. After all, it is the nurses’ right to care, even in research!

A relational caring ontology invites the researcher to understand the phenomenon under study with openness, consciousness, and humanness (Cara, 1997, 2002;
IV: DIVERSE FORMS OF CARITAS INQUIRY

O’Reilly & Cara, 2014). It encourages both mutuality and relational dialogue between the researcher and the participants, thereby sharing each person’s uniqueness, perspective, meaning, and creativity. The co-created stories will become deeper, reflecting the participants’ reality, as perceived and lived (Cara, 1997). Without being considered exhaustive, the list of the aforementioned caring attributes is a starting point of what we consider significant to a caring ontology, as they are essential to the way of being and becoming a caring nurse researcher. Using the word *becoming* is paramount, since the RCI embraces a transformation for both the researcher and the participants. Such transformation emerges from the co-creation generated within the relational dialogue, encouraged by the relationship as well as the research caring moment. Indeed, one of the goals of the RCI is to be transformative (Cara, 1997, 1999, 2002; O’Reilly & Cara, 2014). Such perspective also appears to us as being coherent with a constructivist research paradigm (Creswell, 2013), since research participants can share their lived experience and co-create their meaning. Hence, the co-construction of the research findings, encouraged by the RCI’s relational dialogue, seems consistent with the constructivism movement (Creswell, 2013). Truly, we believe that empowering research participants to share their perceptions and outlooks can enable their contribution to new knowledge on how to improve the phenomenon under study within nursing domains.

Finally, we also wanted to share our journey involved in the creation and utilization of this nursing research method. This journey has been both enriching and transformative for us, and is still in progress, using the RCI in mixed methods designs and in various domains of the discipline of nursing (Brousseau, 2015; Brousseau et al., 2016; Cara, 1997, 1999, 2002; Delmas, O’Reilly, Iglesias, Cara, & Burnier, 2016; O’Reilly, 2007; O’Reilly & Cara, 2010, 2014; O’Reilly et al., 2011). Hence, we are convinced that the RCI opens the path for the emergence of new epistemologies in nursing.

THE ESSENCE OF OUR CHAPTER

*Nursing in this context may be defined as a human caring science of persons and human health-illness experiences that are mediated by professional, personal, scientific, aesthetic, and ethical human care connections and relationships. Such a view requires the nurse to be a scientist, scholar, and clinician but also a humanitarian and moral agent, wherein the nurse as a person is engaged as an active participant in the human caring process and relationships. (Watson, 2012, p. 66)*
DEDICATION

We would like to dedicate this chapter to the memory of Dr. Georgette Desjean, a professor, a nurse researcher, a mentor, and a friend. Dr. Desjean was a source of inspiration for introducing phenomenology at the Université de Montréal in the mid-1980s. A special thanks to all our research participants, who, over the years, have graciously shared their stories and co-created meanings with us.

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