GENERATION OF AN EXPLANANTORY MODEL OF HUMAN CARING IN REGISTERED NURSES

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To the Dean of Graduate School:

I am submitting herewith a dissertation written by Deborah Davenport, entitled "Generation of an Explanatory Model of Human Caring in Registered Nurses." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

Gail Davis, RN, EdD, Major Professor

We have read this dissertation and recommend its acceptance:

Accepted:

Dean of Graduate School

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ABSTRACT

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The idea of caring is central to nursing. The purpose of this grounded theory study was to qualitatively explore caring attributes or characteristics of registered nurses (RNs) and how these caring characteristics are thought to evolve. The goal of this study was to generate an explanatory model of human caring in RNs.

The study participants were recruited from one healthcare facility, a 394-bed, for-profit acute care facility in a southwestern city with a metropolitan population of over 200,000. Nineteen RNs were included in the study using a purposive, theoretical sampling technique. The study participants ranged in age from 23-61, with a range of 1 ½ to 24 years nursing practice. Interviews were conducted using a semi-structured interview guide and were audio taped and transcribed verbatim.

Data were analyzed using constant comparative analysis. Axial coding was used to explore relationships among the conceptual themes, which yielded four separate, yet interrelated domains of caring characteristics (e.g., knowing, connectedness, intent, and integrity). Within these domains, 23 categories of caring characteristics emerged. The domain of intent was identified as the central domain, representing one's core capacity

for caring. Within this domain is found many of the properties that comprise one's character including, a positive attitude, positive intent, kindness, compassion, concern, consideration, desire and willingness, perceived obligation or duty to serve God and others, hope, and trust. The domain of integrity includes the categories of honesty, respect, humility, and courage. The domain of connectedness includes the categories of connecting with others, temporality, and open-mindedness. The domain of knowing specifically addresses nurse knowing as it relates to caring and subsumes the categories of experiential knowing, self-knowing, relational knowing, and shared knowing.

Centered upon one's intent to act in caring ways, the theoretical model is representative of the nurse caring characteristics explored. Possessing a positive intent to be caring directly affects and is affected by one's integrity, a feeling of connectedness, and one's knowing of the other. In conclusion, this study provides illumination of an area of nurse caring that has not yet been fully explicated.

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CHAPTER I

INTRODUCTION

Caring, especially nurse caring, evolved as a phenomenon of interest for me during my first doctoral nursing theory course. As a nurse educator, I am always fascinated with senior nursing students' explanations of why they are drawn to the study of nursing with anticipation of soon becoming a registered nurse fully engaged in a unique practice. These students convey a desire to care for others or to help others. Often this desire is driven by a personal or family experience with nurses or because they know a nurse they admire. So, during my first nursing theory course, when asked by my professor what concept I was interested in exploring, I immediately replied, "caring." Thus began a journey of study that, at times, has been overwhelming simply because of the wealth of literature devoted to the concept of caring. As I began to peruse the body of nurse caring literature, I realized that, for the past 25 years, nurse scholars have focused on nurses' and patients' perceptions of caring. Specifically lacking among the extant writings on caring was an explication of the attributes or characteristics possessed by nurses, which enable them to be caring. These are the intrinsic qualities, characteristics, attributes, or virtues possessed by nurses who interact with others in caring ways, in order to produce outcomes that will benefit the patient. How these caring attributes evolve has been examined only in a few previous studies (Higgins, 1996; Kosowski 1995; Nelms, Jones, & Gray, 1993; Paterson & Crawford, 1994; Paterson, Crawford, Saydak,

Venkatesh, Tschikota, & Aronowitz, 1995; Simonson, 1996). Therefore, this study's focus was to determine what attributes are present when one acts in caring ways and how these attributes are believed to evolve.

Use of the Term "Caring"

Caring, as the action verb of the noun care, means to feel concern or interest; to feel affection or liking; to feel willing; to see to the safety or well being of another (Oxford American Dictionary, 1980). Caring specifically relates to professional social service occupations (i.e., the caring professions) (Oxford English Dictionary, 1989). The word care was derived around the late 14th century from the Old English carian and the Old Saxon caron, which means to have concern for; to feel an interest in; to look after or provide for; or to have a liking, inclination, or regard for (Oxford English Dictionary, 1989, Green-Hernandez, 1992). Many scholars have described caring in the literature, including non-nurses such as Mayeroff (1971), a philosopher, and Noddings (1984), a professor of philosophy and education. In addition, several nurse theorists, including Leininger (1970, 1981, 1995), Watson (1979, 1988), Green-Hernandez (1991, 1992), and Swanson (1991, 1993), have made explicating the concept of caring their lifework through theoretical discourse. Mayeroff and Noddings have explicated caring as it pertains to society-at-large and one's interactions with others through the course of daily living. The nurse theorists have illuminated nurse caring more specifically, providing insights related to the unique and specialized formal educational process, which enables a nurse to act in caring ways while assisting her patients to meet their needs.

Mayeroff (1971) defined caring as a process of helping another individual grow and become actualized. This process involves a relationship with another person that develops with mutual trust and results in a transformative change, distinguished by a new depth and quality, within the relationship. Mayeroff's conceptualizations on caring suggest that a helpful interdependence exists between the caring person and the one for whom care is given. While assisting the one for whom care is given to grow and become actualized through a caring presence, the caring person also grows and becomes actualized. All caring relationships, regardless of the nature of the relationship, exhibit common patterns with one another. Mayeroff referred to the common pattern in helping another person grow and become actualized as a general pattern of caring. Mayeroff depicted caring as a stabilizing force in one's life through an ordering of one's values and thus one's activities. Through one's caring for others, one lives the meaning of one's own life. In his seminal work, Mayeroff identified eight ingredients necessary for caring, including knowing, alternating rhythms, patience, honesty, trust, humility, hope, and courage. To date, there have been no studies that have explored if these eight ingredients are wholly definitive in capturing the essential qualities needed in order for one to be caring. Mayeroff's eight ingredients may, however, provide an organizing structure for current and future caring research as caring ingredients (i.e., attributes or characteristics) are explored and explicated.

Noddings (1984) defined natural caring as caring done out of love or having a natural inclination for the other. One's motivation in caring for another is aimed at the welfare, protection, or enhancement of the one for whom care is given. Ethical caring,

which is given to another in a moral context, arises from natural caring. An assumption of Noddings' work is that one cannot maintain a caring relation if one has not first experienced natural caring; that is, to be able to care for another, one first must have been a recipient of caring. In this way, caring is learned from experience; it is assumed all humans have an innate desire to care and be cared for. Noddings identified the following components of a caring relationship to include being present with the other, an all-encompassing, authentic presence of the caring person directing full attention toward the other; receptivity or being receptive to the other, by experiencing the other's needs by receiving "the other into myself" (p. 30); and reciprocity with the other, acknowledging that by caring, the caregiver also gains positive benefits, as does the one who receives the caring.

Leininger (1981) described caring as the essence of nursing and "the central and unifying domain for the body of knowledge and practices in nursing" (p.3). Leininger (1970) defined caring as a noun, care, to mean encompassing the provision of personalized and necessary services to help one maintain one's health status or recover from illness. Caring, used as a verb according to Leininger, portrays a feeling of compassion, interest in the individual and concern for people. Leininger (1981) refined caring as being "those assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway" (p.9). Leininger described caring as human acts and processes aimed at assisting others in meeting the needs of those who are in need of care; and in doing so, she identified over 28 caring constructs (p. 13), which are listed in Table 1.1.

These constructs of caring include personal characteristics or attributes as well as behaviors or acts. For example, empathy is a personal attribute, while health maintenance acts and helping behaviors are actions taken for the good of another. Clear delineation of precursors to caring behaviors is not evident in Leininger's model.

Table 1.1

Leininger's Constructs of Caring

Comfort	Compassion	Concern	Coping behaviors
Empathy	Enabling	Facilitating	Interest
Involvement	Health Consultative Acts	Health Instruction Acts	Health Maintenance Acts
Helping Behaviors	Love	Nurturance	Presence
Protective Behaviors	Restorative Behaviors	Sharing	Stimulating Behaviors
Stress Alleviation	Succorance	Support	Surveillance
Tenderness	Touching	Trust	Others

Watson (1988) defined caring as "the moral ideal of nursing, whereby the end is protection, enhancement, and preservation of human dignity" (p. 29). Watson posited that caring is a value and an attitude that becomes "a will, an intention, a commitment, and a conscious judgment that manifests itself in concrete acts" (pp.31-32). Watson reasoned that "the goal of nursing… is to help persons gain a higher degree of harmony…which generates self-knowledge, self-reverence, self-healing, and self-care processes while allowing increasing diversity" (p. 49). Nursing's goal is accomplished through human-to-

human caring processes and caring transactions through which nurses help individuals find meaning in their lives. Human caring requires values, which lead to the will and commitment to care, knowledge about another's need for care, implementation of caring actions based on one's knowledge, and the consequences or outcomes that result from caring. Watson stated the most abstract characterization of a caring person is someone who is responsive to another as a unique individual, is perceptive of the other's feelings, and who distinguishes between one person and another, recognizing both as unique individuals.

Natural caring, caring done out of love for another, precedes professional nurse caring (Green-Hernandez, 1991). Professional nurse caring arises from one's lived experience of natural caring and engages in a direct and intentional process that specifically includes therapeutic nursing interventions. These intentional therapeutic actions include physical and psychosocial interventions that promote healing and are based upon formal nursing education, technical competence, and professional experience. In explicating a caring nursing model, Green-Hernandez (1992) explored the concept of being there as the basis for the development of the Professional Nurse Caring (PNC) Model. In this model, a caring nurse who possesses a foundational base of knowledge, the competence to skillfully act, and the confidence to act on the behalf of the patient defines professional nurse caring. Green-Hernandez identified seven concepts, including being there, support, empathy, communication, helping, time, and reciprocity, which are attributes of nurse caring and which guide the PNC. As in previous frameworks, there is

no clear delineation of the precursors to caring behaviors (e.g., caring characteristics or attributes) and how these evolve.

Swanson (1991) inductively derived a definition of caring: "caring is a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 165). Swanson developed a theory of caring that consists of five categories or processes, including knowing, being with, doing for, enabling and maintaining belief. Swanson (1993) stated that being with, that is, being emotionally present with another is a caring act that conveys to patients that they and their experiences do matter. Being there comprises not just one's physical presence, but also includes a clearly conveyed message of availability and ability to endure with the other. Being with another is to give time, authentic presence, attentive listening and contingent reflective responses and to do so in such a manner that the one being cared for recognizes the commitment, concern and personal attentiveness of the one caring (Swanson). Noddings (1984) labeled this acknowledgment by the recipient the completion of caring. Thus, completion of caring occurs when the recipient of care has a feeling or inner awareness of being cared for by the caregiver. Swanson delineated behaviors of a caring person, but did not address personal attributes or characteristics of a caring nurse.

Concepts Related to Caring

Many of my musings and experiences in the pursuit of understanding the concept of caring have led me to believe that caring is multidimensional and complex. Other concepts that relate to caring or that may be dimensions of caring are discussed in the literature, including advocacy, nursing as art, and motivational factors for entering the

profession of nursing. Understanding these related concepts may add to an overall understanding of caring in nursing, as there are facets of caring inherent in each of these.

Advocacy

Marshall (1994) noted that advocacy, as an aspect of an ethic of caring, delineates an essential role for nurses to act on the behalf and in the interests of one whom, for whatever reasons, is unable to do so on his own. The goal of advocacy is to restore the patient's autonomy when it is threatened or diminished. In acting as an advocate for another, a nurse needs several attributes or characteristics that are similar to those comprising a caring orientation: an intent to act, courage, compassion, a sense of duty, a sense of connectedness with the other, knowledge, and empathy (Marshall). These characteristics or attributes are similar to those identified by Mayeroff. Mayeroff's caring ingredients of courage and knowing explicitly mirror courage and knowledge identified by Marshall. Marshall's sense of connectedness closely resembles Mayeroff's patience, which requires full active participation in a presence of connectedness with another, and Marshall's empathy echoes Mayeroff's honesty, a genuine, authentic openness with another in which one sees the other as he is; this requires empathy or the ability to perceive the other's feelings. Mallik (1997) argued that advocacy is a potentially risky role that requires a moral choice to be made by the individual nurse, which may result in a moral dilemma and conflict. Courage, therefore, noted by both Marshall and Mayeroff, may well be the impetus for caring actions. The nurse's unique knowledge of the patient, based on the immediacy, intimacy, and sustaining connection of the nurse-patient relationship, predisposes advocacy as a role of the nurse to support the patient's decision-

making, to promote the patient's self-determinism, and to assist patients to find purpose in their living or dying (Mallik). Mallik's premise of advocacy is congruent with both Marshall's discussion on advocacy, and Mayeroff's conceptualization of caring.

Nursing as Art

Inferences to caring are apparent in a discussion of nursing as an art. Jenner (1997) undertook analysis of the concept of the art of nursing, and derived the following definition of nursing as art:

> The art of nursing is the intentional creative use of oneself, based upon knowledge and expertise, to transmit emotion and meaning to another. It is subjective and requires interpretation, sensitivity, imagination, and active participation. Understanding and appreciation are derived. Beauty and pleasure often are associated with art but are not essential attributes. Art is to be differentiated from mere dexterity or skill; creativity, innovativeness, or ingenuity are distinguishing hallmarks (pp. 8-9).

Identified attributes of nursing as art include those that are creative, interpretative, evocative, communal, subjective, and expressive. Antecedents of nursing as art include expertise, knowledge and intention; consequences of nursing as art include emotion, meaning, understanding and appreciation (Jenner). Jenner's analysis of nursing as art supports the professional nurse caring model of Green-Hernandez (1992), whose three requisite conditions of professional nurse caring includes a sound nursing knowledge base, along with technical competence that together result in the professional confidence to help another. Characteristics or attributes of caring inherent in Jenner's analysis of

nursing as art include having knowledge and expertise, which infers confidence in self; an intention to act or to use the self positively for the good of another; and the ability to understand and appreciate the other, which infers empathy, compassion, and tolerance of the other.

Clark (1998) stated that nursing uses knowledge from many different disciplines and that nursing's unique knowledge base is like a cake, unique not in its elements but in the way they are combined to create something special. She believes that nursing is not merely the doing of technical tasks but that it blends four distinct activities, including intellectual activity (clinical decision making based on current knowledge), emotional activity (working with patients to understand their perspective and to assist them in meeting their goals), moral activity (based upon a relationship of trust, in an environment where choices and decisions may not depend entirely upon scientific knowledge), and political activity (involving the allocation of scarce resources). The creative process that comprises Clark's view of nursing embodies the art within nursing, given that the nurse must interpret cues about the other's needs, and possess the necessary knowledge and desire to act with positive intent for the benefit of the other. Caring characteristics that might be inferred from Clark's explanation of nursing include knowing the other, critical thinking, empathy, trust, faith, and hope and commitment to the other. The unique function of the nurse as delineated by Henderson (1966) describes a collaborative partnership between nurse and patient to promote health or recovery or peaceful death. This function, as described, is consistent with caring and with nursing as art. It is a mutual participation, using a nurse's unique creative contribution, in assisting another to

optimal living or peaceful death (Clark). In accomplishing these goals, the nurse engages in caring from an emotional, rational, esthetic, intuitive, physical, and philosophical aspect.

Several different nursing theorists' definitions of nursing and eight different theoretical perspectives of nursing, including nursing as art, as interpersonal relations, as therapeutic intervention, as science, and as caring were compared by Hilton (1997) who determined that the body of work by these scholars validates nursing as a helping and caring profession, although one central and unifying definition of nursing does not exist among them. The nurse's concern with the well being of others is consistent with the underlying premise of nursing as a caring profession. It would follow, therefore, that nurse caring has attributes or characteristics that are foundational to caring behaviors and actions.

Motivational Factors for Entering Nursing

Several researchers explored motivating factors for entering nursing, finding evidence that caring for and helping others are motivating reasons for entering nursing (Boughn, 1994; Kelly, Shoemaker, & Steele, 1996; Kersten, Bakewell, & Meyer, 1991; Perkins, Bennett, & Dorman, 1993). Three of these studies focused on reasons why men enter nursing; and one study looked at reasons for entering nursing using female and male nursing students in their first nursing course. Twelve male nursing students were participants in a study to determine why they had chosen to enter nursing (Boughn, 1994). Using grounded theory methodology, Boughn discovered three emergent themes regarding why the male students had entered nursing: (a) motivation to care for others,

(b) job security and salary, and (c) feelings of power and empowerment. Kelly et al. (1996) examined male nursing students' experiences in relation to motivating factors, barriers and frustrations in becoming a nurse. Eighteen male nursing students, representing one associate degree program, two baccalaureate degree programs, and one diploma program, participated in one of four focus groups. Findings showed that the male students had a positive image of nursing and believed nurses were caring, compassionate and connected with people. Motivational factors included altruistic reasons of helping others as well as practical, economic reasons. Kersten et al. (1991) surveyed 752 randomly chosen participants during their first nursing course using qualitative, open-ended questions regarding reasons they selected nursing as a career. The most frequently chosen reason found for entering nursing included altruistic caring and nurturing of others, as well as helping, bringing relief or hope, and interacting with people in need. Perkins et al. (1993) surveyed 146 male nursing students. Findings showed the most common reason men chose nursing was because of career attributes, followed by helping others and contributing to society in a positive, valuable manner.

Measurement of Caring

Much of the current caring theory development has been derived from both qualitative and quantitative studies. While some quantitative tools exist for measuring nurse caring, these tend to center on nurses' perceptions or patients' perceptions of nurse caring behaviors or actions. Caring, as a disposition or as having internal characteristics or attributes, has yet to be consensually defined by the nursing profession. As a result,

caring and its many attributes have not been operationally defined; therefore, the ability to quantifiably measure all potential caring attributes or characteristics does not exist.

Basing her work on Mayeroff's eight caring ingredients of knowing, alternating rhythms, patience, honesty, trust, humility, hope, and courage, Nkongho (1990), a nurse, developed the Caring Abilities Inventory, an instrument that measures three of the eight ingredients (knowing, patience, and courage). While her work has promise as a means for measuring some of the caring abilities; it seems, that this tool is, so far, an incomplete measurement of all the concepts that may possibly comprise one's internal attributes for caring.

Davenport (1997), using Nkongho's Caring Abilities Inventory, discovered that sophomore nursing students at the midpoint of their first clinical nursing course scored significantly higher on all three subscales of the instrument than did sophomore students of majors other than nursing. These findings supported the investigator's belief that caring individuals select nursing as their major of study because they have an innate desire to help others. The findings of this study raised further questions: "What are the characteristics of nurses that contribute to the development of caring within their nursing practice, how do these evolve, and are these characteristics present in nurses' accounts of caring?"

If caring is indeed central to the practice of nursing, then the profession of nursing needs to fully define and explain what caring is and what those characteristics are that facilitate a caring disposition. Newman, Sime, and Corcoran-Perry (1995) proposed as a defining focus statement for the discipline of nursing the following core idea: "...nursing

is the study of caring in the human health experience" (p. 36). What the essential caring characteristics are that caring nurses possess, how these caring characteristics evolve, and why caring nurses care are salient areas of inquiry that need to be addressed by nursing as a profession.

Problem of the Study

The concept of caring is central to nursing; yet it remains abstractly and incompletely explicated. There is no unifying definition of caring within the profession of nursing. Although caring within nursing has been extensively studied for the past 25 years, what the characteristics or attributes that comprise a caring disposition are and how these evolve has not been fully explored.

What is known is that caring traditionally has been taught from mother to daughter as part of a female apprenticeship or learned as a domestic task (Reverby, 1987). Traditionally, because caring has been seen as women's work, it has been undervalued by society; and historically, nursing has struggled as the profession that is ordered to care in a society that does not value caring (Reverby). This dilemma suggests that research is needed to determine the essential caring characteristics of a caring nurse and how these characteristics evolve.

Research Questions

Three broad research questions were used to guide and frame this study. These were: (a) What constitutes caring in nursing?, (b) What attributes or characteristics are needed for caring to occur?, and (c) How do these evolve?

Purpose of the Study

The purpose of this grounded theory study was to generate an explanatory model of human caring in registered nurses (RNs) by exploring what constitutes caring in nursing. This exploration focused on the caring attributes or characteristics of caring nurses (i.e., nurses identified as caring by their peers) and how these characteristics evolve. The generation of this explanatory model extends the body of nursing knowledge related to caring with intent to guide future study in the measurement of caring attributes possessed by caring RNs. Knowing and understanding how caring characteristics evolve may assist nurse educators and nurse administrators in developing methods that facilitate the acquisition of caring characteristics in nursing students and nursing staff.

Rationale of the Study

Discovery of caring attributes and understanding how these evolve will advance the profession's knowledge related to caring, a valued concept in nursing. Indeed, caring is professed to be the essence of nursing and its central, unifying domain (Leininger, 1981; Watson, 1988). The knowledge generated by this study may be useful in nursing education, nursing administration, and nursing practice since better understanding should facilitate the development, validation, and support of RNs' caring characteristics.

Knowledge of caring attributes and how these evolve can be used to facilitate nurse educators' design of appropriate teaching strategies for modeling or assisting students in the acquisition of caring characteristics that are requisite for a caring nurse-patient interaction (Eddy, Elfrink, Weis, & Schank, 1994; Higgins, 1996). Eddy et al. (1994) conducted a national study of seven essential values (i.e., altruism, equality,

esthetics, truth, freedom, human dignity, and justice) identified in the American Association of Colleges of Nursing's (1986) *Essentials of College and University Education for Nursing*. Participants included 646 senior nursing students and 312 nursing faculty. The investigators found that nursing faculty had statistically significant higher value scores than senior nursing students. The authors recommended that nursing faculty role model sensitivity and empathy while caring for diverse patients to assist nursing students in learning how to treat all humans with dignity and respect (Eddy et al.). The values examined in this study and how these are acquired support my belief that nurse caring behaviors are dependent upon caring attributes or characteristics and that these can be learned.

Higgins (1996) described a project to "implement caring as a nursing therapeutic" in a community college nursing program (p. 134). The two goals of the project were to provide students with a caring space for mutual sharing of stories and to experience themselves as both caring and being cared for; and to value caring and implement caring interventions for the betterment of the patient. Additional knowledge about caring, it's attributes, and how to act on these will be useful in developing specific methods in assisting students to acquire these attributes.

Nurse administrators, who with today's nursing shortage and competitive healthcare climate want to emphasize the importance of caring nurses as a value-added service to clients and customers, may be able to use the knowledge derived from this study in seeking out potential employees who demonstrate caring characteristics. A previous study evaluated implementation of a caring model consisting of five caring

behaviors (i.e., introduce self to patients and explain your role in their care, call patient by preferred name, sit at the patient's bedside at least 5 minutes to plan and review care, use a handshake or touch on arm, and use the mission, vision, and value statements in planning your care) in a 48 bed acute care community based hospital six months after implementation (Dingman, Williams, Fosbinder, & Warnick, 1999). Evidence showed that caring nurse behaviors significantly increased patient satisfaction. Translating these behaviors into their foundational antecedents of the caring characteristics (e.g., respect for others, empathy and compassion, and commitment and intent) suggests these characteristics can be further developed and refined through experience and practice as a means of improving patient satisfaction.

Ultimately, as a result of the knowledge generated by this study, it is sincerely hoped that nursing practice is validated as to its importance, since nurses will have an increased knowledge of the components of caring in their practice and of how these attributes can be individually and collectively fostered. Validation of one's caring practices through the concept of "being there," in a fully engaged, attentive presence with the patient, has been reported by Green-Hernandez (1992). Benner and Wrubel (1989) described caring as an interpersonal interaction that involves being connected, an outcome of which is that the one caring is enriched in the process (p. 398). When caring is viewed within an interactional situation, a nurse who is able to fully connect with the patient on a personal level and who shows interest conveys real concern about the patient's well being, is able to orchestrate optimal outcomes (e.g., alleviation of pain and anxiety, and saving or enhancing the person's life) (Montgomery, 1993). Acknowledging

the commonality of being human and being committed to make the human connection with another are the necessary components for caring as interpersonal interaction (Montgomery). This type of commitment by the nurse to the patient is expected to result in the enrichment and enhancement of both individuals.

Conceptual Orientation

I selected to use Mayeroff's (1971) conceptualizations of caring and his eight caring ingredients (i.e., knowing, alternating rhythms, patience, honesty, trust, humility, hope, and courage) as a conceptual orientation for this study. Having used the CAI to measure caring abilities of beginning nursing students, which were significantly higher than those of non-nursing students, I believe caring persons are attracted to nursing. Of Mayeroff's eight caring ingredients, only three are included in the CAI. This led me to question the CAI's ability to provide a complete measure of caring abilities or if, indeed, Mayeroff's eight caring ingredients provided a full explication of what attributes were necessary for caring. This, in turn, fostered in me a desire to know more about the characteristics or attributes of caring. Caring as explicated by Mayeroff denotes that a cooperative interdependence exists between the caring person and the one being cared for that enables both to maximize their potential being. One's caring for others and serving others through caring, allows one to live the meaning of one's life and to be "in place" in the world (p. 2). One's being in place in the world is not accomplished through domination, explanation, nor appreciation, but through caring and being cared for (p.2). The outcomes of caring and being in place in the world assists one in understanding one's own life better. Mayeroff's eight caring ingredients provided a conceptual orientation for

exploring whether the data elicited by this study included the eight caring ingredients as conceptualized by Mayeroff, or if the data incorporated different or expanded attributes of caring. These eight caring ingredients are summarized in Table 1.2.

This research study was undertaken in order to contribute to a fuller understanding of these attributes and characteristics of nurse caring. In addition, how these attributes evolved was also examined.

Figure 1.1 illustrates how the caring dimensions of attributes, behaviors, interactions, and outcomes are viewed within the context of the attribution-empathy model (Graham & Folkes, 1990). Since Mayeroff's eight caring ingredients provide a conceptual orientation, those eight attributes appear in the conceptual model guiding this study. The attribution-empathy model for prosocial behavior provided an orientation for this study that supports the assumption that, as one is able to empathetically perceive another's condition, an increase in prosocial behaviors (e.g., helping, sharing, and cooperating) results.

A person's increased empathetic perspective also affects one's perceptions of the ability to assign attributions for outcomes. This then directly results in an increase in prosocial behavior, as well as through increased levels of empathetic feelings toward the other. Nurses who believe themselves to be empathetic will behave in caring ways. As the nurse's empathetic perception increases, so shall the nurse's capacity for caring. While general caring (Mayeroff, 1971; Noddings, 1984) may guide a caring person into the profession of nursing, nursing education provides the structure from which nurse caring emerges (Green-Hernandez, 1992).

Table 1.2

Mayeroff's Eight Caring Ingredients

Caring Ingredient:	Description:
Knowing	Knowing the person, especially what abilities he possesses, including his powers and limitations, what his needs are, and how one can help him grow. An important aspect of knowing includes knowing one's own powers and limitations. Knowing is explicit (able to verbalize) and implicit (unable to articulate), knowing that (general knowledge of what is) and knowing how (specific knowledge of how to do), and direct (encountering and apprehending the other's existence) and indirect (knowing about something without having experienced fit or experiencing something without knowing it directly) (Mayeroff, 1971, pp. 9-11).
Alternating rhythms	Refers to fluctuations in the scope of caring; at times, caring involves doing for the other; at other times, caring involves doing nothing for the other. Implies past actions and behaviors directly influence future caring acts. Patterns make it possible to learn from previous experiences and to modify one's behavior to facilitate future growth; also refers to a rhythm of moving back and forth from a narrow focus to a broader one; in looking at an act as a separate, isolated incident or within a wider context in order to discern patterns. Caring cannot occur by sheer habit, one must be able to learn from one's past; an evaluation of one's past actions, and whether or not these were helpful, so that maintenance or modification of behavior can allow one to better help another (pp. 11-12).
Patience	Active full participation with the other, while being tolerant of chaos and confusion during the transformative growth of the other. Patience allows the other to grow in his own way and in his own time. Patience allows another both time and space for living and growing. One must also be patient with oneself; one must give oneself the opportunity to grow and learn to see and to discover both self and the other (pp. 12-13).
Honesty	Being open with the other; being genuine and authentic in one's caring for another. Congruence between what one feels and does. Also, seeing the other as he is, not as one would wish him to be; as well as seeing oneself as one truly is (pp. 13-14.)

(Table continues)

Table 1.2 *(continued)*

Caring Ingredient:	Description:
Trust	Involves risk and letting go while trusting in the other to grow in one's own way and in one's own time. Involves having confidence in one's own abilities to care as well as the other's abilities to evolve. Trust encourages and fosters independence (pp. 14-16).
Humility	Involves a constant readiness and willingness to learn more about the other and oneself and what caring involves. Humility is present in realizing that one's caring is not in any way privileged, others can be caring and of equal importance to one's own caring. Humility also means overcoming pretentiousness, allowing other to see oneself as one truly is. Humility allows one a sense of pride in a job well done; partners with an honest awareness of what one has done and the extent of one's dependence and cooperation of others and on various conditions (pp. 16-17).
Hope	Allows one to express the possibilities of what can occur and to become energized into making that happen. Hope requires courage: if one does not believe that one would stand up for another in a difficult circumstance, then one's hope for the growth of the other is undermined. Courage makes hope possible, hope makes for courage, hope implies that there is or could be something worthy of commitment (pp.18-20).
Courage	Allows one to venture into the unknown while trusting in the other's ability to grow along with one's own ability to care. Courage is informed by insight from past experiences and is open and sensitive to the present. Trust in the other to grow and in one's ability to care gives one the courage to go into the unknown, but without courage to go into the unknown, trust is impossible. The greater the sense of going into the unknown, the greater the need for courage (p. 20).

Definition of Terms

Caring. Caring is defined as a process of helping another grow and become actualized; in doing so, caring is a process of relating to someone else (Mayeroff, 1971, p. 1).

Nurse Caring. Nurse caring is defined as creating a caring interaction between nurse and patient, based upon knowledge, competence, and confidence (Green-Hernandez, 1992).

Caring Registered Nurse (RN). Caring Registered Nurse (RN) will be defined as a licensed RN who is currently employed fulltime in nursing and is identified by at least one other RN as one who exemplifies caring in the practice of nursing.

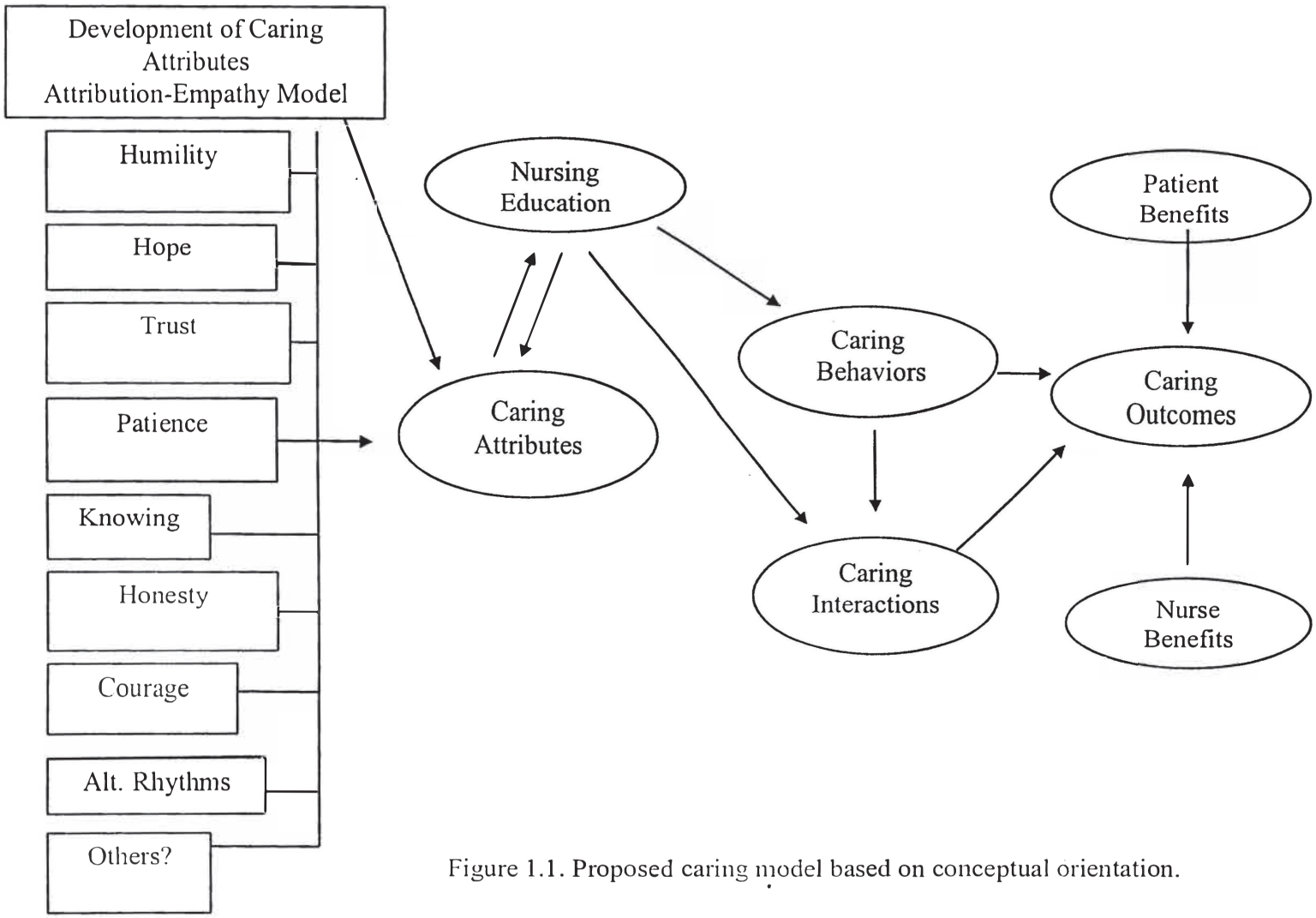

Figure 1.1. Proposed caring model based on conceptual orientation.

CHAPTER II

REVIEW OF LITERATURE

After spending a considerable amount of time reviewing the literature on caring in my doctoral courses and with my growing awareness of the many nuances on caring found in the extant nursing literature, I discovered a gap pertaining to the question of what constitutes a caring disposition. More specifically related to nursing, the question becomes, "What are the character traits or attributes possessed by a caring nurse?" Believing this missing gap could provide a vital piece to more fully understand nurse caring, I chose to explore existing internal attributes or characteristics that enable nurses to act in caring ways.

Using grounded theory methodology, one does not use the literature in the same manner as one does when using a more traditional research method (Glaser, 1992; Strauss & Corbin, 1998). The literature review, as part of this study, serves as an acknowledgment of the relevant literature that shaped my perspective on the problem under study. Acknowledgment of this body of work had two purposes; first, it raised my consciousness of potential biases and, second, it provided a basis for preliminary development of theoretical sensitivities by presenting ideas, concepts, categories, and structures from which to make data comparisons (Glaser; Strauss & Corbin). Creswell (1994) delineates three methods for use of the literature in a grounded theory study: (a) the literature is used to frame the problem in the introduction to the study, as was found

in Chapter I; (b) a review of the literature is placed in a separate section, generally to satisfy readers most familiar with a traditional, positivist approach to research; and (c) the extant literature is revisited and presented along with a discussion of the findings at the end of the study, whereby it serves as a basis for comparing and contrasting the findings of the study.

A review and discussion of the caring literature that influenced this study follows. Both theoretical literature and empirical literature on the concept of caring, generally, and on the values or predisposition for caring, in particular, are summarized. In addition, the related concepts of advocacy, nursing as art, and motivational factors for entering the profession of nursing are presented as these may contribute to nurse caring.

Theoretical Literature

Many scholars have contributed to the theoretical literature on caring over the last 25 years. Those formative writings that have shaped my understanding of caring include the writings of Nel Noddings, a professor of philosophy and education; Carol Gilligan, a social psychologist; and nurse theorists Madeleine Leininger, Jean Watson, Carol Green-Hernandez, Kristen Swanson, and Sister Simone Roach. General similarities exist in these theorists' writings. A predominant theme is that caring is a learned behavior, driven by one's genuine concern for the well being of another. Also evident within these theorists' works is that caring is basic, universal, and necessary for survival. It is assumed that in order to be caring, one must have first experienced being the recipient of care. Caring results in positive outcomes that benefit both the one who receives the caring and

the one who gives the caring. None of these scholars fully address or delineate those character traits or attributes that comprise the disposition of a caring person; however, based on the theoretical premises evident in their writings, caring attributes or characteristics may be extrapolated. The following section summarizes these theorists' seminal works on the development of caring theory, in addition to their influences on my understanding of caring.

Nel Noddings'- A Feminine Approach to Caring

Noddings focused upon caring as the essential basis in the educational process of socializing young children into caring human beings. Natural caring is defined by Noddings (1984) as the caring done by one who cares out of love or natural inclination for the other. One's motivation in caring for another is aimed at the welfare, protection, or enhancement of the one being cared for. Ethical caring, which is given to another in a moral context, arises out of natural caring. Caring, as a primary value arising from the natural caring a person has previously experienced, requires an interpersonal connectedness to the other. Motivation to care depends upon the contextual intimacy of the relationship. For example, in many families, caring arises from love, or natural caring; in a less intimate relationship, caring arises from a natural imperative to care that is based on learned values, or ethical caring. One cannot maintain a caring relationship if one has not experienced natural caring personally; that is, to be able to care for another, one must first have been the recipient of caring. In this way, caring is learned from experience; it is assumed that humans have an innate desire to give and receive care.

Caring is both other-serving and self-serving, as both the one caring and the one receiving the care benefit from the caring relationship. Caring, based in receptivity, denotes a way of being that may or may not involve action. The nature of caring can vary in intensity and be enduring or episodic, depending upon one's perceived obligation to the other. Using Nodding's writings on caring to extrapolate the characteristics or attributes needed for caring, there are certain, predominant values that are necessary for caring for another (e.g., respect for others, compassion, motivation to care, intention or will, and commitment to care). In addition, the caring person acts with the other in a dyad of connectedness and receptivity, which mandates a need for certain caring characteristics such as empathy, hope, trust, and patience. Noddings' discourse on caring within a framework of receptivity, as well as variation of intensity and duration of caring may be related to Mayeroff's (1971) caring ingredient of alternating rhythms, or of knowing when to act or when not to act, which may involve the use of one's intuition.

Carol Gilligan's Caring and Moral Decision Making

Caring and moral decision-making may be influenced by gender (Gilligan, 1993). In her work on moral decision-making, Gilligan discovered differences in how men and women identify and describe themselves. She noted that men most often describe themselves by their individual work achievements, while women describe themselves in terms of their interconnectedness and relationships with others. Gilligan believed a dilemma is created by these differences in how men and women describe themselves; a conflict may exist between integrity and care, for both men and women, because of the

diverse moral ideologies of the two genders. For example, the predominantly male identity of separation is defensible by an ethic of rights or justice while the predominantly female identity of attachment is supported by an ethic of care. Gilligan argued that women, through their attachments with others, learn to care differently than men do because their interactions with others enable them to learn caring behaviors. People may use different orientations or perspectives in making moral decisions; however, the caring orientation and the justice orientation are two problem-solving approaches in making moral decisions, which appear to be gender influenced. The person who bases decision-making on relational aspects is considered to have a caring orientation, compared to the person who bases decision-making on rules and principles, which is considered representative of a justice orientation. Women, and especially female nurses, seem to largely operate from a caring orientation, while men more often support their decisions on what they perceive to be right, based on rules and principles. Walker (1997) argued that an ethic of care frames a private morality, rather than a public one, centering on personal rather than universal obligations. The immediate beneficiary of moral action in an ethic of care are particular others (e.g., one's family member or one's patient) rather than generalized others (e.g., society at large). Feminist theory asserts that one should be capable of "bearing the tension" or "living the ambiguity" between a rational ethic of justice and one's own ethic of care (Walker, p. 24).

Benner, Tanner, and Chesla (1996) referred to the dominant ethic found in stories of everyday nursing practice as one of caring, characterized by responsiveness to another

and responsibility for the other. Use of a particular ethic may be related to situational factors and influenced by gender or worldview. Additional research is needed to determine which type of ethic nurses, both male and female, use as a basis for their decisions and actions. Caring attributes that might be inferred from Gilligan's writings include commitment to another, connectedness with another, receptivity and reciprocity, patience, hope, and trust.

Madeleine Leininger's Sunrise Model of Transcultural Care Diversity and Universality

Leininger (1970) posited that nurse caring behaviors are implemented based upon the nurse's perception and understanding of the other's need. Thus, a variation in caring nursing actions exists that allows the nurse the freedom to blend professional knowledge and skills with philosophical and personal views about health, nursing and assisting persons. Leininger (1981) described caring as human acts and identified 28 caring constructs that comprise caring. From 1964-1981, while explicating a body of knowledge on ethnocaring, Leininger studied 30 cultures to determine the definitions, nature and scope of caring, with the ultimate goal of improving health care to people, by the provision of both cultural specific and cultural universal nurse caring practices. Based upon her preliminary research findings, Leininger (1981, p. 11) identified eleven assumptions that guide a nurse's thoughts on caring (Table 2.1). One's humanness engenders one's ability to be caring; additionally, caring is culturally based (e.g., caring for oneself and for others involves the use of behaviors that are valued and learned from

within a cultural context, primarily from within one's own family) (Leininger, 1995).

Table 2.1

Leininger's Assumptions for Nurse Caring

1.	Human caring is a universal phenomenon, but the expressions, processes, and patterns vary among cultures.
2.	Every nursing care situation has transcultural caring behaviors, needs, and implications.
3.	Caring acts and processes are essential for human development, growth, and survival.
4.	Caring should be considered the essence and unifying intellectual and practice dimension of professional nursing.
5.	Caring has biophysical, psychological, cultural, social, and environmental dimensions, which can be studied, and practices to provide holistic are to people.
6.	Transcultural caring behaviors, forms, and processes have yet to be verified from diverse cultures; when this body of knowledge is procured, it has the potential to revolutionize present-day nursing practices.
7.	To provide therapeutic nursing care, the nurse should have knowledge of caring values, beliefs, and practices of the clients(s).
8.	Caring behaviors and functions vary with social structure features of any designed culture.
9.	The identification of universal and non-universal folk and professional caring behaviors, beliefs, and practices will be important to advance the body of nursing knowledge.
10.	Differences exist between the essence and essential features of caring and curing behaviors and processes.
11.	There can be no curing without caring, but there may be caring without curing.

Delineation of some caring characteristics such as empathy, compassion, concern, interest, and trust can be found in Leininger's writings. Within her assumptions, additional caring characteristics can be inferred; these include (a) knowing the person for whom one is caring, or in particular, knowing the caring values, beliefs, and practices of that person; (b) reciprocity and receptivity, or that all nursing situations have caring needs

and caring acts essential for human development, growth and survival.

Jean Watson's Human Science and Human Care

Watson (1988) reasoned that human caring requires values, a will and a commitment to care, knowledge, caring actions, and consequences. The science of human caring operates from a phenomenological perspective of developing human consciousness and self-awareness. Two basic premises for a science of caring include that (a) caring and nursing have existed in every society, transmitted culturally as a way of coping with changes in the environment and (b) there is often a discrepancy between theory and practice or between scientific and artistic aspects of caring, possibly because of the dissociation between scientific values and humanistic values (Watson, 1979). Watson (1988) stated that caring calls for a philosophy of moral commitment toward protecting human dignity and preserving humanity and identified 10 carative factors that provide a structure and theory for caring and that differ from curative factors. Carative factors are a part of the caring process that allows an individual to attain or maintain health or to die a peaceful death, while curative factors aim to cure the individual of a disease process. Watson's (1994) 10 carative factors that provide the foundation for her theory of caring include a humanistic-altruistic system of values; the instilling of faith-hope; sensitivity to self and others; helping-trusting human care relationships; expressing positive and negative feelings; creative problem-solving caring process; transpersonal teaching-learning; supportive, protective, and/or corrective mental, physical, societal, and spiritual environment; human needs assistance; and existential-phenomenological-

spiritual forces (p. 6). These carative factors guide and support the nurse in the delivery of human care. The first three factors provide a philosophical foundation for the science of caring, and the last seven form an interrelated scientific, caring basis for nursing education and practice (Watson).

Watson (1988) defined nine concepts as components of her theory, listed in Table 2.2; several of these concepts influenced my thinking on caring. Two that were especially germane to my growing understanding of caring were her conceptualizations of nursing (a) as an intersubjective personal human contact within the lived world of the person experiencing the nursing care and (b) as being comprised of knowledge, thought, values, philosophy, commitment, and action, with some degree of passion. Other concepts of Watson's, which influenced my thinking, included human needs, transpersonal human care and caring transactions, and time. The concept of human needs identifies such needs as the need to be loved and cared for and about; to receive positive regard and to be accepted, understood, and valued; and, to have union, transcendence of one's individual life, and harmony with life. The concept of transpersonal human care and caring transactions are characterized as those scientific, ethical, aesthetic, creative and personalized giving and receiving behaviors and responses between two people that allow for contact between the subjective world of the experiencing persons. These are processes that symbolize a human-to-human relationship in which the person of the nurse affects and is affected by the person of the other. These processes culminate in a caring event or caring occasion. This phenomenon occurs when two persons (nurse and other) come

together with their unique life histories and phenomenal fields in a human care transaction, which involves action and choice by both persons. The actual caring occasion can transcend physical time; therefore, the last concept of influence is time, which is characterized as a moment where the past, present, and future merge as the nurse and patient interact with one another (Watson). As a result of a caring interaction, the nurse and the patient both benefit and both experience enhancement. I believe some of the caring characteristics that can be derived from Watson's work include commitment and concern, will and intent to act, faith, hope, trust, patience, empathy, and compassion.

Table 2.2

Watson's Concepts of Caring

Nursing	Consists of knowledge, thought, values, philosophy, commitment, and action, with some degree of passion; related to human care transactions and intersubjective personal human contact with the lived world of the experiencing person (p. 53).
Person	Viewed as "being in the world," the locus of human existence, and who exists as a living, growing gestalt; possessing three spheres of being (body, mind, soul) influenced by the concept of self (p. 54).
Self	An "organized consistent conceptual gestalt composed of perceptions of the characteristics of the 'I' or 'me' and the perceptions of the relationships of the 'I' or 'me' to others and to various aspects of life, ... with the values attached to those perceptions. It is a fluid and changing gestalt, a process, but at any moment a specific entity (p. 55)." One's sense of self is an unending process as new experiences are turned into knowledge, and as each psychological moment shapes the next.
Phenomenal field	Frame of reference known only by the individual; unique, subjective reality; incorporates consciousness along with perceptions of self and others, feelings, thoughts, bodily sensations, spiritual beliefs, desires, goals, expectations; environmental considerations; a blending of past, present and future (pp. 55-56).
World	All the forces in the universe, as well as one's immediate environment and situation that affect the person, including internal, external, human, artificial, natural, cosmic, psychic, past, present or future (p. 56).
Human needs	The need to be loved and cared for and about; for positive regard; to be accepted, understood and valued; and to achieve union, transcend one's individual life, and find harmony with life (p. 57).
Transpersonal human care & caring transactions	Those scientific, professional, ethical, aesthetic, creative and personalized giving and receiving behaviors between two people (nurse and other) allowing for contact between the subjective world of the experiencing persons through physical, mental, or spiritual routes or some such combination (p. 58).
Actual caring occasion	Involves action and choice by both nurse and individual; a moment that becomes part of the past life history of both persons and presents each with new opportunities; based upon the belief that we learn from one another how to be human by identifying ourselves with others or seeing their dilemmas in ourselves (p. 59).
Time	A moment where past, present, and future merges as the nurse and patient intersubjectively interact with the other (p. 60).

Carol Green-Hernandez' Professional Nurse Caring Model

According to Green-Hernandez (1992), professional nurse caring enfolds natural caring; nurses gain the ability for professional nurse caring following or concurrently with their living the experience of natural caring. Three of the five propositions that organize the Professional Nurse Caring model influenced my perspective on caring intent. These propositions state that the nurse believes in the value of professional nurse caring, has a desire to act, and knows that one will intentionally act (Green-Hernandez). The seven concepts of the Professional Nurse Caring model were all cogent to my perspective of nurse caring. Of these, the first two concepts, being there and support, hold that the nurse will demonstrate a predictable, non-judgmental presence for the patient, and will demonstrate nurturance, advocacy, alliance, and access. The next two concepts include empathy, which reasons that the nurse will enter into the patient's reality in order to gain understanding and knowledge; and communication, whereby the nurse effectively communicates with the patient, using all forms of communication, such as verbal, nonverbal, and tactile ways. Two more concepts, helping and time, are interrelated because in order to be able to assist others requires that the nurse perceives that time is available in which to act. Reciprocity is the seventh concept of the model and is fundamental to the nurse's practice of professional caring; reciprocity of caring enables the nurse to attain self-actualization (Green-Hernandez). Caring characteristics are evident in these seven concepts and include will and intent to act on the behalf of another, empathy, patience, knowing, tolerance without judgment, trust, faith and hope.

Kristen Swanson's Theory of Caring

Another theorist whose work shaped my thinking was Swanson (1991), who developed a theory of caring that consists of five categories or processes including knowing, being with, doing for, enabling and maintaining belief. These five caring processes have been empirically identified and described in three separate studies conducted by Swanson (1991). In a later paper, Swanson (1993) showed the interrelationships of these five caring processes in a model called the structure of caring. This model is linked to five components: (a) the nurse's philosophical attitude, encompassing the caring process of maintaining belief; (b) informed understanding, encompassing the caring process of knowing; (c) conveyance of message, encompassing the caring process of being with; (d) therapeutic actions, encompassing the caring processes of doing for and enabling; and (e) intended outcome, encompassing client well-being. Swanson's writings show an interrelationship with several caring characteristics including concern for the other with positive intent to act on the behalf of the other, knowing the other, empathy, patience, faith, trust, and hope.

Sister M. Simone Roach's Five C's of Caring

Attributes of professional nurse caring identified by Roach (1992) include dimensions of compassion, competence, confidence, conscience, and commitment (i.e., the five C's). While Roach acknowledges that this conceptualization is not exhaustive of all possible attributes of caring, she believes the five C's are an organizing framework for the expression of professional nurse caring. Roach (1991) began her inquiry on caring

with reflections on the ontological perspective, "What is the 'being' of caring?" (p.8). From this perspective, caring is conceptualized as the human mode of being and is the expression of one's humanity, vital to one's development and fulfillment as a human being. Roach defined nursing as the "professionalization of the human capacity to care through the acquisition and application of the knowledge, attitudes, and skills appropriate to nursing's prescribed roles" (p.9). I believe that Roach's description of these caring dimensions or categories subsumes Mayeroff's eight caring ingredients.

Advocacy

Caring is a mutually empowering relationship in which nurses, acting as patient advocates, assist patients in mobilizing their own resources in order to meet their goals. Mallik (1997) noted that advocacy directly translated from Latin means "to call." In the legal sense, it is a "calling to" by the client who calls for assistance, whereby the concept of "agency" replete with its contractual intent is created between the client and the legal advocate, who is the client's agent in the matter at hand. However, within the healthcare system, an advocate is the initiator of contact with the client, thereby reflecting not a "calling to" by the client, but a "giving of " aid by the professional (Mallik, p. 131). Within the legal system, an advocate is one who pleads the case of another in a court of justice, while in the healthcare system, an advocate is one who creates an atmosphere of openness to and support of the patient's decision-making (Mallik). Advocacy inherent in caring, as defined by Montgomery (1993), is "a natural state of social involvement and responsiveness that is an integral part of our human condition" (p. 14). The nurse acts as

an advocate through assisting the patient to achieve individual goals, resulting in empowerment of the patient. The nurse, however, also benefits from this interpersonal relationship, as both participants in a caring relationship of this nature experience self-actualization. Nelson (1988), Marshall (1994), and Mallik offered multiple ways nurses serve as advocates. Nelson (1988) posited that advocacy for the patient has evolved from its original goal of interceding on the behalf on a patient to the extant role in which the nurse acts as guardian to the patient's rights to autonomy and free choice. Acting as a patient advocate for an anesthetized patient undergoing a surgical procedure, the nurse advocates to safeguard the patient's well-being, while taking positive action in restoring the patient's autonomy when it is threatened or diminished (Marshall, 1994). Nelson posited that currently the advocacy role insures the protection of the patient's self-determination. Inherent in this conceptualization of advocacy, one discovers the foundation upon which it rests to be a valuing of, above all other matters, the individual's autonomous right to make choices and decisions. Characteristics of caring that are evident in the concept of advocacy are concern for the other, positive intent to act for the good of the other, valuing the other's right to autonomy, faith and trust in the other. Inherent also within the concept of advocacy is the caring characteristic of knowing the other.

Nursing as Art

Nightingale (1969) published her *Notes on Nursing* in 1859 as a guide for the laywoman who nursed within the context of caring for ill family members. Within this

seminal work, she delineated what she saw as nursing's work, in which she depicted nursing as an art. Nightingale saw the art of nursing to not only be important in the management of the sick but also in the management of the well; in doing so, she implored women to learn health promotion strategies, which would improve the nation's health and decrease the death rate, especially among children who at that time were especially vulnerable as one out of every seven babies died before its first birthday. Prior to her *Notes on Nursing,* the word nursing was associated with little more than the administration of medications and application of poultices, yet Nightingale believed the true scope of nursing should lie within management of the environment with the proper use of well-ventilated air, direct sunlight, warmth, cleanliness of both the environment as well as the individual's hygienic cleanliness, quiet, and appropriate nutritional management. In carrying out these guidelines, the nurse would place the patient in the most optimum position for nature to do its work in restoring health or maintaining health (Nightingale).

Henderson (1966) conceptualized nursing as art when she defined nursing by discussing the function of the nurse. She stated, "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible" (p. 15). In order to carry out its function, Henderson believed that nursing required constant observation of the patient and analysis

of the patient's behavior in order to formulate what the needs of the patient were. These needs were then to be validated by the patient prior to nursing action. This collaborative practice is founded upon knowing the person, knowing what needs the person has, empathy for the person, honesty in the communications between nurse and patient, trust, hope, and a positive intent to assist the patient in becoming self-sufficient. Henderson believed nursing's unique function belonged to the nurse, who as an independent practitioner was the authority on basic nursing care (i.e., primarily the activities of daily living). While acknowledging the importance of knowledge in the biologic and social sciences, nursing is primarily an art because of the way in which nurses use their unique knowledge to create an individualized plan of care for each patient, based upon input from the patient, while continually evaluating the patient's progress toward a goal of independence (Henderson).

Research Literature

The review of the research literature uncovered many studies that focused on caring; yet, agreement upon the definition of this complex concept was not found to exist among nurse researchers. Morse, Solberg, Neander, Bottorff, and Johnson (1990) conducted an extensive review of the literature on caring and identified thirty-five authors who have defined caring. From this, the authors formulated five categories of caring: (a) caring as a human trait, (b) caring as a moral imperative or ideal, (c) caring as an affect, (d) caring as an interpersonal relationship, and (e) caring as a therapeutic intervention. Caring as the subjective experience of the patient and caring as a physical

response were two additional categories identified; these represent patient outcomes, rather than nurse caring. In order to present those studies that have most influenced my understanding of caring, I have used four of these categories as a framework to structure my discussion of the research literature. Caring, as a human trait is discussed first, followed by a combined discussion on caring as therapeutic intervention and caring as patient outcomes (i.e., caring viewed as the subjective experience of the individual and caring viewed objectively as a physical response). In addition, studies that focused on nursing as art, caring in nursing education, as well as motivational factors for entering the profession of nursing are discussed.

Caring as a Human Trait

Caring as a human trait focuses on the worldview that caring is an innate and essential human trait, which characterizes one's human mode of being, indelibly a part of human nature and vital for human existence (Morse et al., 1990). All humans have a capacity for caring, although this varies from person to person. The ability to be caring is influenced by one's previous experiences (Noddings) as well as derived from one's culture (Leininger). Caring as a human trait motivates all caring nursing actions (Morse et al.). Studies that influenced my growing understanding of caring as a human trait include Morrison (1989), and Montgomery (1993); and especially the studies in nurse caring abilities that used Nkongho's (1990) Caring Abilities Inventory (CAI), including those by Coberley (1993), Simmons and Cavanaugh (1996), and Davenport (1997).

Previous investigations for uncovering what caring abilities or attributes exist in

nurses were conducted by Morrison (1989) and Montgomery (1993). Eight caring bipolar constructs were generated by Morrison (1989) that encompassed nurses' perceptions of ideal caring and included safe, compassionate, empathic, tolerant, kind, gives freely of self, over protective, and mature. A caring nurse, in my viewpoint, would be sensitive to and supportive of the other but not be over-protective, which Morrison's sample of 25 experienced nurses identified as the bipolar opposite of "lacks awareness" (p.424). In comparison, Montgomery (1993) identified seven predispositional qualities that comprise a caring disposition. The first two of these include having a person orientation rather than role orientation, and possessing concern for the human element in health care. The next two predispositions involve a person-centered intention, as well as transcendence of judgment. Additionally, hopeful orientation, lack of ego involvement, and expanded personal boundaries were found to play a role in the development of a caring disposition. The caring attributes or abilities identified by these scholars, and as these influenced my thinking, include compassion, empathy, tolerance, kindness, knowledge (i.e., to be safe, one has to know what and how to do), concern for others, outward locus of orientation (i.e., other-focused), humility, and intent to act for the benefit of the other.

After discovering no existing tool that measured an individual's ability to care, Nkongho (1990) developed the Caring Abilities Inventory (CAI), using Mayeroff 's eight caring ingredients as a theoretical framework, for the purpose of measuring the degree of one's ability to care for another. The final instrument consisted of 37 items with three subscales representing Mayeroff's caring ingredients of knowing, patience, and courage;

it can be used with any population as none of the items require nursing knowledge or experience. Reliability of the CAI was reported by a coefficient alpha of .84 (n = 537) and a test-retest correlation coefficient (r) of .75 (n = 38). A content validity index of .80 was reported. Construct validity was determined by comparing the scores of experienced nurses with those of college students of varying majors. An unpaired t test indicated a significant difference between the groups (t = 7.06, p = < .001). A second measure of construct validity was computed by correlating CAI scores with the Tennessee Self-Concept Scale (r = .53); supporting the premise that higher caring scores are positively correlated with higher self-concept scores (Nkongho).

Having hypothesized that nurses employed in State prison facilities would demonstrate fewer caring abilities than nurses employed in an acute care hospital setting, Coberley (1993) used the CAI to compare correctional nurses with non-correctional nurses and found no significant differences in caring abilities between these groups (t = -0.486, p > .05). Simmons and Cavanaugh (1996) explored relationships among early parental care, the caring climate of nursing schools, and caring abilities of senior baccalaureate nursing students. They discovered a curvilinear relationship between level of parental care, measured by the Parental Bonding Instrument, and subsequent caring ability, measured by the CAI. Higher caring abilities scores were seen in participants who scored both at the highest and lowest level of maternal care, which contradicts many theories that caring results from having being the recipient of care. A caring school climate, measured by the Charles F. Kettering School Climate Inventory, was found to be

the strongest predictor of caring ability ($r = 0.16$, $p < .01$). These findings suggest caring can be learned from caring mothers, non-caring mothers, and in schools. A second study three years later demonstrated that although parental bonding scores were unchanged from the initial study, caring ability scores significantly increased after entry into practice. The strongest predictor of postgraduate caring was student caring ability scores ($r = .58$, $p < .001$) (Simmons & Cavanaugh, 2000). In a pilot study that used the CAI, I explored caring abilities, among sophomore nursing students ($n = 38$) and sophomore college students of other majors ($n = 38$) and found that nursing majors scored significantly higher than other college majors on all three subscales (knowing, $t = -3.23$, $p = .002$; courage, $t = -2.72$, $p = .008$, patience, $t = -2.06$, $p = .043$; and total caring ability, $t = -3.46$, $p = .001$) (Davenport, 1997). Overall, these studies support that caring persons enter the profession of nursing; that caring is learned; and that caring ability acquisition can benefit from a caring home and learning environment. I believe the major disadvantage of the CAI may be that it measures only a portion of caring, addressing only three of the ingredients identified by Mayeroff.

Caring as Therapeutic Intervention and Patient Outcomes

Morse et al. (1990) discovered that caring as therapeutic intervention may encompass specific caring actions, such as attentive listening, technical competency, and advocacy, or may include all nursing actions that benefit the patient. The predominant feature of a caring intervention is knowledge, particularly knowing what to do and how to do, as well as when to do, based on the agreement between the nursing action and the

patient's perception of need. Caring actions and interventions as therapeutic should contribute to positive patient outcomes. The studies that most influenced my developing consciousness of caring as therapeutic intervention in combination with caring as positive patient outcomes include qualitative as well as quantitative methods. The studies discussed include Dingman, Williams, Fosbinder, and Warnick (1999), Rieman (1983), Watson (1988), and Wolf, Giardino, Osborne, and Ambrose (1994), as well as several studies using Larson's (1986) Caring Assessment Instrument (CARE-Q). These include studies reported by Komorita, Doehring, and Hirchert (1991), Mangold (1991), and von Essen and Sjoden (1995).

Dingman et al. (1999) evaluated a caring model on patient satisfaction. Five caring behaviors were selected from a synthesis of the literature: (a) introducing oneself to the patient with an explanation of one's role in the patient's care, (b) calling the patient by his or her preferred name, (c) sitting at the patient's bedside for at least 5 minutes per shift to plan and review the patient's care, (d) using a handshake or touch on the patient's arm, and (e) using the institution's mission, vision, and value statements in planning the patient's care. Findings from the study showed significant impact on patient satisfaction (Dingman et al.).

Using a phenomenological method, Rieman (1983) explored the essential structure of a caring interaction and its outcomes. From these data, Rieman described both caring interactions as well as non-caring interactions, from the experiences of five men and five women who had experienced the care of a registered nurse. Her findings

provided a description of a caring nurse-patient interaction in which the existential presence of the nurse was seen by the patient as both an attitude and a behavior (e.g., the nurse sitting down with the patient and really listening and responding to the patient's unique concerns). Three clusters of common themes were generated: (a) nurse's existential presence, (b) client's uniqueness, and (c) consequences. The nurse's existential presence is comprised of both physical and mental presence that is conscious, willing, and often unsolicited, inferring caring characteristics such as sensitivity to and awareness of the patient's needs by the nurse as well as intent to assist the other while valuing the uniqueness of the other. In a caring interaction, the nurse responds to the patient as a valued individual, which causes the patient to experience and feel the caring within the interaction. Rieman described the outcomes of a caring interaction as feelings of relaxation, comfort and security experienced by the patient, as well as a sense of worth. Rieman differentiated non-caring nurse-patient interactions with patients' descriptions of the nurse's presence as being there just to get a task done, with no recognition of the patient's individual value or uniqueness. The patient, aware of this devaluation as an individual, becomes depressed, frustrated, scared, angry, or upset in response to a non-caring interaction (Rieman).

Watson (1988) discussed a 1979 study by Watson, Burckhardt, Brown et al. in which empirical research verified that caring indicates a personal response to another. Five caring categories were derived from the data: (a) treating the individual as a person, (b) concern and empathy, (c) personalized characteristics of the nurse, (d) communication

process, and (e) extra effort. Concern, empathy, and awareness of the uniqueness of the individual, illuminate some of caring abilities or attributes subsumed within these caring behaviors. The unspecified personal characteristics of the nurse need further clarification. Data from a 1983 cross-cultural study conducted by Watson supported these earlier findings and revealed further caring categories: (a) nurse presence, characterized by touch and physical presence across time; (b) sharing of experiences; (c) exchanging feelings and love; (d) sharing sorrow and pain; (e) letting a person feel; and (f) giving time and taking time (Watson). These findings do not represent caring attributes, but instead, describe caring behaviors.

Wolf et al. (1994) explored dimensions of nurse caring, using a 43-item 4-point Likert scale Caring Behaviors Inventory (CBI). Reliability of the CBI was reported with a coefficient alpha of .83 in the nurse sample and .96 in the combined nurse and patient sample. A panel of four nurse experts established content validity but no CVI was reported. Construct validity of the contrasted groups type was estimated by comparing the nurse responses with the patient responses. An unpaired t-test indicated that the groups were significantly different ($t = 3.01$, $df = 539$, $p = .003$). Using principal components analysis along with a conceptual analysis, the investigators identified five dimensions of the CBI: (a) respectful deference to the other, (b) assurance of human presence, (c) positive connectedness, (d) professional knowledge and skill, and (e) attentiveness to the other's experience.

Several studies, which focused on nurses' perceptions of nurse caring behaviors

or compared nurses' perceptions of nurse caring behaviors with patients' perceptions, have been conducted using the Caring Assessment Instrument (CARE-Q) (Larson, 1986; Komorita, Doehring, & Hirchert, 1991; Mangold, 1991; von Essen & Sjoden, 1995). A study of cancer nurses identified nurse caring behaviors perceived to be the most important in caring for cancer patients (Larson, 1986). "Listening to the patient" (M = 5.86, SD = 0.95) and "putting the patient first, no matter what else happens" (M = 4.47, SD = 1.68) were the two items identified as most important by the study participants (p. 89). A similar finding was described in a study of 110 nurse educators, managers, clinical specialists, and advanced practitioners who participated in a study to determine their perceptions of nurse caring behaviors (Komorita et al.). The participants ranked the most important caring behavior as "listens to the patient" (M = 5.99, SD 1.04). Mangold (1991), using the CARE-Q, compared perceptions of effective caring behaviors of senior nursing students with those of professional nurses. The most important caring behavior, emerging from this study, which was cited by both groups, involved listening to the patient. Using a Swedish version of the CARE-Q, von Essen and Sjoden (1995) discovered differences between nurses' and patient's perceptions of the importance of caring behaviors. The patients selected "explains and facilitates," and "monitors and follows through," as the most important caring behaviors, while the nurses selected "comforts" as most important (von Essen & Sjoden). These differences in perceptions of caring reflect a lack of congruence between what nurses and patients perceive to be the most important caring behaviors, suggesting that frequent validation of perceived patient

needs and actual patient needs should be conducted as well as the consequences or effects of nurse perceived caring nursing actions.

Nursing as Art

Nursing is often portrayed as both an art and a science, often with more emphasis placed on the scientific knowing that nurses possess and frequently with conceptual incongruence on what nurse scholars mean by nursing as an art. Johnson (1994) undertook a dialectical examination of nursing as art in order to attempt to clarify this concept. She reviewed 41 authors' works, published between 1860 and 1992, using a process of constructive interpretation in order to derive a neutral, objective, and impartial report of this complex construct. Five distinct conceptualizations of nursing as art were discovered: (a) the nurse's ability to grasp meaning in patient encounters, (b) the nurse's ability to establish a meaningful connection with the patient, (c) the nurse's ability to skillfully perform nursing activities, (d) the nurse's ability to rationally determine an appropriate course of nursing action, and (e) the nurse's ability to morally conduct one's practice (Johnson). These categories are congruent with nurse caring behaviors.

Citing the purpose of a study as further defining the humanistic act or art of caring by asking the question, "What is the meaning and value of caring in the practice of nursing (p. 171)?," Chipman (1991) explored the meaning of caring and its place in the practice of nursing. The sample consisted of 26 second-year diploma nursing students who described incidents in which they observed nurses engaged in caring and noncaring ways with patients. Themes that emerged from this qualitative study were nurse

behaviors that were considered to be caring. These behaviors were described in humanistic terms, including the giving of self, meeting patients' needs in a timely fashion, and providing comfort measures for patients and families.

Caring in Nursing Education

Caring is a generic function of being human and is learned from having experienced caring, most often within the family context (Leininger, 1981; Noddings, 1984). Nurse caring is that ideal for which nurse educators strive as they facilitate the development of nurse caring behaviors in nursing students. Several studies have examined ways of teaching caring or assisting nursing students to develop caring behaviors in nursing education. Discussion of those studies, which influenced my thinking, includes Higgins (1996), Kosowski (1995), Nelms, Jones, and Gray (1993), Paterson and Crawford (1994), Paterson, Crawford, Saydak, Venkatesh, Tschikota, and Aronowitz (1995), and Simonson (1996). All of these studies agreed upon the premise that caring can be learned, facilitated within a caring learning environment.

Higgins (1996) examined the implementation of a caring project in an associate degree nursing program using Watson's (1988) 10 carative factors as a framework. Two of the underlying assumptions of this project were that students primarily learn caring from nurse educators who establish caring learning environments that are non-threatening, and students learn to value and integrate caring into practice primarily through the modeling of caring by caring nurse educators and practitioners. An additional assumption was that it was imperative for students to have a sound knowledge base of

nursing theory and nursing process so that patient needs could be identified and appropriate nursing interventions could be chosen and carried out in order to produce a positive outcome. Two goals of the project were to provide a caring space for the students, and to value and practice caring by implementing creative, knowledgeable, intentional actions for the benefit of the patient (Higgins).

Eighteen female baccalaureate nursing students participated in a study conducted by Kosowski (1995) who explored how nursing students learn to care. This phenomenological study identified the relational theme of caring and interacting with patients as the focus for caring. Two patterns were identified: (a) creative caring, which subsumed seven caring themes of connecting, sharing, being holistic, touching, advocating, being competent, and feeling good and (b) learning caring, which subsumed the five learning modes of role modeling, reversing, imagining, sensing, and constructing.

Role modeling was studied as a method for teaching caring in a nursing program (Nelms et al., 1993). One hundred and thirty seven nursing students viewed a videotape of a nursing instructor engaged in a caring interaction with a patient; following the videotape, participants completed a questionnaire. Categories emerging from the data included connection, relationships and caring. In addition, subjects were able to identify many aspects of caring, and these were grouped into three themes: (a) caring and time, (b) caring and communication, and (c) caring combines the meeting of physical and emotional needs. The researchers concluded that nurse educators need to be consciously aware of oneself and one's actions as being potentially powerful for role modeling and to

maintain a commitment to being caring, authentic and congruent in teacher-student relationships (Nelms et al.).

Several studies on caring were reviewed by Paterson and Crawford (1994) who concluded that more research is needed to determine how student nurses learn to care. They noted that gender influences have not been fully examined in the caring literature with previous research finding that males are traditionally viewed as more independent and self-directed in their learning, and choose to learn from texts, manuals, and policies rather than from other persons. Paterson and Crawford argued that research is also needed to determine how certain variables (i.e., motivation, self-esteem, gender, past history, and expectations of success) affect the nursing student's ability to learn to care. Males in nursing, as the minority gender, have been expected to adapt to typically feminine ways of knowing and learning even though Belenky, Clinchy, Goldberger, and Tarule (1986) cited there may exist gender-based differences in knowing and learning. Based on the lack of research on how male nursing students learn to care, Paterson, Crawford, Saydak, Venkatesh, Tschikota, and Aronowitz (1995) conducted a study to explore this phenomenon. Using phenomenology as the methodology, the investigators studied 20 male nursing students and their lived experiences as they learned to care as nurses. Learning to care was an emergent category that revealed how the participants gained insight into what it means to care as a nurse through an evolutionary process. Learning strategies identified by participants as helping them learn to care were storytelling, observing and giving care, modeling, the "aha" encounter, and being the recipient of care

as a nursing student in interaction with nursing faculty.

A phenomenological study that explored how caring was taught in an associate nursing program was conducted by Simonson (1996). Six faculty members and 12 students were interviewed for the study. Using Watson's theory of caring, data were coded and examined for congruence with Watson's 10 carative factors. Four major themes emerged that helped explain how caring and caring values were communicated in the nursing program. These included formation of a humanistic-altruistic system of values; cultivation of sensitivity to one's self and others; promotion of interpersonal teaching-learning; and provision for a supportive, protective and (or) corrective mental, physical, sociocultural, and spiritual environment. Supporting Watson's theory of caring, Simonson concluded that this study could be used as a framework for curricular design on integrating caring into a nursing curriculum.

Motivational Factors for Entering Nursing

When exploring the meaning of the lived experience of nursing education, Nelms (1990) explored nursing students' reasons why they chose to enter nursing. These motivational factors centered on a desire to interact with other humans in certain ways or because they believed nurses act in certain ways with specific knowledge. Other studies focusing on motivational factors for entering nursing found similar reasons and are included in this discussion (Boughn, 1994; Kelly, Shoemaker, & Steele, 1996; Kersten, Bakewell, & Meyer, 1991; Perkins, Bennett, & Dorman, 1993).

Boughn (1994), using grounded theory methodology, studied reasons why males

chose nursing as a profession. In the stories of 12 male nursing students, Boughn discovered three emergent themes of motivation for entering nursing: (a) motivation to care for others; (b) job security and salary; and (c) feelings of power and empowerment. Boughn noted that the theme, desire to care for others, is consistent with findings from other studies. I also found that this theme appeared in the findings of studies conducted by Kelly et al. (1996), Kersten et al. (1991), and Perkins et al.(1993). Kelly et al. (1996) examined, among other factors, motivation in choosing nursing as a profession among male nursing students from three types of nursing programs (i.e., baccalaureate, associate and diploma nursing programs). Findings showed that the students had a positive image of nursing, and believed nurses were caring, compassionate, and connected with people. Motivational factors cited included altruistic reasons as well as practical, economic reasons. Kersten et al. (1991), examined motivating factors that led to a student's choice of nursing as a career. Participants (n = 752) were randomly selected from their first nursing course. The most frequently chosen reasons for entering nursing were altruistic caring and nurturing of others; other motivations included helping, bringing relief or hope, and interacting with people in need. Perkins et al. (1993) found that among 146 male nursing students, the most common reason for entering nursing was because of its career attributes; in order, this was followed by helping others and contributing to society in a positive and valuable manner. These studies support that people who come into nursing do so in order to pursue caring for others.

Summary of Literature Review

In the nursing literature, there have been both qualitative and quantitative studies on caring; participants have included nursing students, RNs, and patients. Of these studies in nursing, none have fully examined caring attributes or what attributes comprise a caring disposition. Also, little is known about how attributes of caring evolve. Attributes of caring can be considered to be precursors to actual caring behaviors. This lack of empirical evidence identifying the scope of caring attributes and ways in which these attributes are acquired or evolve propelled my intellectual curiosity onto this path to knowledge.

The review of the caring literature, overall, emphasizes that caring is a construct with many nuances that are difficult to define and measure. To date, there is no consensus among theorists and researchers about either a unifying definition of caring in nursing or a full illumination of the concept. Perhaps, because the construct of caring is so difficult to capture in a manner that is amenable to quantitative testing, some researchers have opted to focus on a piece of caring, such as caring behaviors (Larson, 1986; Komorita et al., 1991; Mangold, 1991; Rieman, 1983; von Essen & Sjoden, 1995; Wolf et al., 1994) or caring abilities (Coberley, 1993; Davenport, 1997; Nkongho, 1990; Simmons & Cavanaugh, 1996). What is known is that nurse caring requires special knowledge and skills, a commitment to serve others, and physical presence. We also know that nurse caring can be modeled and learned (Higgins, 1996; Kosowski, 1995; Nelms et al., 1993; Paterson & Crawford, 1994; Paterson et al., 1995; Simonson, 1996). Qualitative methods

hold the most promise in generating theory that can explain how attributes of caring evolve; these precursors to caring are a necessary step in the understanding of this complex concept. A beginning has been provided by Mayeroff (1971), a non-nurse who described eight caring ingredients necessary for human-to-human caring, and Roach (1992), a nurse, who specified five categories for RN caring which appear to enfold Mayeroff's caring ingredients; their work may be helpful in guiding further illumination of caring attributes or characteristics of RNs. This research study attempts to contribute to a fuller understanding of RN caring by exploring what those attributes are that allow an RN to be caring and how these evolve.

CHAPTER III

METHODS AND PROCEDURES

This research study was conducted using the grounded theory methodology, which originated in the Chicago School of Sociology in the years between 1920 and 1950 and represented a paradigm shift from previous ways of knowing about social problems. Having its roots in symbolic interactionism, grounded theory is a philosophical foundation that focuses on the individual rather than the whole, thus using an inductive method for arriving at knowledge. Grounded theory method contrasts with a deductive approach whereby the researcher starts with a theory and then attempts to empirically validate it in the real world; conversely, grounded theory starts in the real world with empirical data and constructs a theory from the data. In this manner, the theory is "grounded" in the emergent data or in the case of this study, in the stories of the participating registered nurses (RNs) (Bowers, 1988; Glaser & Strauss, 1967; Glaser, 1992; Strauss & Corbin, 1998). Grounded theory provides the researcher with relevant predictions, explanations, interpretations, and applications (Glaser & Strauss, 1967). The purpose of this method is to generate a theory by analyzing a phenomenon that originates from how people define the reality of their experiences and how their beliefs are related to their actions.

Many studies have been conducted on caring. Yet, a full and rich description of the attributes or characteristics of a caring disposition has not emerged from past studies.

I believe that, by using grounded theory methodology to study the attributes or characteristics that comprise a caring disposition and how these are believed to evolve, a more complete description of nurse caring may be constructed. An outcome of this study is an explanatory model that explains human caring in registered nurses (RNs) by exploring what caring attributes are and how nurses perceive they acquired these characteristics.

In grounded theory, data collection and analysis are interrelated processes. Analysis begins immediately because the findings from the first data collection will direct the next piece of data collection. This method of data analysis (i.e., constant comparative analysis) allows the researcher to explore pertinent clues that may shed additional light on the topic under study. In this manner, the research process guides the researcher toward examination of all possible avenues to understanding the topic. Ultimately, this process grounds the emerging theory in reality through discovery. Grounded theory must "fit the situation being researched and must work when put into use" (Glaser & Strauss, 1967, p. 3). The fit of the theory to the situation under study refers to the applicability of the theoretical categories to the data obtained; while the relevance of the theoretical categories to the behavior under study, as well as the ability to explain that behavior becomes the work of the theory.

Concepts are the basic unit of analysis in grounded theory. Data are compared for similarities. From these, phenomena are named and then categorized according to their properties and dimensions. Sampling in grounded theory follows a theoretical sampling

method that allows maximizing of as much variation in data as possible, thereby allowing the researcher to achieve representativeness and consistency. Representativeness refers to concepts, not subjects, under study. Representativeness of concepts is a hallmark of grounded theory. Constant comparative analysis of the data results in greater precision and consistency in categorizing the data. Hypotheses can be formulated as data analysis shows emergence of relationships. All hypothetical relationships proposed deductively are tested with incoming data and are verified, revised or discarded (Glaser & Strauss, 1967; Strauss & Corbin, 1998).

Generalizability of grounded theory occurs through a process of abstraction that takes place over the course of the study. The greater the abstraction of concepts evidenced, the wider the theory's applicability; also, the more systematic and thorough the theoretical sampling, the greater the uncovering of concepts and variations. This allows greater generalizability, precision and predictive capabilities (Glaser & Strauss, 1967; Strauss & Corbin, 1998).

Research Questions

Three research questions were used to guide and frame this study: (a) What constitutes caring in nursing?, (b) What attributes (characteristics) are needed for caring to occur?, and (c) How do these attributes evolve?

Purpose of the Study

The purpose of this study was to generate an explanatory model of human caring in RNs by exploring what attributes or characteristics constitute a caring disposition in

nursing. This exploration focused on the caring attributes or characteristics possessed by caring RNs and how these characteristics are believed to have evolved. The generation of this explanatory model is intended to further the body of nursing knowledge related to caring. This framework will provide a basis for understanding RN caring attributes and their acquisition or evolution.

Limitations of the Study

Several factors that may have intervened with data acquisition and interpretation in this study represent possible study limitations. Recruitment of the participants, based upon nurse managers' identification that they were caring nurses, presupposes that these nurse managers made honest assessments and reflect the beliefs these managers have about caring . Since a purposive convenience sample was used, persons who chose to participate may have had different perceptions regarding the phenomenon under study than those persons who chose not to participate. The interview questions asked the participants to think back to a specific moment in time; such recall may be affected by the passage of time or current life experiences. The setting and comfort level the participant experienced in relation with the investigator as well as the experience of being audiotaped may have influenced the participant's responses. As the investigator, my knowledge and experience related to the phenomenon under study, as well as my biases and theoretical sensitivity to the interpretation of the results, may have influenced the results of the study. These limitations should be noted in relation to the interpretation of the results.

The Sample

The study participants were recruited from one health care facility, a Level III Trauma designated, 394-bed, for-profit acute care facility in a city with a metropolitan population of over 200,000, located in the southwestern region of the United States. The purposive sample was chosen from currently employed full-time RNs who were identified by one other RN as exemplifying caring in nursing practice. Using the data obtained from nurse managers about RNs whom they identified as caring nursing practitioners, I recruited potential participants by phone call, with a brief verbal explanation of the study, including how I had obtained their names, and an invitation to participate in the study. Two RNs whom I contacted chose not to participate in the study, although not with a direct refusal, but indirectly by not returning my phone calls.

There was no exclusion of participants based on educational preparation, age, experience, or gender. Differences that were hypothesized based on educational preparation, age, experience, or gender were explored by theoretically sampling representative groups in order to further explicate the phenomenon under study.

For a grounded theory study, sample size depends upon a variety of issues and cannot be predetermined to an exact number. For planning purposes, a sample of twenty participants was initially anticipated. The final sample size of 19 RN participants was reached when data saturation had been obtained and no new data emerged from the interviews.

Data Collection

Data collection consisted of a face-to-face audiotaped interview, using a semi-structured interview guide following a short demographic questionnaire (Appendix A). Interviews were conducted in a variety of private settings conducive to interviewing, at a mutually agreeable location and time for both the participant and myself. Locations of interviews included private homes of the participants, a private office of one participant, and private conference rooms within the study facility. Other interview locations included my home and my office. Interviews lasted approximately one hour.

Data were collected during the summer of 1999. I first met with the health care agency's nurse managers and asked them to assist in the study by identifying RNs who, in their opinions, were caring. Each nurse manager signed a participation consent form and then mailed to me the names of the RNs they identified as caring, along with a brief statement as to why they selected each of these nurses. Seventeen of the 19 RNs who comprised the final sample were selected from these statements made by nurse managers who identified a total of 28 caring nurses. Two of the 17 RNs, when interviewed, each named a particular nurse mentor who they identified as being a caring role model for them; thus, those two RNs were also recruited into the study. A total of nineteen RNs were interviewed, and their responses were audiotaped and transcribed by me. Interviews began on June 3, 1999, and were concluded on July 8, 1999, when it was felt that no new data were emerging from the interviews and that data saturation had been reached.

During each interview, participants were asked to describe what caring meant to them, and to describe an incident which they felt exemplified caring to the patient, as well as what caring attributes they felt were necessary to be a caring nurse. Additionally, participants were asked to describe how they believed their caring attributes had evolved. Using a theoretical sampling technique, the interview guide was adjusted during subsequent interviews as data emerged and patterns were discovered. This process of simultaneously collecting, coding, and analyzing data influenced my decision about which data needed to be collected next in order to develop the emerging model. Field notes of my observations were made immediately following the interview and were part of the audit trail during analysis. I transcribed each tape immediately following the interview, allowing for revisions or additions to be made to the interview guide for purposes of theoretical sampling during subsequent interviews. Participants were informed of their right to review the audiotape and the transcript of their individual interview for accuracy of the transcription; however, no participant chose to do so. Two participants were randomly selected and asked to review the emerging categories and themes, thereby assisting the investigator to remain true to the interpretation of the data during the theoretical coding of the data.

Protection of Human Subjects

Prior to data collection, permission to conduct the study was obtained from Texas Woman's University's Institutional Review Board (IRB), the IRB at the institution where I work, and the agency where the participants worked. Participation in this study was

strictly voluntary and each participant was informed of the right to stop at any time during the study without penalty. No participant withdrew from the study.

Prior to the actual interview, participants had the study explained to them in detail, and written consent for their participation was obtained. Permission for audiotaping was obtained at this time. Privacy and confidentiality of the participants were assured by coding the audiotapes and transcripts with a number ascribed to each participant; only I knew this information. Audiotapes were transcribed by me. Transcripts and tapes were maintained separately from the coded list of participants and remained under lock and key in my home.

Data Analysis

Analysis of data was conducted using the guidelines of grounded theory analysis described by Glaser (1992). Data from the transcripts of the interviews were initially reduced into concepts; concepts were reduced to emerging thematic patterns; and relationships between themes were theoretically coded in order to develop the emerging model. Using a constant comparative technique during data analysis, each subsequent interview was compared with the previous interviews as emerging patterns and themes were examined for their fit with subsequent interview data. Revisions of themes and patterns were made as necessary to ensure these accurately represent the data. The complexity of the constant comparative analysis involved an on-going review of the tapes and transcripts, as well as reviewing extant literature in order to explicate the emerging model.

My theoretical sensitivity contributed to the development of the concepts, themes, and categories. Development of theoretical sensitivity was dependent upon my maintenance of an open mind during analysis of the data, with as few predetermined ideas as possible (Glaser, 1978). Field notes, journaling, and memos contributed to the analysis of data during the conceptualization of the emergent categories. Field notes were written during and immediately after the conclusion of each interview; occasionally notes were recorded by me as soon as the interview concluded. My impressions and observations contributed to the content of these notes.

During analysis of data, I initially read each transcript line-by-line and performed open coding, extracting concepts from the text and recording these in the margins of the transcript. These concepts were then transcribed onto 4 x 6 plain index cards with notations reflecting the transcript's line numbers from whence they came. Each subsequent interview transcript was comparatively analyzed with previous interviews. This process continued until no new concepts emerged from the data. Concepts were examined for similarities; extrapolation of comparable and similar concepts were arranged categorically. In this manner, related categories were then grouped together, further reducing concepts to themes and patterns. Using Mayeroff's (1971) work as a conceptual orientation, I noted references to his eight caring ingredients and transcribed those onto colored 3 x 5 index cards; other concepts were transcribed onto white 3 x 5 index cards and grouped for similarities. Data were re-evaluated for accuracy and fit to concepts, themes, and patterns. Theoretical coding of the relationships between categories

was carried out simultaneously during the process of analysis.

This process of analysis required multiple occasions of listening to the audiotapes and multiple readings of the transcripts. Concurrently, extant literature on nurse caring was revisited and examined, with inclusion of relevant literature in the interpretation of the findings, as well as in the conclusion of this study.

Definitions

Terminology specific to grounded theory analysis was used for analysis and interpretation of the data. Glaser (1992) defines these terms as follows:

Concept. A concept is defined as the underlying meaning, uniformity, and/or pattern found within a set of descriptive incidents (p. 38).

Category. A category represents a type of concept, which is generally used for a higher level of abstraction (p. 38).

Property. A property is a type of concept that conceptually characterizes a category, at a lesser level of abstraction than the category; a property is a concept of a concept (p. 38).

Coding. Coding is the conceptualization of data by constant comparison of incident-to-incident, and incident to concept in order to emerge more categories and their properties (p. 38).

Open Coding. Open coding is the first stage of constant comparative analysis, performed before delimiting the coding to a core category and its properties, or selective coding. The analyst begins analysis with no preconceived codes and remains entirely

open to discovery (p. 38).

Theoretical Coding. Theoretical coding is a property of coding and constant comparative analysis that identifies the emerging conceptual relationships between categories and their properties. Used as conceptual connectors, theoretical codes are used implicitly and explicitly in the way and style in which the analyst writes (p. 38).

Constant Comparative Coding. Constant comparative coding is the fundamental operation in this qualitative method of analysis in which the analyst codes incidents for categories along with their properties and the theoretical codes that connect them. Using two basic analytic procedures, the analyst first makes constant comparisons of incident to incident, and then as concepts emerge, constant comparisons of incident to concept are made, resulting in the generation of the properties of a given category (pp. 38-39).

CHAPTER IV

THE PARTICIPANTS

The stories of the 19 registered nurses (RNs) who participated in this study engendered in me an appreciation of the wealth of concepts related to caring and a caring disposition. As each story unfolded, the richness of concepts became the threads of caring woven into an illuminating tapestry of the attributes that contribute to a caring disposition. Each of the stories reflected a unique perspective from the lens of the narrator, yet there were common patterns and themes among their narratives.

Prior to data collection, and during the meeting with the agency's managers in May 1999, I gave each manager forms for submitting caring RNs' names, which included an area for comments of why they believed the RN to be caring. Self addressed, stamped envelopes were given to the managers at this meeting and within a few days, caring RNs' names began arriving via the mail. Upon receiving their names from their immediate supervisors, I began contacting potential participants. When I initially contacted these RNs to recruit them into the study, they uniformly showed surprise at having been identified by their immediate supervisors as being caring nurses. As each RN told her or his story, a quiet humility was displayed at being asked to participate in the study; and, at times, some of them would have tears in their eyes as they relived a memory of a caring encounter with a patient. Each RN who participated was a unique individual and each came to her or his current practice via different pathways. But each of them shared

similar caring experiences during their interviews. To provide the reader with a glimpse of these nurses' valuable contributions to the understanding of caring attributes and how these evolve, I believe it is important to share some history of each of the RNs who participated in the study. This chapter, therefore, will describe the participants as a group and as individuals. The numbers assigned to the RN participants for purposes of identification also reflect the order in which they were interviewed.

Group Characteristics of the Participants

Three men and 16 women, all Caucasian and all from the same healthcare facility, participated in the study. This sample of 19 RN participants ranged from 23 to 61 years of age ($M = 39.7$, $SD = 10.57$) and had practiced as RNs from one and a half to 24 years ($M = 9.4$, $SD = 7.27$). The mode was 18 months, and eight of the 19 RNs had practiced five years or less. Three participants were Licensed Vocational Nurses (LVNs) prior to becoming RNs. Eight were baccalaureate degree nursing graduates, 10 were associate degree nursing graduates, and one was a diploma graduate.

The RNs represented most of the specialties within the hospital, including staff and managerial (i.e., charge nurses, coordinator of services, clinical director) positions. The various specialties represented included medical-surgical, psychiatric, labor and delivery, women's health, surgical services (i.e., operating room, post-anesthesia care, pain services), critical care services (i.e., coronary, surgical, pediatric), and emergency department services (i.e., emergency department, poison center, flight service).

The RNs

I met with RN Participant 1 on June 3, 1999, at 7 p.m. in a conference room at her workplace after she concluded a 12-hour shift; she selected the time and setting of the interview. RN Participant 1 was a 37-year old female Emergency Department (ED) nurse with 16 years experience as an RN at the time of our interview. Her work experience had been predominantly concentrated in an ED setting in a variety of roles; most recently she has been a direct patient care provider in a 24-room, Level III Trauma Center ED. She also worked for three years as a nurse manager in outpatient clinic settings. Her Clinical Director briefly related in her statement that this nurse was, "a very tenured nurse who still cares," consistently demonstrating her caring towards her patients. Raised in a traditional home where there were certain defined gender roles (i.e., women cared for and met the needs of the other family members), Nurse Participant One stated,

> Well, I always told my mother that I became a nurse because I waited on my four brothers and father all those years....I was the only girl, and literally, in my house, my father was the king and the boys came right after that and so we did a lot of caretaking, I guess you could say, of the rest of the family.

This participant related that she was the baby of the family. I then asked her, "You were the baby ...and yet you still had to care for your older brothers?" In reply she said,

> Well, I shouldn't say take care of...we had very womanly duties and we had very manly duties. Womanly duties where you get up and fill the plates and you get up and fill the tea... and you get up and make the beds. You know what I mean? That

sort of stuff.

After her first year in college, she got her first real nursing job working in a nursing home during the summer months. She enjoyed her experiences with elderly patients so much that she was sad and cried when she had to leave at the end of the summer in order to return to her nursing studies. Upon reflecting back to times when her career choice had been questioned, she said, "I don't know, it's just in me, I think."

During our interview, RN Participant 1 appeared earnest, helpful, and humble in her responses. Having just finished a 12-hour shift in the ED, fatigue may have played a role in her answers, which typically were brief and to the point.

RN Participant 2 met with me at her home on June 8, 1999, at 9 a.m. on her day off. At the time of our interview, she was a 27-year old female ED nurse with four years RN nursing experience and five years prior experience as an LVN. She became interested in nursing from her mother who is an RN. At age thirteen, RN Participant 2 became the primary care provider for her mother who had hip surgery and was placed in a Spica cast on total bed rest. RN Participant 2 relayed,

> ...That's basically how I got my start. My mom...told me a few things to do but it just came natural in the long run just to care for someone and be at the bedside and make sure they got what they needed. And then when I was in high school, I worked at a nursing home 'cause I knew I wanted to be a nurse....

Her work experiences in nursing have included working as an LVN in orthopedics, working in an office setting, and working in the ED. Her Clinical Director described her as very nurturing and compassionate towards patients. During our

interview, RN Participant 2 spoke very quietly and humbly, while being forthright in her responses. She spoke enthusiastically and passionately about nursing and caring, saying, "(caring) means taking something to heart and – doing something that you feel is right and that you want to do."

RN Participant 3 met with me in a hospital conference room on June 9, 1999, at 2:30 p.m. on her day off. She was, at the time of our interview, a 40-year old female with five years experience as an RN and specialist certification. Her Clinical Director noted that she was one of the most compassionate and caring individuals she has ever known. While interviewing her, I immediately was taken with her calming and quiet voice, which had a gentle and comforting quality. She had an outgoing personality and appeared to be comfortably at ease during our interview. RN Participant 3 was forthright and appeared concerned and passionate when giving her responses. When asked what caring meant to her, she responded, "that is the big thing you have to learn in nursing…no one can teach it to you in school, …you have to come around to that." In addressing how she believed she evolved into a caring nurse, she said,

> …Some of the lectures…on caring and love of nursing-- those are the things that at the time, I must've stored the information subconsciously, because I was so geared to that next test and geared towards the clinical skills, …but as you...run across situations ... and that's relationships with patients, and caring for different types of patients—those are the things that come back to me…those are the things that stay close to me…and those are the things that would pop into my mind as I would meet different situations with patients. I can't even tell you – I don't

remember what skills necessarily different nursing instructors taught me-- the things that come back to me are …the things that were said to me in relationship to …how you cared for patients and being kind to patients.

RN Participant 4 was a 29-year old female, who worked as a critical care Charge Nurse. She had attained American Association of Critical Care Nurses (AACN) certification as a CCRN, a mark of distinction that demonstrates, through testing, a certain standard of critical care knowledge. We met for our interview at 5:30 p.m. on June 11, 1999, on her day off, in a hospital conference room. At the time of our interview, she had nine years experience as an RN. She has worked mostly in this critical care unit since she graduated from her nursing program. Her immediate supervisor stated that she was empathetic towards patients and families and that she actively listened to patients and used touch while listening. In addition, her knowledge and willingness to share her knowledge with patients and families was seen as a positive factor, resulting in a reduction of anxiety in her patients and families. Her supervisor also commented that she developed relationships with her patients that sometimes continued post discharge from the unit. She also demonstrated and modeled for other nurses her commitment to her role as a patient advocate, according to her supervisor. RN Participant 4 had a quiet, yet commanding presence and spoke softly, humbly and carefully during the course of our interview. When asked what caring meant to her, she replied, "As a nurse or as a person?" When I replied, "Both—or if there's a difference, differentiate for me," she answered,

Well—I try to treat my friends and my family the same way I do patients at

work—um, putting them first,…I think it means to put others before oneself and…I come to work with…the attitude of, uh, doing my job for, for God…

RN Participant 4 talked about maintaining her capacity for caring by introspection and reflecting upon what she expected to accomplish prior to going to work. She also spoke about putting her faith in God in order to maintain her level of nurse caring while at work,

…Like on the way to work, I usually think about what I'm going to do that night. That's usually what I do, on my way to work is, is try to pray and say, you know, 'Please let me have a good attitude and…let me do the best I can.' Everyday. On my way to work.

RN Participant 5 was a 32-year old female critical care nurse with 10 years experience as an RN at the time of our interview. We met at 5:30 p.m. on June 12, 1999, in a conference room prior to her 12-hour shift. She began her career in nursing working on an orthopedic-neurosurgical floor, transferring from there to an intermediate care unit and then to a critical care unit. She then took a nurse manager position in a corporate healthcare agency in a community setting for approximately five years. She returned to bedside patient care four months prior to our interview. Her immediate supervisor noted that this RN had the ability to calm and soothe others, using touch often to build rapport with her patients. Also, she actively listened and presented a calm presence during patient interactions. She was seen as being very knowledgeable and willing to share her knowledge with her patients. During our interview, she appeared calm, humble, and earnest, speaking with ease in a soft voice. When asked how she believed she came to be

a caring nurse, she replied,

> I always cared for my grandmother before she died and before I was a nurse. And I've always, I don't know, I've always...played like I was a nurse at home when I was a little girl, you know, my baby dolls were my patients. And my granny would be my patient and when I got older, she moved in with me and I took care of her. I had that need to take care of people and I know it kinda sounds weird but I want to help take care of them.

RN Participant 6 was a 23-year old male critical care nurse with 18 months nursing experience as an RN and three years prior experience as an LVN. Our interview took place in my office on June 15, 1999, at 10 a.m. on his day off. He initially started working as a staff LVN on a medical/surgical unit in a small regional hospital but left because he felt he was not making the kind of difference that he wanted to make. After becoming an RN, he began to work in the critical care unit where he had been employed for the past 18 months. His interest in nursing developed because of a younger sister who had a chronic health condition. He said he felt scared that he did not know how to help her and so, as early as high school, he knew that he wanted to learn what to do that would be beneficial so he would no longer be afraid of not being able to help her. He grew up watching the RNs manage his seven year-old sister's care during her frequent hospitalizations over a two-year period, a formative period for him, which shaped his desire to go into nursing. When asked if he had to overcome any barriers as a male student in order to pursue his interest in nursing, he replied that he had not encountered any barriers and he had support from "everybody" who encouraged him to go to school.

In a brief statement as to why he was seen as a caring RN, his immediate supervisor stated that he was very calming, soothing, and empathetic towards patients. Also, he used touch to soothe and comfort, and he displayed good listening skills in caring for his patients. He said in response to what caring meant to him, "to me, it's...having compassion; understanding of what they're going through actually and trying to help them out. Whatever, whatever it takes to make them feel a little better about whatever's going on." RN Participant 6 was quiet and sounded shy when I called him to ask him to participate in the study. During his interview, he gave the impression that he was embarrassed to be singled out, as if he did nothing special or was different from his peers.

RN Participant 7 was a 46-year old female with 24 years experience as an RN. Her interview was conducted on her day off at my home during the afternoon of June 15, 1999. This experienced veteran demonstrated a calm, quiet, commanding presence during her interview and appeared genuinely interested in our discussion. RN Participant 7 held many specialty certifications, including AACN certification as a CCRN, Emergency Nurses Association's (ENA) certification as a Trauma Nursing Core Course (TNCC) provider, Texas Department of Health certification as an Emergency Medical Technician (EMT), and five American Heart Association (AHA) certifications as a Pediatric Advanced Life Support (PALS) provider, Basic Cardiac Life Support (BCLS) provider, Advanced Cardiac Life Support (ACLS) provider and instructor, and Neonatal Resuscitation Program (NRP) provider. Her 24-year work experience had been in critical care nursing, including pediatric and adult intensive care units. More recent experiences included critical care charge nurse, hospital supervisor, and flight nurse on a helicopter

service. RN Participant 7 was recruited into the study after being identified as a caring RN by a previous study participant, RN Participant 4, who said she learned caring from this veteran nurse nine years earlier when she was a new graduate nurse working her first night shift in the critical care unit where RN Participant 7 was the night charge nurse. The statement provided by Nurse Participant 4 said that this caring RN demonstrated to others a contagious positive attitude, kindness and caring towards others, and empathetic care of her patients and their families. RN Participant 4 exemplified this nurse as a "great nurse." When asked about caring, RN Participant 7 answered,

> I hope that I'm a caring person—I try to be a caring person. The two most important things in my life are first my family—my children and my family and next my patients, and I know that sounds kind of hokey, but—what I do as a nurse, and what I do in my profession directly affects my everyday life. How I feel—my mental well-being—I mean, it's like if I don't feel that I've done everything I can for a patient, it just kills me. I mean that—just does. Bear with me here. Oh—but...it's just very important. I have to know—I've done the best I can for that patient and I don't think anybody reviews—could possibly review my charts harder than I do...But I have to know I've done the best I can—I know the outcome's not always going to be ideal, but...

RN Participant 7 spoke poignantly about her beliefs about caring in nursing from a spiritual aspect as well as trying to be mentally prepared for what she might encounter during her shift,

> ...There isn't a day, a day that I don't go to work, whether it's flying on the fixed

wing or the helicopter, that I—I got this....I know these prayers, I know—go through before I go to work and it's very important for me—to go through that and ask, because of what I do and how I perform, I feel comes directly from God...it's always the same—and I always ask the same thing—like, help me learn the things I need to learn...and retain it.....Help me provide the patient with the care they deserve...Help me check, double check, triple check everything I do. Quadruple check.....To ask—what I need to ask and to notify whomever or whatever I need to notify. That's just my part...it's just me.

RN Participant 8 was a 26-year old female Labor and Delivery nurse with 18 months experience as an RN at the time of her interview. She met me in my office on June 18, 1999, at 10 a.m. on her day off. During her interview she appeared sincere, happy and passionate about her responses. RN Participant 8 had worked in Labor and Delivery since graduation. Her immediate supervisor stated that she was empathetic, loving, kind and caring. Additionally, she possessed a positive, upbeat attitude, had excellent communication skills, treated all of her patients holistically, had boundless energy, and was very spiritual and self-aware. Examples of her caring shared by her supervisor included providing labor support for her patient and family until the patient delivered her baby even after the shift had ended and she had clocked out; and during a busy shift, taking the time to make shirts with the new baby's footprints for the siblings and father of the baby. RN Participant 8 worked well with others and was a joy to work with according to her supervisor who said, based upon her evaluation of her, that she was the epitome of a caring nurse. When I asked RN Participant 8 what caring meant to her,

she replied,

> Caring's such a broad word—I would just say it's, it's a love of ...for what you're doing. A, a love of your work, your—of people—that's a tough question—It's putting yourself aside and putting someone other—someone else's interests usually before yours ...usually you have someone else's interest in mind, you know, it may be 4 o'clock before you eat lunch, because you've been too busy doing stuff for your patients. I think it would just be putting others' needs before your own....Just going--above and beyond; doing little things that make a difference; such as placing that extra pillow or getting what they want from dietary or taking the time to explain—procedures, what's going on with their situation.

RN Participant 9 was a 43-year old female Clinical Director and had 21 years experience as an RN at the time of her interview. We met in her office on June 23, 1999, at 8 a.m. During her interview she appeared sincere, genuine, helpful and was soft spoken. She was recruited into the study after a previous study participant, RN Participant 3, identified her as being a caring Director who had modeled caring for her. The comments shared about this nurse administrator were that she was an "outstanding Director because she managed from the heart." Other comments included that this nurse director was non-threatening and constructive when working with her staff on resolving patient care issues and that she made patient care a priority. She also actively assisted her employees in giving "that caring touch." RN Participant 9's past work experiences included working as a staff nurse in a critical care unit and a pediatric unit for her first

few years in nursing, working as a school nurse, and working in the ED. When asked what caring meant to her, RN Participant 9 spoke of caring as a feeling one has towards another as she replied,

> Well...I guess over the years I've seen a lot of families in crisis and I've seen a lot of nurses that almost, out of, um, defense mechanisms almost—become real hardened—to things, and I'm not gonna say I haven't—gone through some of that myself. But...just to try to continue to take each case...individually and realize that those people are in crisis....That their crisis is the most important thing to them at the time and that it's very important, that, that I—not bring baggage with me because I've been doing this for this many years and that I...show them that I care about them as much as maybe the first patient I ever had. You know. I don't think that because I've been doing this lots of years should mean that I— it should bring some experience and maybe some more insight to it, but it, but I'm afraid that sometimes it makes you where you feel you've seen everything and done everything so maybe you don't pay as much attention or something, so I try real hard not to do that.

RN Participant 10 was a 28-year old female nurse with six years experience in Labor and Delivery. We met at her home on her day off on June 23, 1999, at 1 p.m. During our interview, she was quiet and soft spoken and appeared humble at being asked to participate. She seemed kind and interested. RN Participant 10 had worked in Labor and Delivery since graduation. Her immediate supervisor stated that she was an excellent, assertive patient advocate who educated her patients thoroughly and consistently by

providing accurate and pertinent information in a manner the patient could understand. Also, RN Participant 10 was an active listener and always made her patients feel she was interested in them as an individual person by providing positive feedback and responding to her patients' needs. She made sure her patients' needs were met by paying attention to details to make the patient's experience positive, even when an unexpected event, such as a fetal demise occurred. Other supervisor comments included that she cared about her nursing and the way in which she delivered nursing care, and her positive attitude "trickles down" to her care. While being able to connect with her patients through her provision of a very personal touch to her patients, she maintained a high standard of professionalism. I asked RN Participant 10 what it was about her that told her she was a caring RN. Her reply was,

> ...I feel like I'm a very good listener....I really enjoy what I do....I'm an honest person. And I feel that I'm very trustworthy and that...I hope that my patients see that in me 'cause I, I feel like that—that is what I purvey to the patients.

RN Participant 10 spoke of a caring nurse's need for a good heart. When asked to explain what a "good heart" meant, she replied,

> ...Just being a good person, in general. I think that...you have to be a good person in order to give people the best quality of care that you can. I think that you have to have that just inside in order to give that to others.

RN Participant 11 was a 52-year old female nurse who worked on a women's health floor and had five years experience as an RN at the time of our interview. She met me in my office on June 25, 1999, at 9:00 a.m. on her day off. For the past three years,

RN Participant 11 had worked as a staff nurse at the study facility and had served as the perinatal bereavement coordinator of the facility for the past year. Her immediate supervisor noted that she was sensitive to other people's needs and was always willing to help out and take on extra work. One example of her caring shared by her supervisor was that she sent another nurse flowers "just being nice." During our interview, RN Participant was passionate about her nursing and appeared kind, compassionate, confident and knowledgeable. She was soft spoken during our interview and answered the question of what caring meant to her as,

> …Looking at your heart… Caring to me is—looking at your patient and seeing this person as a family member or perhaps as yourself and wanting to provide the kind of care to this person that you would want your family member to have. And I think—the most important aspect of it is—developing a bond with your patient so they trust you. So that—the care that you give them—if you need to do something—they're gonna trust you to know this is the right thing.

I met with RN Participant 12 in her home on June 28, 1999, at 2 p.m. RN Participant 12 was a 61-year old female who worked as a psychiatric nurse and had 19 years experience as an RN. Her work experiences included working on a combined antepartum-postpartum unit, a medical-surgical unit, and a psychiatric unit. Her supervisor stated that RN Participant 12 was a good listener and used a non-judgmental tone of voice when communicating with her patients. Also, she made her patients feel special because she spent time with each one of them, making time to connect with each patient. During our interview at one point, she asked that the tape recorder be turned off

after she became emotionally affected by the story she was relating to me. Her passion for her nursing and her patients was evident throughout her interview. She was soft spoken and humble in her responses. When asked about herself as a caring person, RN Participant 12 replied,

> Well, I've been told that I am and I feel that I am. It's just, to me, it's feelings. Period. Do you really care about a person—I use that word—it's just a feeling you have. You want to get to know them, you want to know what they're thinking, what disturbs them, what concerns them because you do care about them as a human being—a fellow human being. And so, anything that can help you to help them, you wanna know....Ah, it's not just a job....I don't do minimal—I don't—I try to be with my patients as...much as possible. We have to do paperwork. I mean, it's just no getting around that. But, I try to spend as much time as I can with each one of them...I just do everything I can to make them comfortable, to make them feel valued, important, and...that they are respected as a human being. It doesn't matter that they have a mental illness. No different from any other illness—doesn't make them less...I love my job. And it's just—I look forward to going in there. No matter how stressful it becomes, I look forward to going back the next day. It's a new challenge every day, new situations every day...it's always that way in nursing.

RN Participant 13 was a 37-year old female nurse who worked on a surgical floor with 18 months experience as an RN at the time of our meeting on July 2, 1999. Her interview was conducted in her home on her day off. She had worked on a post-operative

surgical unit since graduation. Her immediate supervisor noted that this nurse was soft-spoken, soothing, compassionate, dedicated and focused. In addition, her supervisor said she truly focused on her patients and her nursing and that she had a positive, upbeat approach while being soothing at the same time. Also, she consistently demonstrated compassion for her patients. RN Participant 13 appeared sincere, earnest, humble and honest. She was quiet spoken, yet enthusiastic in her responses. In response to what caring meant to her, RN Participant 13 replied,

> Well…I just like people. And…I like to help them, and everybody that I—when I started nursing, I found out what, what being judgmental meant and everything, and…I was not going to be a person like that. And…I just, really just love the people that I work with….I want the best to come out for them. I want to make 'em well and send 'em home (laughs). That's what I like to do…I've only had to experience, actually, 2 deaths of my patients and that was very hard. So, but, I just really like people. I like to see them get well and I like to help them and, you know, make their stay in that type of situation as pleasant as possible…So, but…I just, I don't like to see anybody sad, you know. So I just do my best to make their stay a good stay, a good experience.

Although RN Participant 13 came into nursing in her late 30's, she mentioned she had originally wanted to become an RN right out of high school, but was dissuaded from doing so by a family member who told her it would be depressing to be around sick people all the time. In her experience, however, she said she's found quite the opposite, "I'm not depressed…I like helping."

RN Participant 14 was a 44-year old female Charge Nurse in a critical care unit with four years experience as an RN. We met in a conference room at her workplace on her day off. She had worked at the same facility since graduation, as a staff nurse on the Pediatric Unit, and as a critical care nurse. Her immediate supervisor stated that this RN took the time to do the little things that made a difference no matter how hectic it was. She was compassionate, kind, and soft-spoken, all which conveyed a picture of caring. Additionally, she was considerate of patients, families, and other staff members. One example related by her immediate supervisor was how she was able to help a patient's out-of-town relative secure part-time employment while displaced by the family member's hospitalized circumstances. Her supervisor also said RN Participant 14 empathized with her patients and their families and did whatever she could to improve the situation. She was knowledgeable and honest in communicating and educating her patients and families. When asked what caring meant to her, RN Participant 14 replied,

> ...You know, we don't really even think—I just don't think about it, you know. It's...I think it's just a basic human decency and dignity and...it's just a basis of how I practice. I mean, that's why I'm here—is to care for the children. That's, that's my job and I love it...We try to help 'em any way that we can whether, if they're not local, we try to find arrangements, you know, so that they can stay with their child...The children, we just try to make sure that it's...which it's never a pleasant situation being here, we're just trying to make it so that it is as less problematic as it can be for them and that their stay is not totally a horrible situation. And...you just give them a little love. And that's, that's basically, like I

said you're just getting down to basics again. It's, it's just, you just care for them and make sure that, that they're taken care of. And that they're getting what they need.

When asked how she knew she was a caring nurse, RN Participant 14 promptly answered,

I feel it. I, um, it would have to be caring because I, I love children, to begin with, and I do become very attached emotionally to my patients, and I—we shed a lot of tears and I just, uh, it's just a feeling on the inside. That's hard to explain.

During our interview, RN Participant 14 was soft spoken, modest, sincere and humble. She often spoke of "we" not "I" and emphasized it took a team approach to provide the best possible care. She also spoke of her deep faith in God and said that her faith was the basis for all that she did.

RN Participant 15 was a 37-year old female RN with 12 years experience. Her most recent work had been in pain management, where she served in a clinical management position. We met in her home on her day off. She was forthright and earnest, and I could determine she was proud to be an RN. At times, our meeting was distracted by her toddler, who was fussy for most of the time I spent with RN Participant 15. We had to interrupt taping twice so that she could meet his needs. She kept apologizing for the distraction, but once we finally decided he just wanted to be part of our interaction, he quit crying as she held him on her knee. RN Participant 15's work experience included working in the ED, the OR, and Pain Management Services. She coordinated pain management services throughout the facility for acute in-hospital

patients, as well as for the outpatient pain clinic for the treatment of patients with chronic pain. Her immediate supervisor stated that she was a strong patient advocate who truly cared for her patients emotionally and physically. When asked what caring meant to her, RN Participant 15 replied,

> Caring means you need to understand what's going on with that person, with the patient....You need to listen, and I think, they, that person or patient, needs to understand that you hear what they're saying....Sometimes it's almost a mirror type communication, you know, and...caring means that, you know, you're a part of what they're going through. You know, you, you, what's the word, it's not, is it, sympathy for them or –it, I guess, basically it's just understanding what they're going through and don't dismiss what, what they're feeling.

RN Participant 15 stated that caring nurses go the extra mile in meeting the needs of their patients and are willing to do whatever it takes to do what's right for the patient. She unwaveringly spoke about professionalism in nursing as being synonymous with being a caring nurse.

RN Participant 16 was a 41-year old female nurse with nine years experience who worked as an Operating Room (OR) nurse. Our interview was conducted on July 5, 1999, in a conference room at her workplace after she completed a day shift. During our interview, she was soft spoken and kind, and was confident and forthright in her responses. Previously, she had worked in a critical care unit as a staff nurse and Charge Nurse. She also had past experience in the ED. For the past three years, she had worked as a staff nurse and charge nurse in the OR, serving as the laser safety officer for the

hospital. She was a strong patient advocate who was caring to all others, according to her immediate supervisor. In describing what caring meant to her, RN Participant 16 replied,

> To me, caring means, first off, having a good knowledge base and the ability to take care of your patients and do the things that they need...for their body. And then also, I feel like it's very important to know your patients, to have empathy, and sympathy for their situations and be able to...take care of their—them mentally and spiritually as well as physically. I also think it means having a connection, if you're working in the work place where you can, with their family members because they usually need a great deal of care, too.

In response to how she felt about herself as a caring nurse, RN Participant 16 answered that she felt like she was a caring RN by doing the things that showed others her care and concern for them. She replied, "Just taking time to talk to people, trying to understand where they're coming from and help them understand what's going on around them."

RN Participant 17 was a 51-year old male nurse with 20 years nursing experience who worked in the OR. We met on July 6, 1999, at 11:30 a.m. prior to his shift. His interview was conducted in a conference room at his workplace. In addition to his experience in the OR, he had worked as a cardiac catheterization lab nurse, for a private orthopedic surgeon, and in the ED and critical care units. His immediate supervisor stated that he demonstrated a strong ethic of patient advocacy and was a nurse who consistently cared for his patients' emotional, as well as, physical needs. RN Participant 17 had a calm, peaceful presence during our interview and confidently stated his beliefs. When

asked what caring meant to him, he replied,

> I believe that caring...encompasses...primarily taking, looking at that patient and saying, and telling yourself, that depending on the age of the patient, that, that patient, if they be geriatric, they're somebody's grandma. And, and the younger patients, you know, they're somebody's daughter, somebody's son and if you look at that patient in that perspective, I think, that it brings it more to a personal level because...it takes away some of the technical environment and brings it more human. Because you can see that person...you may have a daughter, you may have a son, everybody has a mother, everybody has a grandma...that makes it a lot more personal...and I think that that enables me to do a lot better quality of patient care. 'Cause I never lose perspective of that.

When addressing his entry into the profession at a time when it was not a common career choice for men, RN Participant 17 talked about love for the profession of nursing,

> ...People who, who are in the profession that complain of burnout of whatever, I really don't think that they have a real genuine love for the profession as some of us who got into it...years back. It wasn't the thing to do, I mean, uh, for me personally, that's the reason why I got into nursing, you know, uh, and there wasn't that many of us males in the profession at that time. I can remember my dad saying, 'Son, why are you--where did I go wrong?' You know, but it was my love for the profession. It wasn't, it wasn't wages, it wasn't the hours, it wasn't,...what I perceived as benefits...it was just, that's what I wanted to do.

In addressing this love of nursing, RN Participant 17 acknowledged that for him, a genuine love for nursing was connected with his desire to help others.

RN Participant 18 was a 48-year old male nurse with 2½ years experience who worked in Surgical Services. We met at the hospital in a conference room on July 7, 1999, at 4:30 p.m. after he completed his shift. As part of his last class in nursing school, he spent a rotation in the Post Anesthesia Care Unit (PACU). This rotation was an experience that he really enjoyed, allowing him to become comfortable with the different types of patients for whom he cared, as well as building solid, positive working relationships with the nursing staff. He stated that he liked seeing a variety of patients; in particular, he liked having the knowledge and skills to care for the diverse needs of his patients quickly. His charge nurse stated that he was a very quiet, spiritual, and caring individual whose calm presence provided reassurance to his patients. According to his supervisor, one example of how he demonstrated his caring towards his patients was that he got the family back into the recovery area as soon as possible to see their loved one after surgery. An example of how he exemplified caring toward his co-workers was by helping them with their patient care or getting food for them to eat when it is too busy for them to go to the cafeteria. While interviewing RN Participant 18, I noted a calm, spiritual peace about him as he spoke and told his story, relating that his faith as a Christian underpins all aspects of his life.

> ...It's a very big part of...anything I do. The fact that...well, you know, God, we're, we're creatures, we're His creations and that really gives us all value and...you know, the Lord, Jesus Christ, He, He certainly respected life. That was

a big part of what he did here, was healing and, uh, uh, caring for people and He, He felt compassion for people and…I'll work to imitate him so, ….

When asked what caring meant to him, RN Participant 18 reflected quietly for a moment then answered,

> Well, in my job, caring means that…especially where I work, surgery is, uh, is a big deal and a lot of people, I know if I had to go through surgery, I would be scared, I would be anxious. And…part of my job is to, I think, to be kind. You know, a lot of it involves skill and keeping 'me breathing and, and of course, getting their pain under control and all of that, but showing them respect. Not just…you know, I mean sometimes, it's, it's like that. You just, you get so many patients, or you just, they just become like a, a number. But, most of the time, it means treating that person as an individual and trying to find out whether, where they're at, if they're scared or if they're hurting or if they're concerned about something. Maybe they…maybe they had something removed and they don't know if it was cancer or not and, and they're concerned, and I'll find out maybe I can get the doctor. So it's just, caring is, uh, going, a little bit above just the…technical part of nursing. And, maybe showing them some kindness and some encouragement or something.

When I asked RN Participant 18 about how he thought of himself as a caring RN, he spoke about his genuine interest and concern for his patients, again showing his spiritual nature,

> Well-- well, I have, I have a genuine interest in, in my patients, in the people.

And...I, I just, I just kinda do, you know, I'm not...you know, I find myself praying for patients a lot. I don't talk to them much about anything, but I, I can pray for them and you know, I find people interesting. You know, everybody has their own story and their own life. I see a, a 73 year old lady that, you know, I'd think about, well, what year was she born, she, I mean, where she was during the depression, you know, and I'll, I'll talk to them about things like that, they're, the way they usually like to talk about the past and you know, but I mean, I really didn't know if I was a caring person, I, I think I am, you know, I do, because I like people, I, you know, I have my bad days, too, but I used to work on a printing press before I was a nurse. And that, I just, I just, it wasn't for me because I wasn't around people. Just a machine and so, and you never know what God has for somebody. You know, why God send this person to you, maybe there was a reason so....

I met RN Participant 19 in my office on July 8, 1999, at 10 a.m. on her day off. She was a 53-year old female nurse with seven years experience who worked in psychiatric nursing at the time of our interview. She previously had worked for several years as an LVN prior to becoming an RN. Her immediate supervisor stated that this RN was calming in her interactions with others and took time to participate in any activity she felt would help improve her skills in providing care for her patients. Also, her supervisor noted that this caring RN often gave verbal praise to patients and co-workers. During our interview, I came to the impression that RN Participant 19 was extremely kind, forthright and calming in her approach to life. When asked to describe what caring

meant to her, she replied, "...Caring means to me an outgoing concern where you're able to, ah, to kind of project your feelings or your thoughts into the other person enough that you can understand where they're coming from and how they feel." When I asked her how she thought about herself as a caring RN, she replied,

> ...You know, (laughs), I never really thought about being a caring person until you brought this subject up with me....I did have one tech tell me once that I was part of a dying breed because his mother had been a nurse and he's, and I had...stayed out with this lady one night and rubbed her feet until she went to sleep because she was just really having bad, she was convinced she was dying, you know, and she wasn't, she was nervous, you know. But...I rubbed her feet and he said there's not many nurses here that will take the time to go out and rub feet. He says, 'You're one of a dying breed,' and I've thought about it a little bit, and I thought, 'Well, there's still nurses that do that, I know they do, you know, I'm not the only one in the world.' But, I watched to see how many others will take the time to, to begin to do that and I've thought, 'Well, maybe, maybe it's something we need to address in charge nurse meeting, maybe in a unit meeting, you know.' To take the time to do the little touchy things, you know....We have a great big guy now that, that...everybody's been afraid of, and if you pat him on the back and rub his back...he is the calmest big teddy bear you ever saw in your life, I mean, you know, he's not dangerous. People look at him and think he's dangerous by his appearance, but you can't, as the old saying goes, 'Judge a book by its cover.' And...so really I never gave it much thought until, truthfully, this,

thinking about this interview, and I asked my, I even asked my daughter, I said, 'Do you think I'm a caring person?' I said, 'How would I show that?' And she says, 'Well,' she says, 'You've always been as far as I know,' she says, 'At home and every place else,' but she said... 'I think,'...she said, 'I think,' she, she says, 'I've always realized that you took the extra time and that while you've never mentioned a name, there were times when I heard you say to dad, you know, this or that and you'd, you'd cry about somebody.' And she said,... 'You know, I, I thought to myself, well, I don't know that nobody else really cries about somebody.' But that doesn't really matter, the point is she reminded me that I did, or if somebody was getting really better and said something funny, that...I might come in and say, 'Oh, I've go to tell you about John Doe. They did this, you know, and it was so funny.' And you, you can repeat that, you know, and you'd get joy out of it because they're so much better. And I realized I was happy about their accomplishment...and, and that's when she, you know, she kinda brought that to mind. And she said, 'You gotta think about that.' Ah, I do, I have realized that I will take the time, and I've stood up to people, (laughs) you know, before, even before I was a charge nurse, when they've said, 'You're putting too much time into that person,' and I'd say, 'Well, I always get my work done on time, and when I don't, well, then we'll worry about it.' I never had any trouble asserting myself that way because I've always felt if I was not going to be a good nurse, then I'd find something else to do. You know, if I can't do it really well, if I'm not there to care for the patient, if I'm there just to please the state, and do the

paperwork, then I'm going to find something else to do.

Summary

In this chapter, the RN participants were introduced as a group and as individuals with the intent of illuminating how they were chosen and recruited into this study and how they viewed themselves as "caring nurses." This background provides a foundation for the analysis and interpretation of the data, as well as allowing readers of this research to begin to know and understand these RNs through their own stories. Using the data generated by my getting to know these participants, a profile of a caring nurse can be composed. Within the context of these nurses' stories, a caring nurse acts with positive intention to assist others, while showing empathy and compassion for the others' plight, and a caring nurse genuinely hopes that the other gains from their interactions. The caring nurse uses nursing knowledge to meet the needs of those for whom care is given; caring is viewed as emanating from having a good heart, while doing the best one can, going above and beyond, and doing the little things that make a difference. During the course of these interviews, it was evident that while each of the perspectives of the individual nurses and their stories were unique; within these narratives, there were similarities and common patterns of caring.

CHAPTER V

FINDINGS OF THE STUDY

The findings of this study are presented with the intent of explicating the understanding of registered nurse (RN) attributes or characteristics necessary for human caring. Throughout the analytical interpretation of the narratives of the RN participants, Mayeroff's (1971) eight caring ingredients (i.e., knowing, patience, honesty, hope, trust, alternating rhythms, courage, and humility), as well as the social theory of the attribution-empathy model, provided the philosophical and conceptual underpinnings which guided my interpretation of the data. Evidence is discussed that supports or expands each of Mayeroff's concepts, in addition to a myriad of other concepts that emerged from the data, further illuminating my understanding of the attributes necessary for a caring disposition.

Symbolic interactionism, the substantive foundation upon which grounded theory analysis subsists, focuses on interactions among concepts. Therefore, in my attempt to unveil the findings of this study, thematic categories and patterns of caring attributes and characteristics are delineated, as well as the relationships among the concepts within and among these categories, allowing a fuller description of the RN caring attributes needed for human caring. My intent is to provide a "thick" description of the caring attributes or characteristics, which constitute a caring disposition that facilitates nurse caring, as well as how these characteristics evolve.

The literature, which serves to further explicate and clarify these concepts, is discussed along with the findings of the study where appropriate. Discussion of the theoretical categories of caring characteristics and their interdependent relationships, which are grounded in the collective stories expressed by the RN Participants, will follow in Chapter VI as the grounded theory emerges and an explanatory model of human caring in RNs is generated.

The Concepts

Evidence emerged to support or expand all of Mayeroff's (1971) eight caring ingredients into a more fully explicit picture of those concepts as they pertain to nurse caring. Other concepts, representative of caring attributes, also emerged from the study and include empathy, compassion, kindness, love and respect for others, positive attitude and intention, being nonjudgmental, having tolerance for diversity, feeling connectedness through relationships with others, having a genuine interest in and concern for others, having a "good heart," being there, possessing integrity, self-confidence, and a sense of obligation, and a duty to serve God and others.

Evident in these data were several patterns of caring characteristics from which four unique, yet interrelated, domains emerged. Data were first examined for conceptual meaning. Emerging concepts were then analyzed and codified into categories or patterns of caring attributes. Related concepts and patterns were then categorized into one of the four domains of nurse caring characteristics and attributes. These domains (i.e., knowing, connectedness, intent, and integrity) provide an organizing framework within which the conceptual patterns of caring attributes and characteristics are discussed.

The Domains of Caring Attributes and Characteristics

The four unique and distinct domains (i.e., knowing, connectedness, intent, and integrity) illustrate my interpretation of the conceptual patterns and their interrelationships. During my analysis and interpretation of the data, and through my discussions with Dr. Heidi Taylor and Dr. Rebecca Robinson, who have conducted grounded theory research, I believe my groupings of the related patterns and the designation of the categories of the data demonstrate a logical flow of ideas regarding nurse caring and the antecedents or attributes necessary for a nurse to be a caring nurse. Although one of these concepts (knowing) is labeled the same as one of Mayeroff's (1971) caring ingredients, the data that emerged support a richer and fuller description of this concept through the illumination of knowing, and its interdependence among the many kinds of knowing, uniquely from the perspective of nurse caring. Table 5.1 reflects the grouping of concepts congruent to each of these four domains.

Knowing

All 19 RN participants in the study addressed knowing as an important caring characteristic. The data that emerged related to knowing expands and clarifies Mayeroff's (1971) conceptualization of knowing, specifically as knowing relates to nurse knowing as caring. Patterns of nurse knowing can be categorized as: (a) experiential knowing, involving two distinct patterns, "knowing what" (i.e., theoretical knowing), and "knowing how" (i.e., practical knowing); (b) self-knowing, or "knowing me," which involves knowing that one can perform when needed, as well as knowing one's own limitations; (c) relational knowing, including two distinct patterns, "knowing the person" (i.e.,

empathetic knowing) and "knowing when" (i.e., intuitive knowing, which encompasses Mayeroff's caring ingredient of alternating rhythms); and (d) shared knowing or "knowing and teaching what others need to know," including other nurses, patients, and families. Exemplars from the RNs' narratives that best captured the essence of these patterns of knowing follow to facilitate the reader's understanding of my interpretation of the data.

Experiential Knowing

Experiential knowing is founded upon a nurse's possession of a theoretical as well as a practical knowledge base that facilitates the nurse's knowing what to do (i.e., theoretical knowing) in any given situation as well as knowing how to do a particular action or intervention (i.e., practical knowing). It was evident within the stories of the nurses that the two processes of theoretical knowing and practical knowing were so interlinked that one could not adequately discuss one without the other simultaneously. Additionally, the primacy of nurses' possessing the appropriate knowledge and skills in meeting the needs of their patients was discernable in their stories. The data also support that experiential knowing interlinks with self-knowing, relational knowing, and shared knowing, as experience plays an important role in the evolution of each of those thematic patterns of nurse knowing as caring.

Table 5.1

The Four Domains of Caring Characteristics

Domain	Interrelated concepts
Knowing:*	A) Experiential knowing: 1) Theoretical knowing: "knowing what" 2) Practical knowing: "knowing how" B) Self-knowing: "knowing me" (i.e., knowing that I can perform when needed, as well as knowing my limitations) C) Relational knowing: 1) Empathetic knowing: "knowing the other" 2) Intuitive knowing/Alternating rhythms*: "knowing when" D) Shared knowing: "knowing and teaching what others need to know"
Connectedness:	A) Connecting: being there, listening to others, true presence with others, showing attentiveness to others B) Temporality: time spent C) Open-mindedness: acceptance, being nonjudgmental, tolerance for differences D) Patience*: endurance
Intent:	A) Positive attitude and intent B) Kindness and compassion C) Concern and consideration for others D) Hope* E) Trust* F) Desire and willingness to help others G) Obligation and duty to serve God or others
Integrity:	A) Honesty* B) Respect for humans/life C) Humility* D) Courage*

* A caring ingredient identified by Mayeroff

While all facets of knowing were evidently important caring attributes for RN Participant 7, experiential knowing premiered as the most important caring attribute for this 24- year veteran nurse. When asked about her educational background, she replied

that in addition to her basic nursing program and 24 years experience as an RN, she also held numerous specialty certifications for her role as a flight nurse. These certifications include both theoretical and practical knowing as each one tests a theoretical knowledge of specialty content and all but the CCRN certification included a practical examination for skill competencies. Although one's skills are not tested on the CCRN examination, the CCRN certification is based upon the RN's experiential foundation of nursing practice in the care of critically ill patients; therefore the CCRN certification does subsume practical knowing. These certifications demonstrate RN Participant 7's commitment to learning all she can in order for her to be a caring nurse. She strongly believed keeping her certifications current and continuing to build upon her theoretical and practical knowledge was an important aspect of her ability to be a caring nurse. When asked what caring meant to her, she replied,

> ...Having the knowledge to care for your patient...providing that patient with the care that any other prudent RN with the same training would do. And, not only the patient, but the patient's family... like to fly—to have your certifications current—to have a knowledge of that, to retain that knowledge, and...to—education is very important...continuing education is very important.... If you—just—whatever field you're in—learn the most you can about it...staying current, most definitely staying current. And up...if we have lectures, I try to go to those...I became an ACLS instructor so that would keep me current and that really helps me stay familiar especially in airway—you get to practice on a manikin, intubate and airway care...they had an ATLS (Advanced Trauma Life Support) class last

weekend, and...Dr. F. lectured and Dr. L. lectured, and we went to those. We got to sit in on those....

These specialty certifications required of a flight nurse represent a significant amount of time spent on her days off, and on her own time, in continuing education classes. In response to a question about how often her specialty certifications have to be updated, RN Participant 7 responded that her Pediatric Advanced Life Support (PALS), Basic Cardiac Life Support (BCLS), Advanced Cardiac Life Support (ACLS), and Neonatal Resuscitation Provider (NRP) certifications are renewed every two years, her CCRN certification is renewed every 3 years, and her Trauma Nursing Core Course (TNCC) Provider and Emergency Medical Technician (EMT) certifications are renewed every 4 years. Two of the certifications, CCRN and EMT, have mandatory content-specific continuing education hours in order to maintain certification. The CCRN certification requires 100 continuing education hours for each 3-year period and the EMT certification requires 40 continuing education hours for the 4-year period. When answering a question concerning how many hours she spent each year in maintaining her certifications, she addressed the relationship between theoretical and practical knowing as she responded,

> Some years more than others—this year's going to be ugly—I've got to do just about every one of them (laughs)...so quite a bit this year. You mean hour wise? Oh, it'd be easy to get 100 hours in a year.... Oh, yeah, without even trying. With instructing ACLS. I don't have, I don't have certificates for all that. We did a cadaver lab...for flying...like central lines, chest tubes, um—crics—all the

> invasive procedures you do in emergency medicine. So…we went down there in groups of three—that was volunteer, too. You didn't have to. That was on your own...new skills—'cause you don't always get those skills working and you don't want to not have ever done them when you need to do them (laughs)….
>
> Learning's one thing, doing's another.

RN Participant 16, a 9-year nursing veteran who worked in the operating room as a staff nurse, defined caring as knowing, "To me, caring means, first off, having a good knowledge base and the ability to take care of your patients and do the things, that they need…." She reflected on the importance of knowing in order to be a caring nurse in meeting the needs of her patients, specifically describing the interaction between the two components of experiential knowing (i.e., theoretical knowing of knowing what, and practical knowing of knowing how), saying,

> …You have to know what to do and you have to know what to do when things go bad… it plays a role also with the knowledge, just having done these things over and over again, I think it also plays a role in learning to deal with people, I think as nurses we deal with people in a much different way than you ever have in any other job that you've done before. And…I just think the more knowledge…and experience you have, the better you're able to deal with the patients, the families, the physicians.

Swanson (1993) posited that caring practices of nurses are grounded by a specific and unique knowledge of nursing, as well as self-knowing and experiential understanding, with the ultimate goal of nurse caring being the improvement of others'

well-being. Experiential knowing as a vital aspect of caring was also evident in RN Participant 18's statement that his post-anesthesia nursing practice involved skills as an important part of caring, "You know, a lot of it involves skill and keeping 'em breathing, and, and of course, getting their pain under control and all of that…." This level of caring subsumes a theoretical foundation of knowing what to do, a practical capability of knowing how to do it, and the experience of having done it on previous occasions so that one is proficient in caring for and meeting each patient's needs in similar circumstances.

Experiential knowing is implicit within all other forms of knowing; one cannot possess other knowing (e.g., self-knowing, relational knowing, and shared knowing) without first having had some previous knowledge, association, or similar experience from which to draw. In this manner, experiential knowing is the umbrella under which all other types of knowing evolve.

Self-Knowing

Knowing not only entails having the theoretical and practical knowledge to provide the necessary care for another, but also knowing that one is capable of meeting the needs of another. This knowing, self-knowing, involves having confidence and belief in oneself, as well as knowing one's limitations. RN Participant 7 described the introspection she engaged in upon being dispatched on a helicopter flight as,

> Belief in yourself.... I can do this.... We'll get a call...you'll get a call and you'll get information and it may or may not be that—usually it's either worse or better. But I try to prepare myself on the way. I try to look at the situation and the scenarios that could happen.... So I'll be prepared mentally...the comm. center,

after we launch—we go, "Patient information at your convenience," and I've got a piece of tape on my leg—my brains—and I write it down. It usually consists of vital signs, I.V.s—like if they're unconscious, unresponsive, intubated, uh, if they're uh, have chest pain, um, what medications they've received. And it's like, it's a rough draft...it's...a good tool, 'cause you have an idea what you're going in to. Like if it's a pediatric patient, or if it's a respiratory distress, but I try to get mentally prepared...or if it's a...a scene...multiple patients—one car rollover...with a trauma code 99 just—prepared for that so I can deal with whatever I'm—so I can be in the best possible frame of mind for whatever may be needed.

Similarly, practical knowing in relation with self-knowing was addressed by RN Participant 5 as a part of what caring meant to her, "You need to be skillful and confident about what you're doing so that they get...a feeling of ease." Included along with the need to be skillful and confident in meeting the needs of her patients, RN Participant 5 believed that a nurse needs to know one's own limitations, know when to get help, and to continue to acquire new skills in order to foster more confidence. This interaction between one's self-knowing and practical knowing engenders the proposition that the more practical knowing one possesses, the more confident one will be. Additionally, it would follow that the more one knows one's own limitations, the more one should be motivated to learn new skills in order to increase one's confidence.

Being skillful (i.e., practical knowing), along with having confidence in one's skills (i.e., self-knowing), supports the interrelated foundation for nurse caring as

knowing that was first described by Green-Hernandez (1992), who delineated three conditions requisite for nurse caring: (a) learning through formal and informal mechanisms; (b) acquisition of technical competence of psycho-motor skills, which in turn, engenders the acquisition of professional competence; and (c) attaining professional confidence, which is closely interrelated with the acquisition of learning and competence, obtained through one's professional experiences as well as peer and patient validation of one's nursing skills. In satisfying these three conditions, nurses are poised to cultivate exceptional ways of expressing nurse caring through the delivery of therapeutic nursing interventions while working with patients and their families (Green-Hernandez, 1992). In the evolution of nurse caring as knowing, a nurse must obtain theoretical and practical knowing of how to care for others through didactic and praxis in the formal educational setting of one's basic nursing program. Then, with continued practice and experience, the nurse acquires additional theoretical and practical knowing through formal continuing education programs as well as through informal collegial sharing of knowledge and experiences with one's peers. As one gains experience, it follows that one's competence would increase, resulting in an increase in confidence in one's capacity to care for others. While Green-Hernandez posited that these three conditions need not be experienced in any order, I believe there is a definite hierarchal pattern that is evident from the stories of these nurses as well as a logical progression that theoretical knowing precedes or is concurrently attained with practical knowing, comprising experiential knowing. Experiential knowing is antecedent to and culminates in competence, thereby generating

confidence in one's ability to be caring. As such, both competence and confidence are incorporated into self-knowing.

Swanson (1993) posited that knowing is the "anchor that moors the beliefs of nurses" (p. 355) that allows one to understand the realities and meaning of the patient's situation. Citing that one's prior experiences enable the nurse to know the meaning of a particular event in a patient's life, Swanson argued that such experiential knowing, along with self-knowledge, allows the nurse to understand and truly know another's reality, as well as understanding her own capability in meeting the patient's needs.

Relational Knowing

The theme of relational knowing consists of two distinct patterns, empathetic knowing, or knowing the other, and intuitive knowing, which encompasses knowing when to act or not act, which envelops Mayeroff's (1971) caring ingredient of alternating rhythms. Each of these aspects of knowing is embedded in the relationships one has with others, or may be based in part on past relationships and experiences that are similar, thereby facilitating the nurse's knowing what another needs as well as knowing when to act on the behalf of the other.

Empathetic knowing. Knowing, according to Mayeroff (1971), depends upon one's knowledge of the other, the one for whom caring is given. The conceptualization of this relational type of knowing emerged from the data as the concept of empathetic knowing, which was addressed by several participants. White (1997) delineated aspects of empathy, which included sensing, perceiving, and understanding the other, while communicating this understanding back to the other. Thus, empathetic knowing entails

entering that patient's reality and understanding what the patient is experiencing or feeling and reflecting that knowledge back to the patient. RN Participant 1, an ED veteran, said,

> I think I try hard to see it from their point of view, from the patient's point of view, from where they're at...I think in order to be caring you have to be...how do you say this, not self-centered. You have to be able to see the big picture....other-centered. And, and to have a certain amount of empathy. Like I said, to put yourself in their position. To know that they are frustrated because they've been sitting there for six hours with a screaming child. You know, that kind of thing.

This perception and understanding of the patient's reality allows the caring nurse to receive the patient from a compassionate and concerned perspective, enabling the implementation of appropriate interventions to meet the patient's needs. When asked what she relies on to get her through every day and what caring characteristic she felt was most important, RN Participant 1 identified empathy as the most important aspect of caring as she works from the perspective of the patient's reality,

> I think...mostly...the empathy. Going outside myself and looking, at maybe where they're at....I think once you've been doing it as long as I have, maybe, in our particular situation, they say...people say a lot...well, 'Why don't they go to their private doctor...why do they keep coming in here?' Well, if you step back and look, there's not a private doctor in town that'll take Medicaid hardly, much less if you don't have $150 up front. Well, these people don't have anywhere to go. The clinics are packed, and so how can we fault them for seeking care for their child

when we would do the same.... Everybody feeds on that, 'Are you (the patient) worthy?'

RN Participant 2 talked about knowing in her heart what she needed to do in a situation when asked to describe an event in which she felt her nurse caring met the needs of one of her patients. She described her feelings and actions, which were mediated by her empathetic knowing of what the patient was experiencing and what the patient needed to receive in caring for her, even though she had never met the patient before. RN Participant 2 stated,

> ...I really felt like, you know, I went above and beyond, that it just, it struck me in my heart, personally, and in my nursing, that I needed to do. I had a patient who was traveling, and...had a one car rollover and she was in her young twenties and her daughter was 3, 4 years old. And...the daughter turned out to be fine, Lifestar brought in the mom and the car had crushed her right hand and so she wound up losing...the second, third, and fourth digits in surgery overnight. And...the problem was, there was no family and they were all in Alaska—and there was no family here and my heart went out to the mother because I could relate to her—at her age and her daughter ...we didn't know what to do with the daughter as far as overnight. Mom had already had some medication and we could not send the daughter to the Bryant House, or someplace where she could stay under supervisional care so we were stuck looking at mom going to surgery and being drugged up all night; what're we going to do with the daughter? And one of the physicians and I discussed it and I brought the daughter home with me that night.

> Not only did I take care of the mom and meet her physical and psychological needs and get her off to surgery, but I reassured her that I had 2 children and her daughter would be fine at my house and that we would take care of her and I would bring her back first thing in the morning because I'd return to work at 6:30. And mother was agreeable with that but we also looked at risk management and how that would set. And, it was a heart breaking thing for me because I was kind of placed in the middle but I felt compelled to take care of the mom and get her off to surgery but also to care for this child—and even though the child was no longer a patient, I just felt like, you know…and I brought the daughter home and she played with my children and … I took her back to work with me the next day and took her up to her mother's room on the floor and she stayed in her mother's room that morning until Social Services could get them on a flight on to Alaska…

When I asked her what she felt during that experience and why she did what she did, RN Participant 2's answer reflected empathetic knowing as she acknowledged,

> Well, first of all, I mean, just her being my age and having this car accident and being far away from home and no family around and we were all communicating by phone with her family—how she must have felt. And—she just, you know, basically put her and her daughter into our hands at the hospital and just trusted us. And so, I felt, I felt like I was needing to nurture the child as well as the patient as a sister just because I related to them so much…. But, I—just felt obligated and felt the need to bring the child home with me and make sure she was safe and okay so that this mother could rest and rehab okay.

In eliciting further clarification, I then asked, "And relieve her of her anxiety and worry over her child?"

To which she replied, "Yeah. Yeah. And because she was also losing a body part and had other things to think about. I just, you know, was trying to keep her from worrying about everything."

In relating to this mother, RN Participant 2 was able to know and understand the patient from the patient's reality. This empathetic knowing of the patient facilitated RN Participant 2's ability to step outside the normative ways of doing things and devise a plan of action that would meet the needs of both the mother and her child.

Empathetic knowing was also discussed by RN Participant 7 who described how she managed the helicopter environment to demystify it for the ill or injured person who might be frightened by the unfamiliar noises and sights. She discussed entering into the patient's reality in realizing the strangeness of the environment as she intervenes to allay the patient's fears or anxieties. When asked how she created a caring environment in the helicopter, empathetic knowing was evident as she responded,

> I try to put myself in their position. I've never been that sick. But if I were—if it was my family member, how would—I—would want them to be treated.... Letting the patient know what's going on. What's going to happen—what they may feel—what they may hear—when we load 'em, they have to go through a narrow part of the helicopter 'cause we got equipment on one side—and then it opens up, but if they're claustrophobic that could be—pretty scary. So we try to let 'em know, "You're going to go through a narrow space but it's going to open

up." Things like that. It's going to be loud—when we unload 'em, the exhaust is back there, you go by—it's kind of warm—I guess all these things can be pretty scary—and when you're strapped to a backboard—and you can't move—that's even worse. But...I tell them, "We're close by, we're not gonna leave 'em, if they need anything, you know, they can raise their hand," if they are able to do that...and just...mostly what to expect....We had a patient, I can't remember exactly what his injury was, but he had his eyes bandaged—and we were flying him, and my thought was, "He can't see in the helicopter—up in the air—and it's hard to hear." So, my touch was just letting him know I was there....

When asked if her touch helped calm the patient, she positively responded that she thought it did help and that she kept her hand on him and talked with him during the flight to keep him informed. This action reflected her ability to know and understand what needs the patient had. Based on her knowledge that he was unfamiliar with the helicopter and was frightened by his immediate sightless situation and need for aero-medical transportation, RN Participant 7 felt that she was able to effectively calm the patient and allay his anxiety, through her caring nursing actions. White (1997) described the attributes of empathy as (a) recognizing immediately another's need, (b) involving an immediate response that includes active attending and listening to the other, (c) using both verbal and non-verbal communication, and (d) with the ability to imaginatively and intuitively feel and understand the other's feelings. In responding to how communication was facilitated in the helicopter with her sightless patient and family members who travel with them, RN Participant 7 answered,

> And I talked to him—you know, you have to get down there and yell, but—you know--you have to talk loud...we have a headset—so that helps—if they're not in a CID—you can put that on them and, you know—talk to them—sometimes it's kind of hard to hear them, but it hasn't been so bad lately. But just letting them know you're there—keeping them aware what's going on. With our children—I always like to take a parent—and in the EC…we can take a family member...but they can't see—we've gotta curtain up—but they're up front with the pilot…every so often the pilot will check back with us and ask how they're doing, or…we've got an intercom button we can push and we can say, "Everything's going," you know, "Fine, everything looks stable." Just to keep in touch with the family member to let them know how things are going.

RN Participant 7 used empathetic knowing to anticipate and meet her patients' and their families' needs in the unique practice environment of a helicopter. Her ability to critically think about the patient's or family's anxiety, knowing that aero-medical transport was a strange and frightening experience for them, enabled her to empathetically know the patient and family and plan effective actions with the goal of alleviating their anxieties or fears.

RN Participant 11, when asked about caring, discussed how her previous life experiences had helped facilitate empathy in her interactions with others. In knowing the patient from an empathetic perspective, RN Participant 11 recognized what the patient's reality was and was then able to relate to that person in a caring way. She said,

> ...I can only speak for myself. I feel like—in order to have empathy, you have to have—experienced a lot of adversity in your own life. And it may not be true—this is just coming from me and I feel like that I have had a lot, a lot of adversity in my life. Now, I know people who have had a lot of adversity in their life and they don't have any empathy, so it's almost a contradiction. But for me, I fell like that my adversities and all the trials and tribulations I've been through, it's helped me look at other people and understand, 'Oh yes, I've had a situation like that or similar.' ... And I kinda know what they're going through. Maybe not exactly, but, I think that's important.

The ability to see reality through the lens of another person was also important to RN Participant 16 who discussed caring as empathetic knowing of the surgical patient and the needs of a patient undergoing surgery. Acknowledging that fear is the number one emotion experienced by patients who are undergoing surgery, she said,

> ...You need to be able to, at some level to put yourself in the other person's shoes and understand that even though you may deal with surgeries, for example, all day long, this may be the first surgery anybody's had and it's them, and they're scared and they're nervous and you need to be able to understand that and realize it so that you can address their needs.

RN Participant 15 related that understanding and letting the person know that you understand what they are experiencing is an important aspect of caring. An empathetic nurse communicates her understanding of the other's feelings back to the patient or

others, which in turn allows validations of these feelings (White, 1997). When asked what caring meant to her, RN Participant 15 replied,

> Caring means you need to understand what's going on with that person, with the patient.... You need to listen, and I think, they, that person or patient needs to understand that you hear what they're saying.... Sometimes it's almost a mirror type communication, you know, and...caring means that, you know, you're a part of what they're going through. You know...what's the word, it's not, is it sympathy for them or (pause) it, I guess, basically it's just understanding what they're going through and don't dismiss what, what they're feeling.

RN Participant 19, when asked what caring meant to her, described the concept of empathetic knowing as caring. She defined what caring meant to her as, "...Caring means to me an outgoing concern where you're able to, ah, to kind of project your feelings or your thoughts into the other person enough that you can understand where they're coming from and how they feel." This ability to perceive the other's reality and understand how they feel was evident in RN Participant 19's exemplar of empathetic knowing as caring, as she said,

> We have a patient that comes in, probably every eight or nine months that...has a very low pain threshold. She is diagnosed with schizophrenia but she...always concentrates, and becomes very, very anxious, on her pain. The lady genuinely has had a problem with a shoulder resulting from a fall in the past, had recently had surgery on it and when she came in this time, the attitude seemed to follow through, 'Well, she always complains of pain, she always wants pain killers, she

always wants this or that,' but...she still had the sutures in, and...no one really wanted to sit with her or listen to her cry,...and she really needed, more than anything else, if you talked to her for a few minutes, the attention to know that somebody cared, and that she wasn't in that room and forgotten. So, if you take, I took the time to go sit with her and just kind of not really rub her back because she had sutures that went around her shoulders, but just to kind of, you know, like finger movements across her back and I talked to her. I talked to her about closing her eyes and thinking about a place where she had been, you know, and I said, 'We will call the doctor for more medication, but most likely until he sees you in the morning, you won't be able to get it.' But I said, 'You can sleep, just think about some place you really like,' and I stayed with her and talked to her until she fell asleep. And, she stayed asleep then where she'd only been sleeping on pain medications for maybe two hours. So...she did not wake up until after shift change the next morning. So, she obviously needed that little bit of attention, uh, for someone to sit down and do that. Sometimes, I think we worry about the paperwork, and have a tendency to forget that this patient really needs just somebody to let them know that, 'I'm listening to you, and I know you're here, and I know you're hurting, and I haven't forgotten you.'

The recognition of this patient as a person who needed to know that someone truly heard her concerns and cared about her, along with the ability to understand what she was experiencing, facilitated RN Participant 19's capacity for caring for her, while validating the patient's feelings. Similarly, empathetic knowing requires that the nurse

identify with the patient, according to RN Participant 19, who in describing her life experiences, talked about the effect one's experiences has upon one's empathetic perspective. She said,

> ...I think we have to have the...ability to identify with the patient. I think there has to be something in us, that, kind of, we, we can take and say, 'Oh, I know what that is like.' And I think that's important for, for empathy and not everybody has had the same life experiences but life experiences are very, very important in it.... I can take care of...the alcoholic and love him when he smells the worst and he's detoxing because I had a father that was an alcoholic. And I took care of him and loved him....Ah, so I'm able to identify and realize that the alcoholic doesn't have to be a bad person. That they're a person who made some bad choices and I, too, have made bad choices in my life, maybe not the same ones, but bad choices....You know, I can look back when I see the people that are suffering with adolescents, because I have an adolescent son who put me through drugs and alcohol and people I never wanted to meet at the probation offices, you know, and all of this...that I never thought would happen. So, and you know, you could go through it and say, 'Well, these were life experiences that I have gone through,' and it makes it easier for me to accept and say, 'This is not a bad parent; this is a child who made a bad decision and uh, they still got a chance to make it out of it.' .... So I think a lot, an awful lot in my life has been life experiences because I go back to that all the time and it makes me more able to have that empathy, you know.

RN Participant 19, when asked about the characteristics she felt where necessary for caring, discussed empathy as one of the important caring characteristics,

> Well, I think empathy. In the sense of real empathy.... I looked up the meaning of empathy a long, long time ago, matter of fact, when I was here at, at (school). And I think a lot of people really put it very, very close to sympathy, and there's a big, big difference. You know, it's the ability to interject your feelings, your personality, in with theirs and to identify and pick up what they're feeling. I think that's really important to be able to do that because it's a part of listening...and it's, sometimes I have cried with patients, sometimes I've laughed with them. I've done both. You know, with the same patient, depending upon what mood they were in. But it helps you to...identify what that patient is really dealing with, what the bottom line of their problems really are, and not just what they're telling you superficially. And...when a person can pick up on that and do something about what the real problem is, then you have a patient that trusts, that has confidence in the system more, that doesn't feel like, 'Oh well, I'm in here to do my time and then get out.' You know. And they realize that there are people out there that will do something for them. They, I think, maybe they have a little more trust in all mankind that way.

Intuitive knowing as alternating rhythms. Intuitive knowing parallels Mayeroff's (1971) caring ingredient of alternating rhythms and is characterized by knowing when one needs to act, or, conversely, knowing when no action is needed. Intuitive knowing flows from one's instinct, which is facilitated by one's former experiences guiding

current practice. Nyberg (1990) identified the central characteristic of caring as an initial interest in someone that develops through knowing that person until a feeling or a commitment forms to assist the person to grow and to exist. Caring is a way of thinking and acting, based on intuition and relationships; and, caring adds meaning to life. RN Participant 3 was the first participant who addressed the essence of the concept of intuition/alternating rhythms when she said,

> ...Well, I'm a touching person and...sometimes I've, maybe I've crossed the line there, too, because there's some people that don't like to be touched and you have to figure that out, but the majority of people, I think, do—so I always try to touch the person, make eye to eye contact with them...

RN Participant 7, when addressing how she cared for her sightless patient in the helicopter, echoed that knowing when to use touch to comfort a person is something that has to be evaluated on an individual basis. She said, "...You have to also see whether--some people don't like you to touch them, so you have to evaluate that, too...." She agreed that her 24 years of experience in nursing facilitated her ability to know others and to get along with others. In addressing how she had evolved as a caring nurse, she said, "...My knowledge of other people has definitely—or people interactions I guess you would say—how to get along with other people. That's grown." The ability to get along with others and to know others requires one to know many things, including knowing when to act on the behalf of another, specifically as in knowing when one can use touch to convey caring.

RN Participant 11 also spoke about the use of touch and knowing when one could or could not use it. In discussing her interaction with a patient deemed difficult by other nurses, she said,

> ...I tried to be honest with her...keep her abreast of what was going on...I tried to be very patient with her because I could tell she was scared to death...I tried to touch her as much, you know, as I could. Some patients let you touch them, some don't. I tried to watch that. You know, and she did need that. And I felt like she wasn't getting it.... Sometimes you have patients like this and you have to do that....

This example conveys the nurse's ability to know when she needs to change her plan of action and change how things are done in customizing care for each individual patient. The nurse's past experiences are fundamental in guiding her practice with current and future patients. RN Participant 11 called this process insight and explained it as,

> Whether that be ESP, or ah, your Holy Spirit or, you know, whatever...I think that you have to be able to, to be with a patient and kind of read between the line and from what they've told you to be able to have some type of insight as to this is how I need to approach this patient, this is what I need to do. I need to back off. I need, you know, this patient really needs a lot of...attention....

RN Participant 12 also talked about knowing when to spend time with her psychiatric patients and when to back off from spending time, acknowledging that sometimes patients are not yet ready to deal with issues that are affecting them. She recognized what each one was going through and based her actions on her perceptions of

when they were ready to interact with her, relying on her intuitive knowing of when that moment best was. She said,

> ...I try to spend as much time as I can with each one of them. But some of them don't want to spend time with you. It depends on, you know, what they're going through. If they're very, very angry. And so, I just back off a little bit until they're feeling a little better...

Intuitive knowing was alluded to by RN Participant 9 who said of her 21 years experience as a nurse, "It should bring some experience and maybe some more insight to it," but not a sense of callousness or the feeling that she has seen it all or done it all before because each person is a unique individual with unique needs. RN Participant 10 also spoke of every patient being different and having different needs and the importance of the nurse's recognition of these differences in determining how to meet these needs. These views suggest that what works in one situation will not necessarily work in all similar situations and that is the nurse's intuitive knowledge of when it will work that is essential in meeting patients' diverse needs. RN Participant 19 agreed that the nurse should identify what the patient's needs are, which tend to fluctuate or vary. She described the interrelationship of empathetic knowing with intuitive knowing, acknowledging there is a right time to demonstrate empathy, saying, "...The ability to...identify and pick up what they're feeling....sometimes I have cried with patients, sometimes I've laughed with them. I've done both. You know, with the same patient, depending upon what mood they were in..."

RN Participant 17 reflected that even though his experience in the Operating Room (OR) had given him a certain level of knowledge, he still felt as if he learned something new each day that when used with others would make their OR experience better. This ability to continue to learn and grow as an expert nurse, learning new and different ways of doing things that he'd done many times manifested his knowledge as alternating rhythms in caring for the surgical patient. He talked about this growth as a nurse as,

> ...Every day is, even now, I feel like I have...reached a certain plateau or level...in the OR, as far as knowledge and everything else and, but, everyday, I learn something different, a different way of doing things that will—or adding to things that will make the environment more comfortable, and...less stressful for the patient. Just, just little things, I mean, like whenever you, if you have a patient on the table that ...is going to be there for an hour and a half. Those operating room beds, those pads are not the most comfortable, but they are a pad and they won't...give you a decubitus. But I had a patient that the thing they complained about the most, when I saw them postoperatively, was...sores on their heels; their heels were extremely sore. But, the case only lasted an hour. So, if I'm going to do a relatively long case, like an hour and a half or less, or an hour or so, I put heel pads on them. These geriatric patients, if they're going to be laying down on a belly case for a couple of hours or however long, if you lay flat, absolutely flat for that long, when you wake up, you're going to be sore. So, hey, what's wrong

with…some pillows underneath you? It's not going to interfere with the surgeon, and it's not going to cause any problems with the case. Just do it.

This OR nurse's management of the surgical experience for his patients was based upon all of his knowledge and experience, along with his ability to know when to act for the good of his patients. His caring was based in part on his knowing not only what should be done but also when it should be done in order to make the OR experience better for his patients.

Shared Knowing

Shared knowing emerged from the data as a caring theme and represented the sharing of one's knowledge with other nurses, patients, and families. Shared knowing reflects nurse caring not only for one's patients but also for their families. The underlying premise of shared knowing is that if I know something, then all with whom I interact also need to know that same something or pieces of that something so that they can more fully understand what they, as patients and families, are experiencing or should expect to occur; or, what they, as healthcare workers, can do to assist the patient and family in meeting their identified needs.

Shared knowing with patients. RN Participant 4, a critical care nurse, discussed the importance of sharing her knowledge with her patients who may not be able to communicate verbally because of mechanical devices used for respiratory support in the ICU. In her exemplar of sharing her knowledge with her patients, it appeared that shared knowing was interlinked with empathetic knowing. She related,

> ...I just try to picture myself laying in that bed...like if I was a quadriplegic—we have lots of quadriplegics on the unit—and they have to find a way to communicate.... I just could not imagine how scared I would be if I was not able to talk, or if I didn't speak English, and had a tube down my throat, and...things hooked up to me and I didn't have any knowledge of what those things were...I just try to put myself in their place,...and try to explain and reassure them. I mean, I think that's, you know, why this, this is here, and it'll come out soon, or, or if it won't, I tell them that things will get different—they may not get better right away, but they'll get different. I mean, I just try to explain what's going on.

RN Participant 10 discussed sharing her knowledge with her laboring patients as an important aspect of caring in establishing trust with her patients. When asked about the caring characteristics she felt were important in order for her to be a caring nurse, she stated trust, followed by honesty. When I asked her how trust was built with the patient, she illuminated the concept of shared knowing by replying,

> ...I think that you just have to be honest with your patient. I think that, you know, in, in what you're doing with them, in what's going to happen with them and their experience. I think you have to let them know all the knowledge that you have of what is gonna be their experience.

These data suggest that honesty, through the sharing of one's knowledge with one's patients, trust, and hope are interrelated. Honesty in the manner of sharing of one's knowledge with the patient is prerequisite to building trust, which leads one to hope that all will be well. In being honest with her patients in what to expect during their labor

experience, through sharing her knowledge of those expectations, she created a trusting relationship with her patients. Thus, sharing one's knowledge with one's patients requires that one is honest. Honesty builds trust, which in turn fosters hope for a positive outcome.

RN Participant 17 discussed that as a result of honestly sharing his knowledge with patients undergoing surgery in the OR, he believed he alleviated their anxieties by telling them what to expect as part of their experiences, thereby facilitating trust, which then fosters hope, by implanting in his patients a positive idea that their surgical experiences will have positive outcomes. He stated in response to how he helped his patients relax immediately prior to the surgical procedure,

> ...You just talk to them. And just tell the patient what's happening. When they're starting to, before they push Fentanyl to help them relax a little bit, or Versed, you tell them the world's gonna, I just tell my patients, 'The world's gonna start spinning and getting a little fuzzy. If it bothers you, close your eyes.' And when the induction medication is...started, I always tell them that. Tell them, 'You're fixing to go to sleep, it may burn,' you know, diprivan burns a little bit sometimes, and I've had some patients, when they wake up, tell me that they want to go back to sleep because they haven't finished their dream yet. And I always tell them, 'You have pleasant dreams, and I'll see you in the recovery room. And I'll take good care of you,' I say, 'I promise you I will.' And that's...a promise that I don't take lightly....

RN Participant 18 acknowledged that in dealing with a patient with altered consciousness, such as in the post-anesthesia care unit, he often shared his knowledge

with the patient to decrease anxiety and promote ease, during the emergence from the anesthetic medications. Sharing his knowledge included orientation of the patient to what had transpired during the surgical procedure, as well as reinforcing what the surgeon had said to either the patient or family post surgery. RN Participant 18 stated,

> I try to orient them, you know, because they don't know if they've...woken up in the surgery, the last thing they remember is probably being brought to the room and anesthesia puts a mask on them, so they don't know where they're at. And, it's always good because we can tell them that it's over and that it's all done. And that's usually a big relief...oftentimes, they'll need to be reoriented several times. And I've had conversations with patients nice stimulating conversations, and then they, they ask me, 'Where am I? Is it, is it done?' You know. 'Yes, yes.' And then a lot of times the doctors, they know that the patient's not going to remember so sometimes they won't even come over to the bed. And then if they have some concerns about that, and the doctor's gone—to go through the records and try to find some information, or I'll try to ask the doctor, you know, 'Is she going to be okay?,' or 'What did you find? Did you find anything?,' or 'Did everything go alright?' And so, I'll just tell them that, 'Well, the doctor said everything went fine and he, he's going to talk to you,' or 'he talked to your family, he, he's already talked to your family....'

Shared knowing with family. The importance of sharing one's knowledge with families also emerged from the stories of the participants and is founded upon and interrelated with the nurse's intent and attitude. Caring nurses extend their caring to

others through the sharing of knowledge, including sharing their knowledge with families of patients. RN Participant 3 described sharing her knowledge with mothers over the phone, saying that teaching was approximately 50% of her job as a poison center specialist,

> ...We have very few deaths here in the Poison Center...but our role is still so important. When we get the calls from mom at midnight—and they think they've overdosed their child on Tylenol—because they're treating a fever, so as a nurse, not only teaching is...50% of our job, so not only are you able to put that mom's mind at ease because she can't get a hold of her pediatrician, she doesn't have a car and can't get to the emergency room...doesn't know what to do, so not only can you calm her for the situation at hand, but then, you go on, and you tell them how to treat the fever and how to alternate your Tylenol and your Motrin to keep from overdosing. And giving them the bath and keeping them uncovered. And... those little things. And then you offer them a poison packet and say, 'You call us any time....'

RN Participant 4 shared that she thinks it is very important to keep families informed and up to date on their loved one's condition. She told me that she spends a lot of time sharing her knowledge with families, which in turn establishes trust and rapport with them. She said,

> ...Explain a lot to families.... I spend a lot of time with families. I go out to the waiting room, if there's some new information that develops and communicate

that with them. And I've found that has...increased my rapport with families more than anything—is that I try to—if anything develops...

RN Participant 5 gave an example of shared knowing with family when caring for an confused elderly patient in the critical care unit who would likely need skilled nursing care upon discharge from the acute care facility. In sharing her knowledge with the family, RN Participant 5 said she enjoyed the feeling she got from being able to help the family in this way. She related,

> ...And the family had so many questions about when she went home—I have a lot of background knowledge in Medicare, Medicaid, SNFs, and all that so I was just giving them a lot of information. It just kind of made my day—they all came up and said, 'We're so glad you're her nurse today.' That was better than any raise or anything anyone could ever give me—just that feeling.

RN Participant 17 spoke about the importance of sharing his knowledge of the operating room experience with the family during the surgical procedure. He acknowledged that since his time establishing rapport with the patient was limited to the pre-operative period, he therefore felt that the greatest need in sharing knowledge was to expend his time in keeping the family up to date on what was happening in the surgical suite. His reply to establishing patient comfort prior to the procedure was,

> ...It's tough, because...you can tell them how you—who you are, and you can try to...let them know that you're here and you'll take good care of them....I think that perhaps the greatest area of comfort zone is not necessarily acquired by the patient, but by taking care of the patient's family. Because if you let the patient's

family know, if you can establish that, then you've done something to let somebody else know to kind of ease their anxiety because the patient's that, that themselves are going to have experienced anxiety for a short period of time. But if you're in the operating room for 3 or 4 hours, that anxiety continues with the patient's family.... And if I'm out here on call on a bad crani or something... and it's going to take a period, I always tell my patient's family, that it's, about how long it's gonna take...I say, 'I know that telephone number; I will give you a call as soon as we get started and I will keep you updated until we get through, and I'll call you...as we're finishing to let you know.'

In answering my comment about this type of interaction making the family feel connected during this frightening time, RN Participant 17 answered,

Well, you know, you take a whole family, whether it be a husband or wife or kids or grandmother and you put them into a stress situation like trauma...you gotta treat the whole spectrum of it and, and make, by making sure you stay in touch with them, 'cause I have found, I have seen people...and I was the recipient, on the receiving end of that, of being alienated when a significant other was stuck in, went to the operating room and a procedure that was supposed to take 45 minutes, two hours later, I was still sitting there...no communication from nowhere.... And I felt totally out of control. But if you can, if somebody had talked to me, I may have had a little bit of control of, a feeling of, of kind of a pseudo-control, but these families that—they have no idea. It's a whole new world, you know. And they have, they don't even, can't even begin to understand it. So if you can talk to

'em, let 'em in on that world a little bit, let 'em know that yes, you are somebody and, and you do recognize their presence and their anxiety...and that...their concern, then you've...helped out. Done a little bit....I'll bet most...of the time, people want to know, 'Is everything okay, is he, he's not dying on me,' 'cause, you know, people go to the operating room on occasion for elective tonsillectomies and they die. So, you know, you keep telling these people, and, and in a trauma situation or in a crisis situation, ah, these people really don't know. You know, everything comes at them so fast that a surgeon could or you could tell that...patient or the family something and go back three minutes later and ask them to recall it and they can't do it....So, if you continually talk to 'em about it then maybe they'll settle down and begin to kind of understand.

Shared knowing with other healthcare workers. In addition to sharing one's knowledge with the patient and the family, sharing one's knowledge with other nurses or healthcare workers emerged from the data, continuing to expand the concept of knowing as a caring characteristic. In sharing one's knowledge with others involved in the patient's care, a caring nurse extends her caring through others who then know how to meet the needs of the patient. RN Participant 3 discussed the importance of sharing her knowledge of poisons with other healthcare professionals, including doctors and nurses, in order to provide the best possible care to a client who experiences a toxicological emergency. She related,

...We cover 72 counties, so we have, the little hospitals...and they, those doctors and nurses, you may have just a regular MD, pulling a rotation in ER, and he may

do it once a month or twice a month—and so, that physician calls you because he's got an antifreeze overdose or a dig overdose or a rattlesnake bite and...you are their lifeline because they've never treated that before—and it's such a wonderful feeling when you know that you've given, and of course, it goes directly to that patient, the patient care, and how good of care they get. And we tell them what labs to draw, what to watch for on the cardiac monitor, if that's relevant...what the antidote is, signs and symptoms to watch for, is that patient a candidate for transfer to a bigger healthcare facility, do they have the antidote in that small hospital 'cause a lot of them don't, and do they need to be airlifted, and so...we have some of our smaller clinics where you've got an RN who is the only RN in the emergency room, she has a doctor on call, not in the emergency room with her...

RN Participant 7 spoke about shared knowing in discussing how the flight service staff holds an annual pediatric emergency continuing education program for the regional hospitals and Emergency Medical Services in the surrounding region. She said the flight service voluntarily provides this training and education for the region in order to share their collective knowledge with other nurses and paramedics who deal with pediatric emergencies. When I asked her why the flight service puts on a pediatric emergency conference each year, she answered,

...To provide education for the region, which they've asked about—at a cost that's affordable and with, hopefully, information that will be pertinent to them and what they do. We get a lot of nurses but there's a lot of regional people, too,

that come...EMTs, paramedics, intermediates.... Pediatric patients have always been notorious for being—scarier...a lot of services—flight services—do education. I'm not sure how that came about but I think —a lot of it—was because of the pediatric patient.

The domain of knowing as it pertains to nurse caring is central to nursing practice. Tanner, Benner, Chesla, and Gordon (1993) studied 130 critical care nurses and concluded that knowing the patient is a primary caring practice. Swanson (1991) delineated knowing as one of five caring dimensions, and defined knowing as "striving to understand the meaning an event has in the life of another (p. 355)."

Connectedness

The domain of connectedness as a caring attribute emerged from the stories of the RN participants. Within this domain, four main concepts form the substantive framework for the caring characteristic of connectedness, including (a) connecting with the patient and family with true presence, (b) temporality, or the element of time, (c) open-mindedness regarding differences of others, and (d) patience, or the ability to endure and persevere.

Connectedness with another allows the other to feel validated as a human who has worth and meaning to others. Connectedness emerged as a pattern that the nurse participants discussed as wanting to care for a patient with the same care and concern one would have for a loved one. Several of the nurses talked about spending time with the patient as being a caring practice. Others addressed needing the attribute of connectedness in order to see the possibilities of having time to spend with another, as

well as effectively using the time one has to genuinely connect with the other. Also, in caring for others, the nurses' discussions supported the need to possess a tolerance for diversity while maintaining a nonjudgmental attitude, which is germane to being able to connect with another in a caring way. The ability to endure, which entails possessing the quality of perseverance, comprises the patience one needs in order to connect fully with others, which was addressed by several of the nurse participants.

Connecting

The pattern of connecting emerged from the data as being there for the patient, listening to the patient's concerns, true presence with the other, and showing attentiveness to the other. These are actions that convey caring, which each take a certain quantity or a certain quality of time in carrying out in order to convey caring to the patient. All of these actions reflect one's ability to positively connect with the other and are dependent in part on the nurse's possession of a positive attitude and willingness to take the time to care. Many of the nurses' stories reflected connecting with the patient as being interdependent upon using time effectively, remaining open-minded, and having patience, as are discussed throughout the domain of connectedness.

Swanson (1991) stated that being with the other was to provide time, genuine presence, attentive listening, and thoughtful responses to the other. Being with was the caring dimension identified by Swanson that communicates that the patient and his experiences matter to the nurse. Being with the other also conveys that the nurse is available and able to assist the other, oftentimes simply by giving of the self and doing so

in such a manner that the other realizes the concern, commitment, and attentiveness of the nurse.

RN Participant 10 mentioned that one's having a sympathetic ear was an important caring characteristic in truly connecting with another. In discussing this, she alluded to taking the time necessary to really be there for the patient and listen to the patient. She said,

> ...A sympathetic ear—I think that, you know, sometimes your patients just need somebody to listen to more than somebody to take care of them...just being there for your patient. Just listening to your patient. Just listening to their concerns and...what they're going through.

Temporality

The element of time, as a pattern within the domain of connectedness, held an important key to being able to provide nurse caring, and was evidenced in many of the nurses' stories. While many nurses consider time generally to be in short supply, it appears that caring nurses use time creatively and positively in meeting their patients' needs. Interactions between one's empathy and one's ability to connect with others, as well as one's intent (i.e., possessing a positive attitude) and the effective use of time, were evident within these caring nurses' stories. RN Participant 4 noted that it was difficult to establish a caring relationship in the critical care unit with a person who was unable to communicate verbally because of critical injury or illness. Alluding to the interaction between time, as connectedness, and empathy, she said,

RN Participant 19 addressed needing to truly connect and listen to the patient, acknowledging that time was important in caring interactions. When asked to describe a particular situation in which she exemplified caring to a patient, she replied, showing an interaction in empathetically knowing what the patient needed, in addition to spending time with her in order to provide the caring needed,

> We have a patient that comes in, probably every eight or nine months, that...has a very low pain threshold. She is diagnosed with schizophrenia but she...always concentrates, and becomes very, very anxious, on her pain. The lady genuinely has had a problem with a shoulder resulting from a fall in the past, had recently had surgery on it and when she came in this time, the attitude seemed to follow through, 'Well, she always complains of pain, she always wants pain killers, she always wants this or that,' but ...she still had the sutures in and ...no one really wanted to sit with her or listen to her cry, you know...and she really needed, more than anything else, if you talked to her for a few minutes, the attention to know that somebody cared, and that she wasn't in that room and forgotten. So, if you take—I took the time to go sit with her and just kind of, not really, rub her back because she had sutures that went around her shoulders, but just to kind of, you know, light finger movements across her back and I talked to her....And, she stayed asleep then where she'd only been sleeping on pain medication for maybe two hours. So, she obviously needed that little bit of attention...for someone to sit down and do that. Sometimes, ...we...have a tendency to forget that this patient

really needs just somebody to let them know that, 'I'm listening to you, and I know you're here and I know you're hurting, and I haven't forgotten you.'

Time spent with the patient ranked right behind empathy with RN Participant 19, who felt that the two were intertwined and indivisible, as well as being crucial to knowing the patient. When I asked her to talk about the caring characteristics she felt are most important, her explanation differentiated between quantity and quality of time, as she said,

> I think empathy...I think the ability to...put your personality inside that person and feel a little bit of what they're feeling is the most important thing. And taking the time with them. I mean, time is such an important thing that you can't separate it from anything that I said, with anything you do like that it takes time. And they deserve that time, too...but, there has to be some interaction. There has to be...the whole idea is you've got to be able to project that, 'I do understand your feelings, and I care about it'.... And then they recognize that. The human mind just recognizes when somebody really is concerned about you. I can't miss it and I don't think anybody else can either, you know...if you go in with someone, and you take the time to sit down and talk to them, and you know what's going on because you've spent that little bit of time with them, then you know what to do to make it better for them at that time...and that's quality....So, when you have—to have quality time, you've got to sit down, it doesn't have to be—a large amount, but it has to be something that you're interacting with them on their level that lets them know that either you've been there or you're feeling what they're

feeling, and I don't find it any shame to cry with the patient who's crying or laugh with the patient who's laughing....

Open-mindedness

Open-mindedness as a caring characteristic emerged from the data and was characterized as accepting others by being nonjudgmental and having tolerance for diversity, both of which emerged as caring attributes possessed by caring nurses. These characteristics comprise one's ability to accept others as they are without imposing one's own value system on the other. RN Participant 9 related that acceptance was important in order to convey caring towards another. She said,

> ...Well, I think you need to have an attitude of...acceptance. You have to know that...your values are not always their values. That if a child comes in with...no shoes on and dirty clothes and you know, grungy feet and green teeth and all of that...that I can't just always assume that they're skanky people because my value system may not work for them, but yet...I still need to care for that child and for that family and I do.... And with the hope that maybe there's something we can give them in the way of...help and, and teaching maybe that would...improve their life a little bit.

Another type of acceptance as tolerance included in the domain of connectedness is the ability to endure or be patient with the frustrations of the person who is unhappy at having to wait to be seen in the emergency department setting. This attribute of tolerance is important for a caring nurse, as noted by RN Participant 9, who said the emergency department setting alone often conveys to the patient that they and their crisis are not the

most important current event, thus setting up a hostile situation which must be overcome. When I asked how she was able to convey to her patients that she was truly concerned for their well being, she noted,

> ...Well, when I was...in the ER working...you know, we—right off the bat we convey it—that their crisis isn't always as important to us as some other crisis because we assign them a triage level. And we, we, you know, even though it was a big enough crisis for them to feel like they needed to come to the emergency room...we give them a level II or a level I—that right up front tells 'em, 'Well, it's not the biggest crisis we have going on and your crisis will have to wait.' You know. And so, then when they get to the back or when it's their turn to come to a room—you get a room open and you bring them back—they're already mad. They're already frustrated. They're already feeling like nobody cares. So, then you have to just try as much as you can to—explain to them that, you know, their crisis is important to you, but sometimes we just have to sort and, and you know, take care of the ones with the most life-threatening things first, but we're ready for you now and we're here and let's do what we can do to, to get you feeling better or to get your problem taken care of. I mean, it—there's a lot of time spent on—service recovery, you know, because they're unhappy that they broke their arm or they cut their hand or whatever brings them in to the emergency room today. They're already unhappy that that happened to them. They didn't want to come spend the evening in the emergency room, and now that they have and...they've been waiting now for two or three hours and then they're really

upset about that, and so, you, you have to not take those things personally because they do want to lash out and you're the one that's there.... But you also can, there's a way you can de-escalate that, rather than letting it escalate. You can...de-escalate it if you work at it rather than—you can be just as...you can let their attitude frustrate you to the point where you're hateful back to 'em and then it's a lose-lose situation. But if you can realize that it's not you they're mad at, it's the fact that they cut their arm and the fact that they had to be here and the fact that there were—that it was crowded and they had to wait, and now, you're finally there to bring them back to a room and they're just gonna lash out at you. And, just, it's the situation and...not necessarily you that they're mad at.

RN Participant 13 also alluded to the interaction between nonjudgmental acceptance of the patient and making a conscious choice (i.e., having a positive intent) to act in a certain way in interacting with the patient. She discussed that while she had in her 1½ years as an RN become more efficient in delivering her nursing care, she felt she had not made any shortcuts nor decreased the quality of her care. She also mentioned the importance of having a genuine love for people and having the ability to "take them at their worst." I asked if she made a conscious effort to maintain her quality of care and she replied,

Oh, yeah. And...I know I do catch myself—one time, it was my fourth day and I was getting a little irritated with a person but I still tried to—even though they were, irritating me not to let them know that they were, were doing that, you know...'Cause I don't want them to think that. 'Cause it, it's not always that

person's fault. And you're seeing them at their worst. (laughs) So, you can't make, you can't, you have to help them along. 'Cause they might not normally act like that—if they were feeling good. So, …you just have to remember….

Time spent with and given to a difficult person represents caring for that person. Being open-minded and accepting of others enables one to see the possibilities of spending time with another. RN Participant 19 related that she believed she should give more time to the most difficult people because she believed that they needed her time the most. She described her thoughts on spending time with others, and on showing acceptance and tolerance for others, saying,

> …I think we need to give time to the most difficult people. You know, they're, they're the ones we want to neglect most because they're so hard to deal with, you know. The person who, who curses you, the person who tells you, 'Get out of my room before I throw something at you,' obviously they're in need of something, and if it's mental illness, you know it's gonna change. It's so amazing to watch. I had a patient that was cursing me three weeks ago and…but you tell yourself enough, 'You know, a week from now it's going to be different.' A week from then it was. The same man didn't remember the words that were said to him that were right, but he remembered that the feeling that he got was right. And he would come up and say, 'Well, Miss…can I make you a cup of coffee?' … And he would say, 'Can I make you a cup of coffee?' and 'How are you this morning?' This is the same man that was calling me every name and some that none of us had ever dreamed of, you know. So…it makes a big difference what

you do in caring for the person who is the most unlikable, the most, uh, the one you want to reject the most, because chances are he's been...rejected the most because of...attitude. And, it's amazing how, if you take the time, in spite of it all, and say, 'Okay, you really feel angry, and...I understand that. I don't know exactly why, but I've felt angry before.' Sometimes just...having a little self-disclosure, saying, '...So when you're ready to talk to me, you let me know and I'll be here, but I'm not going to push it on you.' Half the time I'll get to the door and they'll say, 'Come back a minute.' That's really amazing.... You can say something like... 'Well, I'll be back when you're ready for me and if there's anything you need,' regardless of what they say, 'If there's anything you need, please let me know.' That lets them know I'm still listening to you, I still care about you, regardless of what you've done. And you have to always wonder, how many people, in a sense, rejected them and they're not going to trust anybody. So you have to kind of build that trust.

RN Participant 19 also spoke of listening to the patient and being nonjudgmental and accepting of the patient as being necessary in caring. These abilities are founded upon and interact with one's patience, or the ability to endure and persevere. She related the following, when asked to elaborate on a more explicit explanation of time spent with the patient, as well as accepting the patient,

...That kind of goes along with...unconditional care.... I think you have to...we can't pick our patients, we can't say because this person has led a terrible life, or...I disapprove personally of what they are doing, that I won't give the same

> quality of care that someone else would get...you know, the care has to be the same...as far as their personal care, there can't be any differences made. You can't avoid, you can't leave, you can't say, 'Well, they're capable of walking—they can get up here, too'...for those patients, you know, I think more than anyone else...that's the challenge, that's the ones that you go to, those that want to toss you out, and those that are unlikable, unlovable, and see if you can kind of find something that'll win them over a little bit, because I always believe there's something in their past that's made them that way.

Patience

Patience is the ability to endure and persevere with another, which enables one to fully connect with the other, being there for the other, and caring for the other. Swanson (1991) alluded to patience within her caring dimension of being with, saying, "Being there includes not just...physical presence, but also the clearly conveyed message...to endure with the other (p. 355)." Patience was evident in the stories of the nurse participants, who discussed patience and the interrelationships with time, open-mindedness, and truly connecting with others.

RN Participant 7 spoke of needing to have patience not just with people but also with situations in her practice as a flight nurse. She spoke of a role model who during stressful code situations was able to lower the anxiety in the room by his calm, controlled presence. In emulating his actions, she said she consciously tried to model the same effect with others when on a regional call in another health facility or when she had to wait for her patient to be extricated from an accident scene. Her positive attitude and intent to

defuse the anxiety within a situation by remaining calm and being patient represented a caring attribute that she identified as being valued by her. She acknowledged patience as an important nurse caring attribute and when I asked her to elaborate, she replied,

> You have to be…in stressful situations…people tend to react in different ways. And over the years, what I've noticed is—have you ever been with Dr. H. in a code or with a sick pedi? That's the best example I can think of. The way he reacts to the situation affects the whole room. So I try to go in and be patient with—you know, whoever may be—if there's somebody who's really stressed, or—how do I put this…in a high stress situation, sometimes people wig out. Try to bring them back to earth—and hopefully not wig out yourself (laughs). You know—and it's not that I accomplish this—I work towards it.

I asked for clarification, "And you try to get rid of the anxiety…by being a calm, patient person?" To which she replied,

> Yeah. And I'll go in and I'll say 'Hello' and it's usually people that I see in the region, you know, and 'What do you all need?' … It's, it's a hard enough situation…without making it harder…. Patience with situations, too, not just the people. If we've got to extricate somebody—these are all things I strive for…

RN Participant 8, discussed patience, empathy and the interrelationship of these with connectedness when she described the importance of putting one's self in the other's place and wanting to do for the patient what she herself would want to have done for her or a family member. This empathetic perspective can assist the nurse in connecting with the other, as RN Participant 8 described when asked what it takes to be a caring nurse,

with the patient through taking the time to listen to the patient with having a positive intent and attitude to take the time to listen. She said,

> …You have to have good listening skills. A lot of them don't want you to do anything—they just want someone to talk to. And if you always go in and act like you're in a hurry, then they don't want to take up your time so they're not going to bother you or if you're real short with them.… You need to be able to spend time with them. I think that they see nurses as always rushing in, rushing out, and never taking the time to just sit down and hold their hand or rub their back or just be there with them. Ask questions—I know I've had patients where they don't want to say anything—they're afraid that, you know, that they're going to take up your time—or, be what we call a bad patient. So, sometimes you have to ask them questions to get them to start talking. You've gotta be willing to go that extra mile when they do start talking and maybe they start telling you problems and you know there's other things you can do for them. You've gotta be willing to take that time and go to bat for them…

In telling me about a particular experience in which time spent with the patient made a positive difference in the outcome of the patient's care, RN Participant 5 talked about willingly taking the time to meet the patient's needs, reflecting a relationship between time spent with the patient, as well as her patience and positive intent to be caring. She told me about a situation in response to a question about how she showed she cared for her a particular patient,

> ...I had one little lady...a couple of weeks ago—very confused—the family very worried that she would fall and hurt herself—and so, instead of restraining her, I spent most of my evening just sitting in there with her so I didn't have to restrain her but I could keep her from hurting herself and just talking to her.

RN Participant 11 also acknowledged the importance of accepting the patient as he/she is as well as tolerating the patient's frustrations even if directed towards her, showing an interaction between acceptance, tolerance, and patience. She told me about a particular instance when she believed she exemplified caring in one of her interactions with a "difficult" patient who had problems with several of the other staff nurses, saying, "...I tried to be very patient with her because I could tell she was scared to death.... I did not take anything personally that she said." In exploring what she thought were the characteristics that were the most important for caring, she talked about patience, alluding to an interaction with having a positive intent, saying,

> ...Patience. I think patience is just so important.... You know, you go into a room and—if ... the patient has called you 10 times and you walk in there and say, 'What do you want?' (roughly said) I can't imagine myself doing that. Now, granted, I do have some patients sometimes that I know are just a pain in the butt. You know, and they want you to take care of them, and they want you to wait on them hand and foot. And so, I—maybe outside the room, maybe with another nurse, I'll say, 'Oh, this patient is really getting on my nerves.' But see, when I go into the patient I leave it out there. And, and, it's—you know, you just take a deep breath and you count to ten then you count to ten again.... I know there are a lot

of nurses that don't do that. And…once again, if you don't have the patience then you don't have that bonding, you don't have that rapport. And I think you have to have that with the patient. You really do.

RN Participant 18 iterated that he believed his patient disposition and his ability to spend time effectively with others arose from love of others and was based upon God's love of him. He addressed what he believed was necessary in being a caring nurse by saying,

> Well, of course, it takes patience and time. Sometimes it's easy to be nice and to care for somebody. Sometimes it's hard. When somebody's coming off the bed and they're cursing at you. It's hard to be caring, well, I mean, caring for them would be trying to protect them and yourself and protect them from harm…and that might mean holding them down or something or restraining but…I really, it all comes, I guess from…love. And, I guess, in my case, I would say that the love that I've been shown, you know, all my life, I look back on it and I'd see how God has loved me and how he's protected and cared for me. He's put people in my life and He's done this or He's done that. And out of that…from knowing that He loves me, I feel secure in that so I know I can begin to share all of that or give love and it's only because of that, I think, or it's because of that, that now I, I feel like that's what I want to do. And I try to do that, I try to live like that.… Let me clarify, love for others is because God loves them. You know,…Jesus said…love your enemies. You know, He said it's easy to love those who love you.…And…you just have to first, understand that this person is important to God

so you had better respect this person. You can't just think that this is nothing here. No matter how—what kind of ragamuffin they are. And so…after love,…that's what the basis would be. You know, we're told…by the Lord to be merciful. You know, to give a cup of water to the thirsty,…to, if somebody's hungry, feed them, somebody needs some clothes, give it to them because that's what he wants us to do, and that's I guess, to…show them, through us, His love, through us if He can. To try to reach people after all, and that's what He wants us to do, that's why He sent Jesus was to try to reach people to show them the love that He has for them and Jesus was that manifested…we try to do that, I try to do that as, because that's…what I need to be doing right now.

Intent

Intent was the third identified domain of caring characteristics and included several interrelated concepts, all of which enable one to freely chose to act in a certain way: (a) one's possessing a positive attitude and intent, (b) being kind and compassionate towards others, which arises out of love for others, (c) being concerned and showing consideration for others, (d) being hopeful, (e) trusting others, (f) having the desire and willingness to help and serve others, and (g) fulfilling one's obligation and duty to God and others through service to others. Intent is a core value, the foundation of which is based upon one's ability to maintain a positive attitude in daily interactions with others and in choosing to act positively towards others. Upon this underpinning, the other concepts are layered providing depth to the meaning of possessing an intent to care.

Positive Attitude and Intent

One's ability to maintain a positive attitude in daily interactions with others as well as choosing to act in a positive manner towards others emerged from the data as the nurse participants related their stories. These nurses' freely choosing to be positive was a hallmark of their interactions with others and affirmed their intent to engage in a caring way with their patients.

RN Participant 1 said simply, "...I think ...because that's what I want to be; that's why I got into this...," expressing her desire and intent to be caring towards others "...I don't' know it's just in me, I think."

RN Participant 3 confirmed that she believed in choosing to be caring by saying, "I just think if you're constantly, constantly striving to be caring—and doing the best that you can...and always try to think that everybody is worth knowing...".

RN Participant 4 addressed the free choice she made in giving her best care to a difficult patient, such as a prisoner, demonstrating freely choosing to be nonjudgmental and showing tolerance, saying,

> ...So I try to focus on...taking care of them, being kind to them, ...because it's not my business what they did. And I try to treat them like I would if that was my mom anyway, and that's real hard to do. But, I really think, I consciously think that when I'm taking care of them. They deserve the best care that I can give them in spite of what they've done...

When asked how she maintained her level of caring, RN Participant 4 replied,

> Well, re-evaluating it—like on the way to work I usually think about what I'm going to do that night. That's usually what I do on my way to work is, is to try to pray and say, you know, "please let me have a good attitude and um, let me do the best I can." Everyday. On my way to work.

Possessing a positive attitude and having a positive intent was evident as RN Participant 5 addressed her conscious choice to be a caring nurse by saying,

> I hope I am, I try. I know, every shift, there's always that patient that tries your patience, and you know, it seems like it's going to break you that night, but I try very hard to treat every patient that I have like if they were my family member, like I would want my family to be treated. That's kinda how I look at it. I wouldn't want them to have bad care.

RN Participant 7 believed she had a positive intent and the conscious awareness to be a caring nurse every day with each and every patient interaction. She noted her effort to act positively and in a caring manner, saying,

> I hope that I'm a caring person—I try to be a caring person. The two most important things in my life are first my family—my children and my family and next my patients…but—what I do as a nurse, and what I do in my profession directly affects my everyday life. How I feel—my mental well being—I mean, it's like if I don't feel that I've done everything I can for a patient, it just kills me…I have to know—I've done the best I can for that patient… Can I provide what's needed? Not only, skill wise, but caring. I think I…could always work on getting that across to the patient and letting them know, but I try, I really try to do that.

RN Participant 8 iterated that part of being a caring nurse entailed "being upbeat—having a positive attitude...." Her beliefs in having a positive attitude expressed her positive intent to freely choose to act in a certain manner with her patients.

When I asked RN Participant 10 to tell me about a situation in which she felt she exemplified caring for a patient, she replied, expressing her positive attitude towards her patient care practices and her intent to be caring, "I hope that every day I do that. I hope that with...all the patients that I care for that I give that little extra special—touch."

RN Participant 11 said her positive attitude was a choice she freely made each day, with the consequences of self-fulfilling prophecy. She noted a positive attitude, which in her opinion was the number one characteristic needed by a caring nurse, was interlinked with her faith in God, saying,

> I think that a person has to have a positive attitude. Um, my cup is always half full. You know, there's very, very few times that my cup is half empty. And I think that, when we get up in the morning, we, we can say, 'I'm gonna have a good day,' or, 'I'm gonna have a bad day.' And I think that if you tell yourself that you're gonna have a bad day, then you go about making that happen. Um, and—I know it's—in these days, you're not supposed to talk about Christianity or any of that—but, I was...raised in a Baptist church, but I haven't been to a Baptist church in years, I go to the Catholic church, so, I'm not going to say it's really religion, but it's my spirituality. I talk to the Lord all the way to work, and sometimes I forget...and the day's going really bad and I say, 'I know you're there, Lord, I know you're gonna help me through this.' So, I think positive

attitude has, has a lot to do with it. But, I don't think I would have the positive attitude without my faith. I really don't. Because that's what gets me through.

RN Participant 13 noted that she wanted a positive outcome for all of her patients and her intent was to "make 'em well, and send 'em home," because that was what she liked to do. She said, "I like to see them get well and I like to help them and...make their stay in that type of situation pleasant as possible." When discussing what she felt she needed to be caring, she replied,

> ...A good outlook on life and a positive attitude. And then if I have a problem at home, I leave it at home and I don't bring it to work. Because I see that that can tend to affect a person and the way that they provide their care to their patients. Liking people, wanting to be helpful and just wanting a positive outcome for that patient is important. So, I hope I never lose it. I had one person say that, 'Well, just give you a year and you're gonna do things a lot differently.' And I really try very hard that I'm not changing the way I do my care. And I haven't. I've gotten more efficient at it, but I haven't changed any—I haven't made—any shortcuts or anything like that. I've just become more efficient at what I do. But, I just, I'm not going to—change anything. I like how I give my care.

Kindness/compassion/love for others

Another caring characteristic that emerged from the data included kindness, which was also addressed in the stories of the nurses' as compassion, which I believe emanates from one's intent to be caring. One freely chooses to be kind and compassionate toward others as one lives out one's life. Showing kindness and

compassion towards others is caring enacted, founded upon one's feeling of love for others. Several of the nurses addressed these concepts when relating their caring stories.

RN Participant 2 said it was important for caring nurses to "have some type of kindness and loving in their hearts," and RN Participant 4 believed that a caring nurse has "love for others as well as yourself."

RN Participant 14 discussed compassion, kindness, and love as important in being a caring nurse. She acknowledged her intent to treat everybody with compassion and kindness. Replying in response to how she knew she was a caring nurse, RN Participant 14 addressed intent as an internal feeling of love and compassion for others,

> I feel it.... It would have to be caring because I love children, to begin with.... It's just a feeling on the inside.... I think compassion of course, which any nurse, whether it's a pedi ICU nurse or an adult nurse, it's compassion. You have to have compassion.... A basic kindness. Love. And...I think, just a, a basic human decency...(Compassion) means, to me...being able to...put my patients first.... A lot of times...we're overloaded and, and we've got eight million things going on, and it's taking the time to go into that room and stay. And just, if nothing else, just listen. Listen to the patient or listen to the family, and just be able to sit down with them and say... 'I'm here for you.' And...it may mean that I have to stay until 9 o'clock finishing my charts but that's okay...that's compassion. You know, that's just genuine caring...(Kindness)...that's like I said wanting this to be as less traumatic for them as that could possibly be.... Whether you're having to start an IV, which you know, scares children to death...it's remembering to put on

that EMLA cream before you have to poke 'em and, and if they want a Popsicle, you'll make sure that they get it ...it's just a basic human kindness...

RN Participant 18 said he tried to model his life after Christ and felt that his mission as a nurse was to emulate Christ through showing compassion and kindness towards others. He said,

> ...He felt compassion for people...and I'll work to imitate Him...part of my job is to, I think, be kind... Caring is...going a little bit above just the...technical part of nursing. And maybe showing them some kindness and some encouragement or something.

RN Participant 3 said showing compassion through her tone of voice was an important caring characteristic for her as a poison information specialist since the majority of her nursing practice was conducted over the phone counseling terrified moms whose children have had an accidental ingestion of some type. During our interview, I noted her very calming, soothing voice, which expressed compassion towards others. When I asked her how she exemplified caring in her current role where she never saw the patient, she replied,

> Well, I think that...you have to learn when you come to the Poison Center because you're doing your care over the telephone. And so you really have to...brush up those voice skills in conveying...compassion and caring over the telephone...because...you can't touch that mom and you can't touch the kiddo...so it's very difficult—or it's harder.

RN Participant 8 identified compassion as emanating from a love of people, saying,

> ...Compassion for people. Just basically a love of people...you've got to...like dealing with people, dealing with different personalities....I have a love for people—my main goal of the day is to be sure my patients—are not only—well taken care of medically—but emotionally and—physically—like I said, adding an extra pillow or an extra blanket—and I usually—warm up to my patients pretty quickly...once you've formed that relationship with your patient, it gives you a sense of—accomplishment maybe. That—you are doing what you live and someone else sees that also, that you are a caring person and that you're willing to go that extra mile for them and—be a patient advocate. Stand up for them.

RN Participant 10 talked about compassion for others as an important caring characteristic as well as having a good heart. The caring nurse's intention to care was evident in her explanation as she said,

> A caring nurse has compassion for her patients as well as for the family...a good heart...just being a good person, in general. I think, that...you have to be a good person in order to give people the best quality of care that you can. I think that you have to have that just inside in order to give that to others.

RN Participant 12 also identified compassion for others as an important characteristic for a caring nurse to possess. She said, "You talk about caring, it's just you have feeling for people, you have compassion, you have empathy..." She identified love as the motivating factor in her caring practice saying,

...It's just a great bunch of people. It's why I love my job. And it's just—I look forward to going in there. No matter how stressful it becomes, I look forward to going back the next day. It's a new challenge every day, new situations every day, just like it is in nursing. It's always that way in nursing. But I love the psych patients...I guess a willingness to sacrifice—but that's kind of the definition of love, isn't it?....You have to be able to love people. That's probably number one. I think all the rest falls right in if you love people. The rest of it is just going to fall right in there.

When asked to explain what caring meant to her, RN Participant 13 replied,

Well...I just like people...I like to help them...I just really love the people that I work with...I just really like people...Just a genuine love for people...It's gonna help. This is not a—you shouldn't get into nursing if you don't like people.

RN Participant 14 also addressed caring as being kind to others as a basic human value. She said, "I think it's just a basic human decency and dignity and...I think it's just a basis of how I practice. I mean, that's why I'm here—is to care for these children...that's my job and I love it." She responded to a question about why she entered nursing,

...I think it's just, I don't know, well...it just seemed like something that I wanted to do. Call it a calling? You know, I don't know. It was just something that I'd always wanted to do. And...I admire the friends that I have that were nurses. I admired them, their attitudes, their hearts...

I asked RN Participant 14 to clarify the concept of heart. In talking about nurses' hearts, she explained,

> ...Their heart...I think...the compassion, the kindness...I just think people set different priorities in life and I think...most nurses have the same priorities in life and...they do base their lives, I think, in a compassionate nature and...being able to love mankind no matter what...a lot of times when its, its hard to love somebody, you know, as when there's somebody yelling at you but you do it anyway. And...I think that's just a special, I think it's a special talent. I do.

RN Participant 15 mentioned love as an attribute needed by a caring nurse as she explained what she believed caring nurses possessed that made them caring. She said, "I think that they need...to be in touch with their own feelings because...I think they need to know what love is, I think they need to have experienced love within themselves and in their own life."

RN Participant 17 felt that a genuine love for nursing formed his intent and allowed him to do what he wanted to do. He believed that if one has love for the profession of nursing all other caring characteristics will follow. He told me, "...if you love it and if you really, genuinely want to be there then all those other things as far as acquiring more knowledge...broadening your horizons, being more adaptable, flexible...those things will follow."

RN Participant 18 also mentioned that caring emanated from love. He explained,

> ...It all comes, I guess from...love. And I guess in my case, I would say that the love that I've been shown, you know, all my life, I look back on it and I'd see

> how God has loved me and how He's protected and cared for me. He's put people in my life and He's done this or He's done that. And out of that, you know, I know that now…knowing that He loves me, I feel secure in that so now I can begin to, to share all of that or give love and it's only because of that, I think…that now I, I feel like that's what I want to do. And I try to do that, I try to live like that.

Concern and consideration for others

Concern and consideration for others were evident in the caring nurses' stories and, I believe, were primary to the characteristics of kindness and compassion, emerging from one's love for others. These interrelated concepts make note of a caring nurse's focus on another and in meeting that other person's needs as a purpose for being. Caring intent was inherent within the following examples of concern and consideration for others.

RN Participant 3 believed showing concern for the patient to be the number one caring characteristic, and was what she tried to do with her patients in caring for them. She discussed how concern was an important caring attribute, saying,

> …Making the patient think that you care about them and care about what happens to them—that is absolutely number one. However you go about doing that…so I always try to touch the person, make eye to eye contact with them and…basically ask them how they're feeling and just show consideration in…all the questions you have to ask—well, like when you get a cardiac patient in—you very quickly have to get certain information—as far as their level of pain and where the pain is,

> and describe it and have you been sweating and do you have any nausea. You've gotta get these things down because it's very important to the patient and you have to do that very quickly. And sometimes that seems impersonal—at the same time you're starting a line on them and putting O2 on them and getting them hooked to the cardiac monitor and during this time…they're very petrified. A lot. They're in a strange environment, they don't know what's being done to them, they don't know what is wrong with them and…you've got to do those things very quickly before you can get to that point where you can show them some compassion….But as quickly as I can, I try to get to that…and talk to the patient for a moment or ask them about their family…I try to get family members at the bedside as quickly as possible so that they don't feel so alone.

RN Participant 3 also talked about the importance of showing concern for the patient's outcome. As a poison information specialist, she routinely called parents back one hour after initial contact to follow-up to see how the child was doing, a practice which was most often mentioned by the parents in thank you notes received after the event. I asked did this follow-up call convey caring through her showing her concern for the child's outcome. RN Participant 3 answered in reply,

> Exactly. Instead of just giving them the information, 'The kid's going to be fine,' and hanging up. When we call back, the mom's a lot more relaxed and feels a lot more comfortable and she's not upset and so, at that point, that's when you do a little more personal interaction with her.

RN Participant 7 spoke of how she showed her concern for her patients and families in the unique practice environment of the helicopter, upon arriving on scene. She said, in response to my question of how she let her patient know that they were in good, competent hands,

> Find out what their name is—very important. If, for some reason, I have sunglasses on, I take those off so they can see my eyes and face. I introduce myself and I try to do that whether it's interfacility or on scene to the—not only to the patient and family but the staff.... Ask them, just ask them, 'Where do you hurt?' You know, try to figure out what I can do to help them—whatever their needs may be...asking if they have any questions...trying to explain to them... who I am and what I do and where we'll be going...(with families) let them know we'll do the very best we can...and I always tell them to be careful going—drive careful, drive safe.

Hope

Hope evolves from a caring nurse's positive intent to make the patient's experience less frightening and more pleasant and is communicated to the patient and family through the nurse's caring concern. Hope, one of Mayeroff's (1971) eight caring ingredients, may directly impact one's having a positive outcome, and is integral to caring. The nurse participants' stories suggested each wished for a hopeful outcome as they talked about wanting the best result for their patients by giving them the best nursing care possible. Swanson (1991) identified a caring dimension as maintaining belief and described this as the foundation to nurse caring through the sustenance of faith in the

capacity of others to go through life events and transitions with the ability to emerge into a future that has meaning. In this sense, I believe that hope is a corollary to the sustenance of faith.

RN Participant 1 talked about establishing a caring bond with her patients in the Emergency Department setting, humanizing the experience by calling the patient by name. This acknowledgement of one's humanity fostered hope for the patient that they are valued and someone did care what happened to them. She explained,

> ...One thing I try to do, and CS taught me this, what that—you know when you're working with a critical patient, everybody tends to distance and you're treating the 'thing', not the 'person'...But...even if they are head injured, or whatever, talk to the patient. Go to the patient and say, 'You're at (hospital); we're going to take care of you,' and whatever. And I mean, the whole room goes quiet...it's like, 'Oh, wow—she's talking to this person.' You know...I try to do that as much as I can and them I also try to be very—cognizant of if I have family available and letting them come in when they can and getting information to them.

RN Participant 3 talked about calming the hysterical mother when a poison center call came in. In taking this call, this caring nurse immediately reassured the mother that all would be done to make sure the child was okay, giving the mother hope that all would be well. RN Participant 3 said,

> ...But...most of our calls, I would say, oh, probably 70%, 80%, I don't really know, are from moms at home, whose child just ate the leaf off the plant or just

ate grandma's medication and so our number one goal, whether the child has to go to the emergency room, whether it's a critical situation, where they need an ambulance, or whether it is something that is basically non-toxic—the mom, to her, it's toxic at the moment—so the number one thing is to calm mom down and it is tougher, but the very first thing you say is, no matter—even if it is a critical situation, 'I want you to know your child is gonna be fine—we're sending an ambulance, but there is treatment for this, we're gonna get him in the hospital,' and you try to...calm mom down. And even when the child takes a swallow of bleach which is basically ...not a problem with that...you've got to tell the mom and the first thing you say to them 'cause very often they call and are crying and it's difficult to get information, is you tell them, 'I want you to know I need more information, but your child is going to be fine....'

Hope is what may sustain a patient through a critical illness or injury. RN Participant 4 related an experience with a patient in which hope played a role in his recovery. Relating to her patient through his Irish heritage, RN Participant 4 promised to make him some mashed potatoes for him when he was well enough to eat. She believed that this small gesture gave her patient hope to sustain him through the critical period of his injury. She told me,

...I had a patient...he was traveling through...lived in Chicago with his wife and ...was going to Arizona to spend the winter, and had a car wreck here. And he'd been on the ventilator for—he was severely injured. And he was unable to eat for probably a month, he was in our unit for about a month. And I promised him,

when he got off the ventilator, I would make him some mashed potatoes. Because he's Irish and I asked him if he like mashed potatoes. So when he got off the ventilator and was able to eat, I made him some mashed potatoes. And…that kinda got him through—every day I'd come in and he'd write me a note…and say, 'Do you have any potatoes with you?' … That's…kinda small, but he and I still communicate.

RN Participant 6 mentioned that when building rapport with his patients he kept them informed, showing a connection between shared knowing and hope. He told me,

…I just go in and tell them who I am—I don't—I wouldn't want to be laying there and have some stranger coming and doing things to me that I wouldn't want done. So I just basically go in and tell them who I am and tell them what we're doing, what we're working for, and that it's going to get better or, or make them as comfortable as I can to help them out.

RN Participant 7 iterated that hope was fostered from sharing one's knowledge. She believed strongly in keeping the patient and family informed during a flight and believed that being honest with the patient and family built a trusting rapport that led to hope. She explained,

With our children—I always like to take a parent…we can take a family member…but they can't see—we've gotta curtain up—but they're up front with the pilot…every so often the pilot'll check back with us and ask how they're doing, or, we'll—we've got an intercom button we can push and we can say, 'Everything's going…fine, everything looks stable.' Just, just to keep in touch

with the family member to let them know how things are going…asking them if they have any questions…trying to explain to them, and, and also introducing myself to them—letting them know I'll be taking care of their child, and who I am and what I do and where we'll be going—inform them—so they know what to expect. Um, if they're flying with us, we'll do a—have to orient them to the helicopter—that's real important. But, um, a lot of times they'll say—'Take good care of them,' as you're walking out the door. So I try to—if they can't go with us—in some way let them know we'll do the very best we can. If the patient is really sick like—in the instance that they may not make it to the hospital—I try to prepare them in some way without, you know—saying—'They're very ill, but we'll do everything we possible can.' And I always tell them to be careful going—drive careful, drive safe.

RN Participant 12 shared how the psychiatric patient needs a safe harbor in order to feel trust, which in turn fosters hope. She explained to me,

…They keep coming back. You know, because they don't take medication for one reason or another…they're very frightened. They have a lot of…trust issues. And they come to the unit, and they know us, and they feel safe. They feel comfortable. I really do care about what they're feeling, what they're going through, and I can sit down and listen to 'em. And sometimes we just sit there. And they're just feeling lonely, and I don't say anything and the patient doesn't say anything.… I can't really define caring—it's just a gut instinct, it's just something you do as a human being. And we're kinda all in this together. And I

read somewhere that life is short but it's long on pain—we're all here to help each other. I think that just says it for me…whatever a person needs, I'm gonna try to give them what they need…

RN Participant 13 talked about wanting a positive outcome for her patients and by orchestrating this, she often shared experiences of past patients in order for solutions to be generated. Hope emerged from empowering patients to take charge of their situation. RN Participant 13 explained to me about wanting a positive outcome for her patients,

> Well…if I can share with them things I've noticed on other patients I've take care of, things that work, then I'll share that with them, or…feeling a positive outcome…I'm thinking of my…alcoholic abuse type patients, you know…. Let them talk to me about what they think their problem is and then have them…I want them to come to realize that they've got a problem…then say, 'Well, how can you help yourself with that problem?' … (Sharing) gives them a better outlook…. Also, a, maybe a knowledge of what to expect, you know. I, I know that everybody can't be happy and so forth, but I like them to be able to—it's not that they enjoy their stay, but make the best out of the, the worst situation. And so that, when they think back on it, you know, I had this terrible thing but I had this person to help me through it and I made it….

RN Participant 13 also shared with me that establishing a positive attitude with her patients made a big difference in their outcome, with hope being generated with a change in attitude. She said her practice was to set a positive tone for the day, with a resultant self-fulfilling prophecy in that she expected to get along well with everybody,

therefore she did. She explained, in response to my question if having a positive outlook could give the patient some hope, and how she set the stage for a positive outlook for the day,

> Yeah, yeah.... I have seen—where someone's, you know, how can I say it—with a positive attitude...I have gone in to where I've gone into a room where a person says, 'You're not going to do this and you're going to do this and I don't want you in my room.' ... And with a positive...outlook, at the end of the day, that person is sad to see me go, you know, and their whole attitude has changed from being very, very negative to being, 'Well, what can I do for myself? And...how can I do this?' And just a different, a totally different attitude...I...come into their rooms and I...always have a smile and...people will say, 'Gee, I haven't had anybody smile at me all....' You know. It's nice to see a smile. Also, I have a way of ...when I go into...my patient's board—we have a board on the wall, and it tells who all's involved in the care of the patient. Okay? And so, on my board, always will be a big smiley face. And everybody...you'd be surprised what kind of...it affects the patient and...if I get a comment about it, I say that I always like to start the day out with a smile. And so, it's just a big, ole smiley face. And it's of course, it's...a little better than just your regular yellow smiley face...there's a character, the face has a character. It just, you know, the eyebrows go up, and the smile is big and it's got indentations (for cheeks)...and it...really does make a...change in the patient. And...if they say something, I say, 'We're going to start the day out with a smile.' And...you'd be surprised how that...changes things. I

like that, too…it also helps you feel out what that patient's feeling that day, too. If they…if they're able to crack a smile with it or not.…That's how I meet everybody first thing in the morning. Names on the board, and smile on the board, and…then we start out the day…and it really works good, I find.

RN Participant 17 talked about giving his patients prior to surgery a place to look forward to be after the surgery. In planting a forward outlook in his patients, he was instilling hope that all would go well during the surgical case. He explained to me, "…I always tell them…I tell my patients…, 'You have pleasant dreams, and I'll see you in the recovery room. And I'll take good care of you.' I say, 'I promise I will.'" In establishing hope for his patient preoperatively by creating a zone of comfort, RN Participant 17 said,

…It's tough, because you can tell them who you are, and you can try to…let them know that you're here and you'll take good care of them.… I think that perhaps the greatest area zone is not necessarily acquired by the patient, but by taking care of the patient's family. Because if you let the patient's family know, if you can establish that, they you've done…something to let somebody else know to kind of ease their anxiety because the patient's that, that themselves are going to have experienced anxiety for a short period of time…

Through this connecting with the patient's family, hope was generated. RN Participant 17 responded affirmatively when I asked him if in staying in close contact with the family during an operative case gave hope that all that could be done was in fact being done, "Yeah…most of the time, people want to know, 'Is everything okay, is he, he's not dying….'"

RN Participant 19 also shared with me that forward thinking and helping her psychiatric patients to focus on the future engendered hope for them. In telling me about the positive patient benefits obtained from a caring interaction, RN Participant explained to me how she helped her patients focus on the future. She told me,

> I think they…gain a certain amount of trust.... They…leave knowing that somebody cares, because…they are treated very badly on the streets…they're not treated with a lot of respect with some of the places that they stay.... Most of them want to work, and can't because they're on disability that says, 'If you work, you don't get this,' and they can't make enough to do it. So they're deprived of that hope and by talking and being with somebody who encourages in other ways, things that they can do to fill their times, to explore their talents, to… continue their medications, you know, to do that teaching, so that they can progress, they realize that somebody has taken the time to look into their life, you know, and, and open up some doors that they can follow through when they leave as well…we had a girl not long ago, that's an excellent artist, just fantastic, and I take *Psychosocial Nursing*, which publishes a picture every time done by someone that has a true mental illness. And…I became fascinated by the idea that she could probably get hers published in that book. So, I wrote to them and got all the information and gave it to her. And she was very, very excited about that because she…can do wonderful things…and she was going to do that. Now for her, that's a big encouragement, because this girl had been on Clozaril and of all our wonderful drugs, it's one that appeared to be stopping working on her.

> And...she'd been on it about, I think...about seven years. So, she was having to get onto something else, and it was not working really well like the other had, so...for her, this was something when she left to follow up on, she...knew that somebody had taken the time to go and write and get the information and bring it to her, you know.... They have something to follow up on when they leave....And they also know, we tell them that they can call us, anytime that they have a problem or a question about medication, or just want to talk. And we do have patients that do that...I think, just to know that there's somebody there, somewhere that is willing to listen if you have a problem makes a big difference.

Trust

Trust flows from one's relationships with others and is based on building connections with one's patients and families. Building trust is an important aspect of caring and is one of Mayeroff's (1971) eight caring ingredients. Trust and hope are interlinked and together help the patient feel cared for. Trust was evident in several of the nurses' stories, showing how relationships built trust, how honesty was foundational to trust, and how showing concern for others built trust.

RN Participant 1 differentiated between working in a clinic setting where you tend to get to know your patients over time, with a resultant bond that fosters trust, versus working in the Emergency Department (ED) where you may see a patient only briefly before they go to surgery or the critical care unit. Her explanation suggested that connecting with the patient built relationships, which in turn built rapport and trust with one another, even in the fast pace of the ED. She said,

> ...In the clinic, it was kind of an interesting, different viewpoint because you knew those people throughout lots of times.... You saw the same people and you intended to see the same people. That was the goal, which is different from the emergency room. So you knew them, you knew their grandkids, 'How's Joe kind of thing?' So I think you developed more of a bond with some of those patients.... When you're working with a critical patient, everybody tends to distance and you're treating the 'thing,' not the 'person....' But... even if they are head injured...talk to the patient. Go to the patient and say, 'You're at (hospital); we're going to take care of you...' I also try to be very—cognizant of if I have family available and letting them come in when they can and getting information to them.

RN Participant 2 related how her empathetic connection with a young mother helped the mother put her trust in her and allowed her to care for her young child overnight, while the mother recuperated from surgery. She described the following experience to me,

> ...Just her being my age and having this car accident and being far away from home and no family around and we were all communicating by phone with her family—how she must have felt. And—she just, you know, basically put her and her daughter into our hands at the hospital and just trusted us—And so, I felt like I was needing to nurture the child as well as the patient as a sister just because I related to them so much...I just felt obligated and felt the need to bring the child

home with me and make sure she was safe and okay so that this mother could rest and rehab okay…

RN Participant 3's discussion of how she immediately tried to calm an anxious mother who had called the poison center demonstrated how building that rapport with the mother assured her that help was at hand and all that could be done would be done. This rapport then fostered trust, which in turn gave rise to hope that the child would be all right.

RN Participant 4 talked about sharing information with the family to build rapport and trust as well as always keeping any promises she made. In keeping her promises, patients and families learned that she could be trusted to do what she said she would do. She told me,

> …I spend a lot of time with families. I go out to the waiting room if there's some new information that develops and, and communicate that with them. And I've found that has, um, increased my relationship with families more than anything—is that I try to, if anything develops, or if I tell them I'm going to do something, I always do it. Even if it's a—a nuisance…. Which is sometimes real hard 'cause you get distracted. But I think means so much to patients when they know you are going to do what you say. If you show that in the small things, they trust you in the bigger things.

Trust can be instilled by the nurse's presence in a frightening situation. RN Participant 7 related how she tried to reassure the patient that she would not leave them, and by being honest and sharing knowledge with them. As a result, trust develops

between the patient and nurse. She shared with me, in relating the interconnection between honesty, shared knowing, and trust,

> ...Letting the patient know what's going on. What they may feel—what they may hear—when we load 'em, they have to go through a narrow part of the helicopter 'cause we got equipment on one side—and then it opens up, but if they're claustrophobic that could be—pretty scary. So we try to let 'em know, 'You're going to go through a narrow space but it's going to open up.' Things like that. It's going to be loud—when we unload 'em, the exhaust is back there, you go by—it's kind of warm—I guess all these things can be pretty scary—and when you're strapped to a backboard—and you can't move—that's even worse. But...if I tell them, 'We're close by.' We're not gonna leave 'em, if they need anything, you know, they can raise their hand, if they're able to do that.

RN Participant 7 also discussed how being honest with parents and families, through keeping them informed, helped establish a bond which then fostered both trust and hope. This honesty allowed the family to know what to expect and to believe in the nurse's ability to provide the appropriate care enroute to the hospital.

RN Participant 10 identified trust was a necessary attribute in possessing a caring disposition. She told me that she believed the first thing a caring nurse had to have was trust. In exploring what she meant by trust and how she believed trust was acquired, she said, showing an interconnection between honesty, shared knowing, and trust,

> ...I think you just have to be honest with your patient. In what you're doing with them, in what's going to happen with them and their experience. I think that you

have to let them know all the knowledge you have of what is gonna be their experience....and answering their questions.

RN Participant 11 iterated that developing a bond with one's patient was essential in order to have trust. She identified this bond as the most important aspect of a caring interaction. She said,

> ...I think—the most important aspect of (caring) is—developing a bond with your patient so they trust you. So that—the care that you give them—if you need to do something—they're going to trust you to know this is the right thing. And basically, to me, being honest with them. You know, um, just really listening, and um, trying to be there for them. At the same time, I also try to give them as much as their power as possible because when you go in the hospital, you lose a lot of that. We tell patients when to eat, when we're going to take their vital signs, when to take their medicines. So, I try to keep them informed on all that. I try to give them as much of that power, as I possibly can.

RN Participant 19 talked about trust forming between patient and nurse when the patient realized that the nurse truly cared about how they felt and what happened to them. This genuine concern for the well being of the patient gives the patient the confidence to trust in the nurse, as well as in the system and all of humankind. She explained,

> ...It helps you to...identify what that patient is really dealing with, what the bottom line of their problems are, and not just what they're telling you superficially. And...when a person can pick up on that and do something about what the real problem is, then you have a patient that trusts, that has confidence in

the system more, that doesn't feel like, "Oh well, I'm in here to do my time and then get out." You know. And they realize that there are people out there that will do something for them. I think maybe they have a little more trust in all mankind that way.

RN Participant 19 believed patience with people and situations helped build trust. She explained how, in working with difficult psychiatric patients, it was necessary to have patience in order to build trust. She said,

> ...I try to do it in a way that...is not pushy to them because they obviously don't want that.... And rather than just leaving them there, saying, 'Well, they can come to us when they're ready and the meds have kicked in.' Everything will be fine. Because they do come back to us and...there's a big difference and they do remember what you've done, when they've cleared and they're a whole lot better.... But you can say... 'Well, I'll be back when you're ready for me and if there's anything you need,' regardless of what they say, 'If there's anything you need, please let me know.' That lets them know I'm still listening to you, I still care about you, regardless of what you've done. And you have to always wonder, how many people have, in a sense, rejected them and they're not going to trust anybody. So you have to kind of build that trust.

Desire and willingness to serve and help others

Desire and willingness to serve and help others was a common thread among the stories of the nurse participants and was essential to one's positive intent to be caring. RN Participant 2 discussed her desire and willingness when relating a patient encounter, "...I

you know, for a little nursing student, I was just in awe—when he explained to me his situation, I remembered him. And he was an old farm guy and—I want to say he'd had a knee surgery, maybe a hip surgery—he had developed pneumonia—he was in pretty bad shape. And I just remember—once we got report and they said he'd been there for about three weeks—he was doing really bad—and I thought, 'You know, he's a farmer, he hasn't been outside in three weeks.' Everyone was talking about how grouchy he was and, you know, noncompliant, which I do not like that word, but—that's what was passed along in report. And so, I was determined that he was going to have a good day. So I shaved him—he hadn't been shaved in a while—I washed his hair—and I got him a wheelchair with a leg that extended out so that his leg stayed up—that's why I want to say it was a knee—problem he had—anyway, I took him outside. And we stayed outside for about 30 or 40 minutes and just talked and—it was fall and all the trees were changing colors, and—and he remembered that. And he looked me up three years later and gave me credit for saving his life just for a little, a little thing like shaving him, washing hair, and taking him outside. So then we both just sat in the hallway and cried and....

When I asked her if she knew she was going to have that big of an impact on her patient, she replied,

Oh, no. As a nursing student, you just are like, 'Get me through the day, God. Don't let me hurt anyone. But let me make a difference.' And—I really didn't, I didn't feel like—but I—when I left I did not feel like I made that big of a

> difference. We only stayed outside for probably 30 minutes and he said, 'Okay, I'm ready to go back in.' And I'd just think—'Oh, man—I wanted him to be so happy and his attitude to change in the snap of a finger,' but I guess in his mind, it did; he just did not show it that day.

Obligation and duty to serve God and others

Some of the nurses spoke of their nursing practice as service to others as a way of serving God or that without their faith in God, they could not be caring nurses. Believing that one's practice served others and God provided a positive intent to act caring. RN Participant 2 related, "...I just felt obligated and felt the need to bring the child home with me and make sure she was safe and okay so that this mother could rest and rehab okay."

RN Participant 4 talked about putting others (e.g., patients, families, and friends) first as well as having the attitude of doing her job for God as motivation for her positive intent to be caring. She talked about her dedication to her nursing practice, demonstrating her service to others and service to God. She told me,

> Well—I try to treat my friends and my family the same way I do patients at work—um, putting them first,...I think it means to put others before oneself and...I come to work with the attitude of, uh, doing my job for, for God...

RN Participant 7 iterated that her caring practice of nursing occurred because of her beliefs in God. She explained to me, "I know these prayers—I...go through before I go to work and it's very important for me—to go through that and ask, because of what I do and how I perform, I feel comes directly from God..."

RN Participant 14 discussed that her beliefs in God were what motivated her caring nursing practice. She told me, "...I do have a very deep faith. I believe in God and that is a basis, I think, for everything I do. I feel like I couldn't do this job if I didn't have that faith."

RN Participant 18 revealed he had a very deep religious belief about how God wanted him to act towards others, which shaped his caring intent. RN Participant 18 explained, "...A big part of what He did here was healing and...caring for people and He, He felt compassion for people and...I'll work to imitate Him..."

Integrity

The fourth domain, integrity, emerged from the stories of the 19 caring nurses as integral to possessing a caring disposition. Within this domain, four concepts structure its substantive framework, including (a) honesty, (b) respect for others and life, (c) humility, and (d) courage. Integrity, I believe, serves as the foundation upon which the basis of one's character is formed.

Honesty

Honesty, one of Mayeroff's (1971) eight caring characteristics, was identified by many of the participants as being central to having integrity and possessing a caring disposition. Honesty, as a caring characteristic, was interlinked with the concept of shared knowing, which included keeping one's patients and families accurately informed. Honesty also included one's consistently keeping one's promises, as well as doing an honest day's work, consistently giving 100% and then giving more, by going above and beyond the expectations of others.

Integrity was addressed first by RN Participant 4 who, linking integrity with honesty, believed integrity was the main characteristic necessary in being a caring nurse. Honesty emerged from her story as being foundational to having integrity. She first said, in discussing how she built rapport with families of critically injured patients, "...Or if I tell them I'm going to do something, I always do it...." RN Participant 4 identified integrity as the most important piece of possessing a caring disposition, and while discussing it with me, she discussed honesty as integrity, and having the courage to do what one believes in as integrity, with the result of building trusting relationships with others. She said,

> Integrity—I think that's probably the main characteristic my Dad tried to instill in me. If you say you're going to do something, do it, and do the best you can and worry about it later. If you go to work, you need to go to work and give 100% and—worry about how tired you are later. Or if you say you're going to do something, always do it, or if you feel a certain way about something, be able to stand up and say you feel that way—even when everybody else may not agree with you. That's what I think integrity is and I think that you have to have that as a nurse—be able to...if you say you're going to go get someone a glass of water, something that simple, go get it.... Which is sometimes real hard 'cause you get distracted. But I think means so much to patients when they know you are going to do what you say. If you show that in the small things, they trust you in the bigger things...

When I asked RN Participant 4 which characteristic she felt was the most important of all, she identified integrity. She explained her beliefs in this way,

> Probably integrity. I just don't think you—exemplify what you want—if you exemplify what you are—and you do what you say you're going to do—I mean, you have, if you've lived that, that's the best life you can live. I mean…if I can come to work and, and do the best job I can and go home and feel good about it, I can't imagine anything better than that….

RN Participant 12 spoke similarly of integrity as being a core value of doing an honest day's work. She attributed her beliefs on caring partially to having been given a strong work ethic while growing up. She told me,

> …I was taught a … very strong work ethic. We all worked hard. All the time. We loved it. First job I had, I said, 'Dad, can you give me any advice?' He said, 'Well, just be sure you're there on time. In fact,' he said, 'I'd, I'd suggest you get there early. Do everything they tell you to do, but do more.' And that's what I've always done.

RN Participant 5 talked about the connection between honesty and trust, saying that without honesty, trust would not be attained. She, in discussing what caring meant to her, cited honesty in a list of attributes she felt were necessary in order or a nurse to be caring. She said,

> You need to be truthful. I think that if you're not truthful with your patients then they lose that sense of where they can trust you and they don't feel like you, you know, they're gonna wonder about everything that you do for them.

In exploring what she meant by truthfulness, and showing a connection with having courage to be truthful, RN Participant 5 said,

> Sometimes I think nurses are afraid when the patient asks them something, even though their situation is bad, they don't want—they're afraid to say anything to them—afraid it's going to upset them and not know how to talk to them about it and I think if you're, if you're not truthful then they're not going to trust you or trust the care that you give to them. They're always going to wonder, 'Are you doing what's best if you can't tell me the truth of what's going on?' Patients, you know, sometimes have a feeling or know something bad is happening and when they ask, we need to be willing to admit, 'Yeah.'

RN Participant 7 iterated how important it was to keep the patient informed, with her explanation showing a link between shared knowing and honesty. She mentioned keeping the patient and family informed four different times during her interview, demonstrating how important honesty was to her in her caring practice. She said,

> ...Keeping them (the patient) aware of what's going on...to keep in touch with the family member to let them know how things are going...letting the patient know what's going on...what's going to happen—what they may feel—what they may hear...and just mostly what to expect...asking if they (the family) have any questions...trying to explain to them, and, and also introducing myself to them—letting them know I'll be taking care of their child, and who I am and what I do and where we'll be going—inform them to—so they know what to expect...

RN Participant 8 addressed honesty as an important caring characteristic in her caring nursing practice. She believed in keeping the patient and family informed of what to expect in their labor and delivery experience; the connection between honesty and shared knowing again becoming evident. I asked her to explain how she made her patients and families feel cared for by being honest with them and she said,

> Just let 'em know what's going on, all the time. And if you're concerned about the baby for some reason, be sure you let them know, don't wait 'til the last minute when it is an emergency and—spring something on them—and—if a miscommunication—is there, you need to straighten that up, be honest with them. You know, if you just said something completely wrong, you've got to say, 'Well, you know, I was wrong,' or if you give them some wrong information, and someone else says something different, which happens a lot in labor and delivery, especially with cervix checks, and you know, no one ever agrees—it seems like. So you just have to be honest with them and…nothing's really a secret. You shouldn't keep anything a secret from your patients. Especially when it has to do with, not only your patient's life, but your patient's baby.

RN Participant 10, also a labor and delivery nurse, in her discussion of honesty as a desired attribute of a caring nurse, iterated that honesty with one's patients manifests as keeping the patient and family informed, or shared knowing. Her discussion also supported the relationship between honesty and trust. She explained her views on being a caring nurse to me as, "Oh, I think your first thing is you have to, um, have trust. Um, as

well as honesty…." When I asked her to tell me how one built trust with one's patients, she replied,

> …I think that you just have to be honest with your patient. I think that, you know, in what you're doing with them, in what's going to happen with them and their experience. I think that you have to let them know all the knowledge that you have of what is gonna be their experience.

RN Participant 11 also linked trust with honesty and felt that a trusting bond was the most important aspect of a caring interaction with her patients. She explained to me,

> …And I think—the most important aspect of it is—developing a bond with your patient so they trust you. So that—the care that you give them—if you need to do something—they're gonna trust you to know this is the right thing. And basically, to me, being honest with them….

In discussing how she interacted with a patient labeled as "difficult" by the rest of the staff, RN Participant 11 addressed honesty first in describing how she "turned" the patient around by discharge. She told me,

> …I tried to be honest with her. I tried to keep her abreast of what was going on. Cause this was one thing that she didn't know what was going on…she had (medical school residents)—and you know, you have 'em coming in and out, you really don't know who your primary doctor is with them…

In illuminating what she meant by honesty, RN Participant 11 told me,

> …I think if you tell a patient, 'I'll be back in 10 minutes,' and you don't come back in 10 minutes, then that undermines the trust. And I think when you first—I,

> what I try to do when I first—have my patient, I really try to develop that, that bond, that rapport….But all you can do is the best you can. But I think that you have to be honest with them. I think they can see through you. I really do.

Respect for humans/life

Respect for human dignity and acknowledging that every person has worth was a basic human trait that emerged from the stories of the nurse participants. Believing in everybody's worth and showing respect for every patient for whom ones cares were threads of discussion found in many of the stories. From this fundamental way of believing, respect for others forms one's integrity and, as a caring concept, is linked with intent, manifested as showing concern and consideration for others, as well as patience, evidenced as connecting with others and being open-minded towards others.

RN Participant 3 addressed the concept of integrity as respect for others, as well as the connection between one's intent to be caring with one's integrity. She explained her beliefs as the following,

> …So, I just think if you're constantly striving to be caring—and doing the best that you can—…and try to always think that every person is worth knowing and you come away with…something—with most—with a lot of the patients that you take care of.

When I asked RN Participant 5 to describe how she showed her patients that she cared for them, she talked about the sanctity of the human life and her belief that all persons have worth and are deserving of being treated with respect and dignity. In telling me about her experiences in caring, RN Participant 5 supported an interconnection

between, integrity as respect, intent, and patience. She shared her beliefs about caring and told me,

> Hmm, I had a patient that was in alcoholic DTs—and they are so mean, and they can be really—where they try your patience. And they can be—they're verbally abusive and physically abusive and you've still go to try to remember that they're not being themselves at that time. And try to still treat them as a human and not lose your cool and I just try to remember that underneath—what they're going through—is still someone's family member and that they are still a human being and try to treat them with respect and dignity and keep them from hurting themselves. You know—and I spent a good part of my shift just in the room.

RN Participant 12 believed in treating everyone with respect, especially her mentally ill patients. In treating them respectfully, and while meeting their physical needs, she believed she helped them feel better about themselves. She shared with me,

> You just have to go that extra mile as they say. You see somebody that perhaps, would not get a bath that day, especially in the psych setting, quite often that's not what they're thinking about. They're trying to deal with, uh, voices and their psychosis…cleanliness is just not something they're thinking about. And just get them the things, here's a towel, here's a washrag and so forth. Because you know that they'll be more acceptable to society and maybe to people who come to visit if they are clean…I have a friend I work with and we always make sure—we'll go in there and we'll help them bathe, whatever they need and do it in such a way that they don't feel, um, bad about themselves…we're very supportive with each

other, towards each other and with the patients and…when it's time for vital signs, you don't say, 'Come here, sit down.' You know, you say, 'Would you please sit in the chair and we'd like to check your vital signs and would you please now stand up so we can get a reading when you're…standing.' And if they say why, we explain it to them. It's just a great bunch of people. It's why I love my job.

RN Participant 19 believed in giving her patients the ability to make choices and to have a say in their participation. Giving back control to the patient and allowing them to make choices showed respect for them as individuals as well as valuing them as a person who has worth, and whose feelings mattered to her. As she discussed her beliefs with me, a linkage between respect as integrity, patience, and trust emerged. She explained to me how she let her patients know she respected them, telling them,

'…So when you ready to talk to me, you let me know and I'll be here, but I'm not going to push it on you.' Half the time I'll get to the door and they'll say, 'Come back a minute.' That's really amazing. The same is true with assessments, I'll come in, and they'll say, 'This patient has not allowed us to assess them at all.' But it seems to be a simple fact among the most angry…if you say, 'May I listen to your heart,' and this one lady says, 'Well, of course you can.' And I said, 'Well, I always ask because I'm going to touch your body,' and I say, 'nobody's got the right to do that without your permission.' And when I said that, maybe that…opened her up that, 'I, too, have a choice here, and I'm not at your mercy….'

RN Participant 4 talked about her beliefs that every human life had meaning and everyone deserved respect and the best care that she could give, regardless of what they may have done in the past. In her story, interconnectedness between being non-judgmental, having a positive intent to care, and having respect for others emerged. RN Participant 4 shared with me her values and beliefs about caring in this way,

> …And I think another big characteristic is not judging what that person has done. Because in…our unit—in the trauma unit—we have a lot of people who come in who may be alcoholic or may have been in a car wreck and killed someone else or things like that. And I really try to focus on not—focusing on what put them in that bed. And…you know, prisoners. You know, I don't know what they did—they may even be innocent for all I know—so I try to focus on, you know, taking care of them, being kind to them, and…because, it's not my business what they did. And I try to treat them like I would if that was my mom anyway, and that's real hard to do. But, I really think, I consciously think that when I'm taking care of them. They deserve the best care that I can give them in spite of what they've done. And when someone says, 'Well, they've killed someone,' well, you know, I can't focus on that—I need to take care of them and they've got feelings and emotions and maybe they will change if we're kind to them or they will see that, um, people do care. You know, I try to—focus on that.

RN Participant 15 mentioned the need to treat every person with respect and to remember everyone was worthy and deserving of care. She explained to me,

> ...You never know who that patient is. And you need to treat them like, they're you know...that could be Jesus' mother. You need to treat 'em that way. You know, it doesn't matter if they're a prisoner, it doesn't matter if they're a district clinic patient, it doesn't matter if they can't pay their bill, they all should be treated the same, whether it's the CEO, you should treat everyone as if it was the CEO. Nobody should be treated any differently....

Humility

Humility, one of Mayeroff's (1971) eight caring ingredients, was evident within the stories of the participants and was supported by the data as a caring attribute of caring nurses. Humility, as conceptualized by Mayeroff, includes a willingness to learn more about oneself and the other and what caring requires, as well as allowing others to see oneself as one truly is. Humility is based in an honest assessment of what one can accomplish, allowing a sense of pride in a job well done, as well as permitting others to assist one as needed in order to complete one's mission (Mayeroff, 1971). Humility emerged from the stories as several of the nurses stated that it takes a team concept in providing the best possible care to their patients. All the participants exemplified humility when I telephoned each one to ask them to be in the study. I had obtained their names from their immediate supervisors, who identified them as caring nurses, or from other study participants, who named them as role models for nurse caring. Each and every one of them expressed surprise and shock at having been identified as a caring nurse by a supervisor or colleague. Many of them whispered in a voice full of disbelief as they responded to my request. At times during the interviews, several of them became very

quiet, as they recalled emotional past events where they remembered being especially touched by a certain patient or family member. Yet, none of them seemed willing to accept the label of being a caring nurse without making sure I understood that they all worked with a great team who together cared for the patients in a caring way. I found their collective reticence humble and unpretentious as they told me their stories.

RN Participant 8 talked about the necessity of knowing when to ask a colleague for assistance in caring for her patients. She talked about,

> …Knowing your limits—I think that's a big deal to being a caring nurse. Not—going over your head and knowing your limits and stepping in and asking people for help or when you're swamped, asking someone to come help you so that your patients are well taken care of. I think a lot of nurses have a big problem with stopping and asking for help. And it's hard, sometimes, 'cause you don't want—anyone to think you can't do it. But at the same time, for your patients to be taken care of, you're going to have to—recognize your boundaries and stop. Get reinforcement when you need it.

RN Participant 8 also spoke of the need to be passionate about one's work and loving what one does as part of a caring disposition, a description that manifests humility. Passion for nursing and for helping others links humility as integrity and intent together to form a substantive structure for a caring disposition. RN Participant 8 said,

> Passion for your work…that's a—main key, I think. You've gotta love what you're doing…. I think a passion for your work just, not, only, you know, caring

for your patients, but the yearning for knowledge and—to be the best you can be....I think that makes you a caring nurse.

RN Participant 3 discussed teamwork in caring for patients and providing the best care possible to them. She believed it took an entire team to best care for others. She said,

> ...Being a team player with your co-workers...that also carries over to your patients when you work as a team.... We all really jumped in and helped each other—and when you do that—the patients get the best care. They get more expedient care...

RN Participant 7 discussed the team concept in discussing how the flight crew interacts with others in hospital settings and at the scene of accidents, and how it took everybody to give the best care possible. Humility was evident in her story in several ways, but most particularly when she described to me how she called back the referring facility after the flight to ask if there was anything she could have done differently to make the call go better or to improve the patient's care. She told me,

> ...We do follow up calls to the facilities, ...after we fly or to the (EMS) services. After you get back and turn your patient over...you call either the facility back or the... (EMS) service back...to let them know how the patient did enroute...you call back and just mostly let 'em know—and what I do—I always say, 'Is there anything we could've done different?' ... it's like if there's anything I can do to improve the care—I mean, ...I want to do a good job for 'em and for Lifestar....I want 'em to have a good impression of us—too. I mean, that's part of it... 'Cause I know...maybe we can be kind of intimidating, we're not any different that

anybody else—we just do it in the air—that's the only difference—so I want 'em to know that I'm just a person like they are. And I'm here—I'm not taking their patient from them…I'm here to help. And I'll walk in, like on scene, and I'll ask the service that's there, I try to do this, it's very important to me--, 'What can I do to help?' Not walk in, take charge…I try to start out by saying, 'What do you need?' and go from there…. JS taught me that…. On scene. Walked up and goes, 'What can I do to help?' I was very impressed with that. So I try to incorporate that and it works very well….It's not us that makes the difference—it's everybody that makes the difference. From that first person on down.

RN Participant 10 discussed having a team concept in helping one care for one's patients in the best possible way. Having a caring team that one trusts benefits the patient ultimately in meeting that patient's needs. RN Participant 10 said,

…I also think you need a good quality of peers to work with. I think that's very important….The team is important, very important….Oh, I think that the people that you work with play an important part in the –the quality of nurse that you can be. I think that, you know, when you...have peers that you work with that you trust and that you enjoy working with just makes your place of…employment even that much more enjoyable….The patient benefits just because you have somebody that you can correspond with and talk with and also help you if you need help with your patient.

RN Participant 11 talked about her development as a bereavement coordinator for the hospital and discussed wanting to continue to grow and develop her knowledge in her role. She discussed her role with me, and at times her voice became quiet,

> …I try to continue to grow. I think that a person should never stop. I think that you need—I get so excited sometimes when I learn something new…I'm still learning—a year's not enough time to even begin to be the type of bereavement coordinator that we need.

Courage

Courage, another of Mayeroff's (1971) eight caring ingredients, emerged as a nurse caring attribute from the nurses' stories. Courage is linked with trust; courage allows one to explore the unknown while trusting in the other's ability to grow along with one's own ability to care. Courage is informed by insight from past experiences, yet it is open and sensitive to the present. Trust is required in order to have the courage to venture into the unknown, but without courage, trust is impossible (Mayeroff, 1971). Courage, as part of one's integrity, calls for risk-taking, standing up for others, and doing what is right. Many of the nurses spoke of going that extra mile or going above and beyond in caring for their patients. I believe these descriptors give structure to the concept of courage as nurse caring.

RN Participant 1 talked about having the conviction to stand up and fight for doing what was right, even if no one else would. She said,

> …Believe in it enough to fight for it when nobody else will….You know what I mean? You have to buck some other staff members in order to say, 'Now wait a

minute—just because they are on district clinic doesn't mean they don't have the same rights a somebody else.' Confident enough. Maybe I should say that. Confident enough in what you believe…

RN Participant 2 spoke of what she believed made a caring nurse, a description in which intent and integrity were interwoven. She had talked on a couple of occasions, during our interview, about going above and beyond in being caring, a concept which entails courage, so I asked her to tell me more about that. She answered,

I do—I think it takes a person to go above and beyond to help someone out. 'Cause we can all care about someone or think about something and what we would do, but acting it out actually is like a different story…

RN Participant 4's definition of integrity included standing up for what one believed in. She said,

…If you feel a certain way about something, be able to stand up and say you feel that way—even when everybody else may not agree with you. That's what I think integrity is and I think that you have to have that as a nurse…

RN Participant 5 agreed that one needed to be willing to take risks in meeting the patient's needs and in being a patient advocate. She said,

…You've gotta be willing to go that extra mile when they do start talking and maybe they, you know, start telling you problems.…You've gotta be willing to take that time and go to bat for them. Maybe it's against doctors or other staff but you've go to be a patient advocate…all times….

RN Participant 8 talked about an experience she had as a new nurse aide during her orientation, and how that experience shaped her desire to be a caring nurse. In meeting the needs of the patient, she had to stand up for what she believed was right, even though she was going against her direct supervisor's directions. She told me,

> …A lot of my experiences before I was an RN brought me to realize that I don't want to be uncaring. One of my first experiences as a nurse tech, and the lady I was orienting with—it was time for us to go on break. A call light had gone off on one of our patients. We went down there and she had thrown up—just all over the place and that nurse tech turned around and said, 'I'll get your nurse.' And went on break. Grabbed my arm and said, 'You're coming with me. If we don't go on break, we won't get to go.' And right then, I stood up to her and said, 'I'm not leaving her back there' –for the nurse to clean up when the nurse was busy doing assessments in another room. That was an incident that taught me.

When I asked RN Participant 15 about her beliefs in nursing, she talked about being a patient advocate and her strong belief in being the patient's advocate. She said,

> Well, I'm a very strong patient advocate. Probably I'm a stronger patient advocate than I am a nurse advocate or a physician advocate. And I sometimes get into trouble for that. I get into trouble a lot for that because I believe what the patient says is true. It's like when, you know…you see these signs up…'The customer's always right,' you know, and then, number two, 'Refer to number one, the customer's always right.' And I believe that…

RN Participant 19 strongly believed in recognizing caring qualities in her colleagues and in encouraging them in their caring endeavors. In doing so, she believed she was helping them develop lifetime habits in caring. She said,

> …Recognize caring qualities in your peers and encourage those, too. Because, you get, you have some that don't and some that do, and if you encourage those that do from the beginning, when they're new, new graduates…then they follow through more for a lifetime. They have the courage to follow though if they get that pat on the back for what they're doing and if they're not just treated like someone that just does their job and walks out.… And I think that's really important and sometimes people can get too busy to say, 'You did a great job,' or, 'That patient really appreciates you and obviously, you spent time with them.' Ah, that's just real important to me and I want to encourage those kind of people…

RN Participant 19 talked about being the kind of nurse who stood up to others in doing what she felt was right in giving the patient the kind of care she believed the patient required. She told me,

> …Ah, I have realized that I will take the time, and I've stood up to people, you know, before, even before I was a charge nurse, when they've said, 'You're putting too much time into that person,' and I say, 'Well, I always get my work done on time, and when I don't, well, then we'll worry about it.' I never had any trouble asserting myself that way because I've always felt if I was not going to be a good nurse, then I'd find something else to do. You know, if I can't do it really

well, if I'm not there to care for the patient, if I'm just there to please the state, and do the paperwork, then I'm going to find something else to do.

Evolution of Caring Characteristics

The evolution of the caring characteristics as perceived and valued by these caring nurse participants piqued my interest during the course of this study. The themes surrounding how these caring characteristics evolved in this group of nurses included: (a) caring learned within the family context; (b) caring instilled by one's faith in God; (c) caring learned from one's life experiences; and (d) caring as an innate quality. The acquisition of caring characteristics appears to be multidimensional and multifactoral as the data supported multiple ways in which caring characteristics are learned or acquired.

Caring learned within the family context was mentioned most frequently when nurse participants were asked how they perceived their caring characteristics had been acquired. Stories included descriptions of having been socialized into caring by traditional girl roles in the family, caring for family members who were ill or frail, caring imparted from having been cared for by loving, caring parents, and caring learned from parents as an expected way of behaving towards others. Noddings (1984) describes this phenomenon as natural caring, which evolves out of having been the recipient of caring. One's motivation to care is founded within a loving relationship or natural inclination for the other, most often described within the family relationship or one's past life experiences. Table 5.2 reflects the grouping of data congruent with the evolution of caring characteristics learned from within the family structure.

Caring characteristics also evolve and are instilled because of one's faith in God, and were addressed by five of the nurse participants. One of the nurses in the study spoke at great length about his faith in God and his belief that he was to live his life modeled upon the life of Christ. Others believed that their ability to be caring was God given. Table 5.3 depicts the grouping of the data congruent with the evolution of caring characteristics as having arisen from one's faith in God.

Another thematic pattern of evolution of caring characteristics that emerged from the nurse participant stories was caring learned from one's life experiences. Several of the nurses spoke about past experiences shaping them into the people they are today. Life experiences included positive as well as negative influences. Positive influences discussed included one's formal nursing education and how caring was framed within this experience as well as one's having positive role models and mentors to help shape their caring practices. Negative influences shared by the nurse participants included those experienced prior to coming into nursing, which shaped how one wants to interact with others generally, as well as those encountered within a nursing context, which shaped how one should interact with one's patients, based on choosing to do what is right and what exemplifies genuine caring for another. Table 5.4 depicts the grouping of data, which emerged from the nurse participants' stories, reflecting the evolution of caring characteristics that are learned from life's experiences.

Caring as an innate quality also emerged from some of the nurses' stories. The possessing of caring characteristics was addressed by a few of the participants as having always been there, inborn, and inherent within one's character. Some of these nurses

linked it with a genetic predisposition for caring; some attributed it to one's personality. Table 5.5 reflects the grouping of data congruent with caring as an innate quality.

Patient Benefits

RN Participant 8, when interviewed, talked about a specific incident in which a patient she cared for three years previously while in nursing school, credited her with saving his life, because of the empathetic caring she showed him. Based on this data and subsequent mention by RN Participant 9 who believed that patients benefit from having a well rested nurse take care of them, I explored how the patient benefits from being the recipient of nurse caring in subsequent interviews.

Data supported that these nurses believed that the patient positively benefited from having been cared for by a caring nurse. This data, which emerged from their stories, centered on patients having good feelings about their experiences or feeling that everything would be done in their best interests.

Hart and Dieppe (1996) cited studies that showed significant patient benefits as a result of nurse caring. One cited study demonstrated that frequent phone contact with patients who had symptomatic osteoarthritis reduced pain, as well as physical and psychological disabilities. Another study of attempted suicides found that further attempts after a first admission were significantly reduced after providing a 24- hour contact number. In a randomized trial, compassionate care was shown to reduce repeat visits to a hospital emergency department among a sample of homeless subjects. Table 5.6 displays data that reflects how these nurse participants believed patients benefited from being the recipient of a caring nurse-patient interaction.

Table 5.2

Caring within the Family Context

RN Participant	Descriptors
1	"I was the only girl" "We did a lot of care-taking of the rest of the family" "We had very womanly duties"
2	"Just growing up, good childhood years" "Nurturing…people caring for me…looking after me" "My mom…had a bad hip…surgery three times…third time left her in a spica cast and a hospital bed at our house…I was basically the little nurse"
3	"I come from a middle class…family" "Extremely normal" "Had a good childhood" "Had wonderful parents"
4	"My dad instilled that in me" "My father is the most caring person I know" "I was just shown all my life…you just put others before you" "My father did that with me…that's probably where I learned it"
5	"I always cared for my grandmother…before I was a nurse" "I …always played like I was a nurse at home…my baby dolls were my patients" "Granny would be my patient…when I got older, she moved in with me and I took care of her"
6	"My little sister has epilepsy…we watched her" "…Just watching the nurses get her back to where she needed to be" "That's what brought me into it, I didn't want to be scared of it any more"
7	"From my parents" "I had wonderful, wonderful parents" "Both were hard workers" "They both had a sense of morals, what was right…what was wrong" "Work ethics—I probably got those from my father" "The way you're raised" "I had a very caring, loving family…I think that influences it"

(Table continues)

Table 5.2 *(continued)*

RN Participant	Descriptors
8	"How you've been brought up to treat others, how to respect others"
9	"From everything that's happened to you as you've grown up" "It's from your cultural background…from your family life…" "If you had a secure…background…you're a secure person…you being a certain amount of security to the table"
10	"I have my parents to thank for that" "I was brought up in a very loving and caring family" "Everybody was very loving"
11	"I think some of these come from your upbringing" "I think maybe from parental example" "My mom…did teach me certain…moral things…to be honest"
12	"A lot of it was the way I was raised" "We were always taught to love one another" "My family was that way" "I learned…not to be judgmental" "I had a very loving, caring family" "That's the way I was brought up"
14	"I had loving grandparents and loving parents"
15	"I think a lot of that has to do with my mom and my dad and my upbringing" "My mom was very loving and very caring"
18	"…Came as a result of… the faith that my Mother has"
19	"I grew up with people that were really (caring)" "My grandmother had a lot of the Indian heritage…everything was to be respected and honored" "My dad was very…caring" "He'd take people in…and do all kinds of things" "My mother would do the same…" "I had good examples as a child" "Early childhood…taught that everything that lives is important"

Table 5.3

Caring Instilled by One's Faith in God

RN Participant	Descriptors
2	"Well, I guess by the Man upstairs"
7	"What I do and how I perform I feel comes directly from God"
11	"I'm not going to say it's…religion, but it's my spirituality. I talk to the Lord all the way to work…I say, 'I know you're there Lord, I know you're gonna help me through this'" "I don't think I'd have my positive attitude without…my faith…Because that's what gets me through"
12	"A strong Christian background" "I went to parochial schools and we were taught to love one another"
14	"I do…have a very deep faith" "I believe in God and that is a basis…for everything I do" "I feel like I couldn't do this job if I didn't have that faith" "If you are a Christian then you would have compassion and love"
18	"I went to Catholic schools most of my life" "My life changed drastically when… I started…going back to church …reading the Bible…put into practice the things that I was learning…the things I knew I should do…church is a very big part of my life" "It's a very big part of…anything I do" "The Lord, Jesus Christ, He…certainly respected life" "He felt compassion…I'll work to imitate Him" "I'm…trying to develop that in my own character…to…be more Christ-like" "I've looked back on my life…I see where God cared for me and loved me and watched over me and He put people in my life that were kind here or did this for me…"

Table 5.4

Caring Learned from One's Life Experiences

RN Participant	Descriptors
1	"One thing I try to do, and CS taught me this…talk to the patient"
2	"…Something happens like you lose a child in the emergency department…it just brings you back to home and warms your heart again…to focus on what you're really doing"
3	"…How to be non-judgmental…that is the big thing you have to learn in nursing" "Some of the lectures she gave us, which was always on caring and love of nursing—those are the things…I've must've stored…subconsciously…those are the things that come back to me" "Those are the things that would pop in my mind as I would meet different situations with patients. I, I can't even tell you…what skills…different nursing instructors taught me—the things that come back to me are the statements and things that were said to me in relationship to…how you cared for patients and being kind to patients"
5	"I don't think I really developed (listening skills) until I went into management…in 4 years, I've been through so many hours and hours of classes on communication and listening" "I think I developed those as being a boss…you've got to be able to listen"
7	"I try to start out by saying, 'What can I do to help?' ... JS taught me that.... On scene. Walked up and goes, 'What can I do to help?'" "Patience…the best example I can think of…the way he (physician) reacts to the situation affects the whole room. So I try to go in and be patient…"
8	"A lot of my experiences before I was an RN brought me to realize that I don't want to be like that—I don't want to be uncaring" "That was an incident that taught me" "It seemed like I was—always in the hospital on the weekends (visiting sick grandparents). And…you could pick out the nurses that loved what they were doing and I remember thinking that back then, even as young as the third grade…'I want…to be like her—I want to take care of patients…just make a difference in their life'"

(Table continues)

Table 5.4 *(continued)*

RN Participant	Descriptors
9	"I think…my life's experience over 21 years has made me more caring" "Every time you're a patient, it makes you, to me, it brought it home to me, how the little things matter so much. And I think I've, after every one of those experiences, was able to be a better nurse" "An attitude of acceptance would be most important…one of the things the…instructors drilled into our heads…" "Some of it, I think has to develop…as…these situations occur"
11	"I feel like—in order to have empathy, you have to have…experienced a lot of adversity in you own life…I feel like that my adversities… I've been through, it's helped me look at other people and understand, 'Oh, yes, I've had a situation like that or similar'…and I kinda know what they're going through" "The self-confidence came through the years…Past experiences…" "There are times when I don't have patience…it just shows that I'm human…I guess…I've learned by example or through experience"
13	"Through the years…I just met all kinds of people that…helped me get rid of those judgmental things"
14	"I admired the friends that I have that were nurses. I admired them, their attitudes, their…hearts and…I thought…I will fit in there and so that's…why I did it"
15	"I think having mentors in nursing…made a difference"
16	"Through experience, through being like a baby nurse and watching the other people who had a lot of experience who were training me, the people who I admired, and…watching them and seeing how they dealt with the different circumstances and all of that until you can combine everything, all the good parts…and incorporate them into your style of taking care of patients"
17	"I think his (Major M) nurturing just kind of really fueled the fire that was already there…and he'd take me up to Labor and Delivery and say "…Let's go catch a baby'"
19	"I think a lot, an awful lot in my life, has been life experiences…it makes me more able to have…empathy"

Table 5.5

Caring As an Innate Quality

RN Participant	Descriptors
2	"I think it's just inborn in you basically"
5	"I had that need to take care of people…I want to help take care of them"
8	"I think a lot of people are just caring by nature"
12	"It's just the way a person is. Some people are just more caring than others"
14	"Well, I don't know if (caring is) developed or if you're born with them...I don't think I've changed much since I was born…I don't think I've really changed"
16	"I think I had a lot of them before…it's just sort of part of a personality"
19	"Let's just basically say, it gets back to genetics, some of it"

Nurse Benefits

The second nurse interviewed acknowledged receiving positive nurse benefits from being a caring nurse, saying she benefited "a good deal," so I chose to explore this theme in subsequent interviews. Perceived nurse benefits from being a caring nurse ranged from a good feeling of a job well done, to having the knowledge that the nurse did everything possible for the patient. Table 5.7 displays data that reflects how the nurse participants believe they benefit from being a caring nurse.

Table 5.6

Patient Benefits of Nurse Caring

RN Participant	Descriptors
8	"He said, 'I give you credit for saving my life"
10	"I think their sense of trust, to know that they are being cared for in the best possible way that they can be cared for"
11	"If a patient is able to perceive you as being caring and able to accept it, it helps their recovery time. It really does. I think so. Because they trust you, and I think it really improves on their recovery time"
12	"They feel good…it gives them some sense of…self esteem and some happiness and lots of joy to feel that somebody really truly cares about them…it gives them a sense of belonging…that there are people that…care…that they see them as…a worthy… human being that…hopefully they feel that God loves them and other people love them, too…I think they just feel much better about themselves"
13	"They feel that they're important…they matter and they're not just lost…I think the patient likes to know that he's cared about…likes to feel important, and I like them to feel important. That they matter…"
14	"People…would rather know that they are genuinely cared for…" "For children, it's less frightening knowing that…I care about them…"
15	"I think if you…can show that you're caring, it's going to set them at ease and make them better…that makes them feel comfortable…"
16	"Their anxiety is decreased…I think…that helps them…have an easier induction into their anesthesia, because they're more calm, and they're more relaxed"
17	"I think that the…patient gets a lot…better…quality of care"
18	"It could be something, just a fleeting moment…that makes them feel good or relaxed or it could be something that stays with them for a lifetime"
19	" They gain a certain amount of trust…they leave knowing that somebody cares…"

Table 5.7

Nurse Benefits from Caring

RN Participant	Descriptors
3	"I can go home everyday feeling good about myself"
4	"When you help someone else…the feelings of them appreciating you or just saying thank you or…just knowing you made a difference in one person's life is—incredible" "When you have that head injury patient walk back in and come see you after you saw that they were so sick and you knew they were going to die—and they walk back in and come visit you, that's, just, that's…why you're a nurse. Right there. That's the best"
5	"It just kind of made my day—they all came up and said, 'We're so glad you're her nurse today.' That was better than any raise or anything anyone could ever give me—just that feeling"
7	"Knowing I can perform—in whatever situation that is needed of me"
8	"I get to keep my job…just forming that relationship with your patients…you just get the satisfaction of knowing that you have helped someone that day and you've made the difference" "You get to take a sense of accomplishment for the day" "It's heart warming" "What a joy!"
9	"It just has to be a good feeling…it just has to be at the end of the day, you feel like you've helped somebody. Or you feel like you've done something" "It just has to be an internal feeling of—that you did something that needed to be done"
10	"I get so much…self-worth… and just…the reason why I do my job" "It just reminds me everyday of why I'm a nurse and why I take care of patients. It's very fulfilling"
11	"When I get these kind of patients, they're a blessing to me…and I tell them that, I said, 'You are a blessing to me. I walk away with something, you give me something.' And it is so true…they give me their strength…"

(Table continues)

Table 5.7 *(continued)*

RN Participant	Descriptors
12	"I feel better about myself if I've given all I can give. I go home feeling good…I have job satisfaction…I feel like I'm doing what, probably, I'm supposed to do in life…I feel good"
13	"I feel good…I feel good about what I'm doing…I really like what I'm doing" "That good feeling. That good neat inner feeling that you just…feel good…it does feel nice to have that good feeling inside. That…you've helped somebody today"
14	"It's what I want to do, and I love doing it so I would say yes, I do benefit from it. It makes me happy"
15	"It rewards me…knowing that I have been able to help someone. It just sends a feeling of satisfaction in here (pointed to her heart). You know, it just kind makes my little heart beam, makes it all warm"
16	"You get the interaction with other people, you get to…even though it's a short time in the OR but you…meet so many people, you see different points of view, they share with you, and you, you just get to grow as a person, too…meeting all these people and learning about them"
17	"I know that I've…taken the best possible care of that person, that they entrusted their life to me…I took the best care that I knew how"
18	"Well, I get…satisfaction in…knowing that…I…having a positive effect on life in general, and on people maybe…. Just knowing that…. Maybe being able to give…that like what God has done" "Some of those few times that I can really maybe make a difference in the person's life is certainly rewarding"
19	"Oh probably (I benefit) more than they do…I really get a good feeling when I go home and I know that I've taken the time…and that…person is feeling better because I was there…I feel wonderful for anything that turns out right, I just really feel good about it and I get very excited when I see people improve…it just gives you a good feeling of…peacefulness, calm…that you've really done you job well…I feel quite excited about that. I get a lot out of it…a lot of personal satisfaction"

Summary

The concepts that emerged from the data framed four distinct yet interrelated domains of caring characteristics possessed by RNs including: (a) knowing, (b) connectedness, (c) intent, and (d) integrity. Discussion of each domain, including its structural concepts, along with relationships among the concepts within each domain, attempted to provide a "thick" description of the caring characteristics that comprise a caring disposition and facilitate registered nurse caring. Also discussed were the relationships of concepts among the domains, as well as how nurses perceive they acquired their caring characteristics or how they believe these characteristics have evolved over time. Literature was used to support the discussion. Patient benefits resulting from a caring interaction with a caring nurse were presented, as were nurse benefits from practicing as a caring nurse. The theoretical categories of these thematic patterns of caring characteristics will be discussed in Chapter VI and an explanatory model of human caring in RNs will be generated.

CHAPTER VI

DISCUSSION

Caring has been described as the "essence of nursing" and the "central and unifying domain for the body of knowledge and practices in nursing" (Leininger, 1981, p.3). Ways of caring are human acts that are carried out in order to assist, support, or facilitate the meeting of another's needs, emanating from one's feeling of compassion for another, interest in another, or one's concern for others. Caring has been defined as the "moral ideal of nursing, whereby the end is protection, enhancement, and preservation of human dignity" (Watson, 1988, p. 29). Caring is a value that expresses itself through conscious judgments, based upon one's feeling of commitment and intent, and evidenced by a freely chosen way of interacting with others. Manifestations of nurse caring (e.g., nurse caring behaviors) have been extensively studied over the last 30 years by nurse scholars whereas this study focused on those intrinsic caring attributes and characteristics, which enable nurses to act in caring ways.

Nurse caring, along with its attributes and characteristics, emerged from the stories of the 19 registered nurses (RNs) who participated in this study. The analysis of the data generated by this study, using axial coding to explore relationships among the properties and categories, yielded four separate, yet interrelated domains of caring characteristics, (e.g., knowing, connectedness, intent, and integrity), possessed by RNs who have been identified as caring nurses. Table 6.1 represents the development from codes to themes.

Table 6.1

Development from Codes to Themes

Codes	Concepts	Categories	Themes
Conscious choice	Choosing to act	Positive Attitude & Intent	Intent
Love for others	Being kind Having compassion	Kindness & Compassion	
Valuing others	Feeling concern Being considerate	Concern & Consideration	
Wanting + outcomes & Building rapport	Fostering hope Building connections	Hope & Trust	
Wanting to make a difference	Wanting to help others	Desire & Willingness	
Serving God & others	Commitment to serve others	Obligation & Duty	
Being honest & keeping promises	Being truthful	Honesty	Integrity
Belief in others' worth	Being respectful	Respect	
Wanting to improve	Striving for excellence	Humility	
Going the extra mile, above & beyond	Willing to take risks	Courage	
+ Connection with others	Being there	Connecting	Connectedness
Listening	Authentic presence		
+ Attention to others	Attentiveness		
Taking time Making time	Spending time Using time effectively	Temporality	
Accepting differences Tolerating differences Not judging differences	Acceptance Tolerance Being non-judgmental	Open-mindedness	
Endurance & perseverance	Having patience	Patience	
Having the knowledge & skills	Knowing what & Knowing how	Experiential knowing	Knowing
Belief in yourself	Knowing self	Self knowing	
Patient's point of view Insight into when to act	Empathetic knowing & Knowing when	Relational knowing	
Telling others what they need to know	Sharing knowledge with others	Shared knowing	

In this chapter, discussion will further theoretically link, using selective coding, these caring concepts and their associated categories into a grounded theory of nurse caring characteristics (Strauss & Corbin, 1998). How these characteristics are thought to evolve will also be discussed, citing relevant literature for support.

The final product of this grounded theory study is not intended to be a grand theory of nurse caring. While much has been written on nurse caring, it still has not been consensually or fully explicated. Much of the previous research in this area has focused on caring behaviors; with this study, I focused on precursors to caring behaviors (e.g., intrinsic characteristics that caring nurses have and which provide a foundation supportive of their acting in caring ways toward others). In examining what I believe to be antecedent to caring behaviors, I hoped to answer my questions of: "What attributes make a caring nurse act in caring ways?," and "What characteristics does a nurse who is caring possess?" In seeking the answers to this phenomenon, my intent was to provide some insight and understanding into those characteristics that caring nurses feel are important to possess in order to exhibit caring behaviors toward others.

The Domains

The four domains explicated in this study represent nurse caring attributes that underlie nurses' caring actions. These domains, while unique in their descriptions, are interrelated and interdependent with one another. From the analysis of data, the domain of intent was identified as the central theme, which serves as an anchor for the other three domains and represents one's core capacity for caring. The domain of intent encompasses many of the properties that comprise one's character, including possessing a positive

attitude and maintaining a positive intent to do good for others. Other properties within this domain include kindness and compassion for others, as well as possessing the intent of maintaining concern and having consideration for others, along with possessing the desire and willingness to help others, often as a result of a perceived obligation and duty to serve God or others. Also included within this domain are the properties of possessing hope and trust, which also are intentional traits, identified by Mayeroff (1971) as two of his caring ingredients. The domain of intent interrelates with all other domains as shown in Table 6.2. It can be hypothesized that as one's intent increases so does one's feelings of connectedness and one's integrity. Also, if intent is high, one will be motivated to learn more in order to help others.

The domain of integrity subsumes the properties of honesty, respect for others, humility, and courage. These internal traits, along with the domain of intent, serve as the underpinning of one's character. Three of these properties (i.e., honesty, humility, and courage) were identified by Mayeroff (1971) as part of his eight caring ingredients. The domain of integrity interrelates with the other three domains as shown in Table 6.2. It can be hypothesized that as one possesses integrity, there is a reciprocal relationship with intent, connectedness, and knowing.

The domain of connectedness involves the properties of connecting with others, through authentic presence with others, being there for others, listening to others, and showing attentiveness to others. Connectedness also entails the element of temporality, or creative and effective use of time spent with others; as well as open-mindedness, or being accepting and non-judgmental of others, while remaining tolerant of existing differences.

Connectedness interrelates with the other three domains, as shown in Table 6.2. As one's feelings of connectedness increase, it is hypothesized that (a) one has a greater desire to help others, (b) one possesses greater integrity in meeting the needs of the other person, (c) one feels more connected to another, and (d) one's motivation for empathetic knowing is increased.

The domain of knowing specifically addresses nurse knowing as it relates to caring and subsumes the properties of experiential knowing, self-knowing, relational knowing, and shared knowing. Experiential knowing includes theoretical knowing of knowing what to do with the practical knowing of how to do. Self-knowing is comprised of "knowing me," which is knowing that one can perform when needed, as well as understanding one's limitations. Relational knowing subsumes the categories of empathetic knowing, or "knowing the other," as well as intuitive knowing, which includes Mayeroff's (1971) caring ingredient of alternating rhythms, or "knowing when" to act or not act. Shared knowing includes knowing and teaching what others, including patients, families, and other healthcare providers, need to know. Knowing, which is also one of Mayeroff's eight caring ingredients, interrelates with the other three domains, as shown in Table 6.2. As one's knowing increases, one's intent to act may also increase and one's feelings of connectedness and integrity may likewise increase.

Table 6.2

Interrelationships Among the Domains

Domain	Intent	Integrity	Connectedness	Knowing
Intent		RNP 3 "Constantly striving & always try to think that every person is worth knowing"	RNP 6 "Something just told me, just go get his kid"	RNP 7 "Having the knowledge to care…learn the most you can…staying current"
Integrity	RNP 5 "Patient was in alcoholic DTs…try to treat them as human—with respect and remember they're still someone's family"		RNP 5 "And try to treat them with respect & dignity…I spent a good part of my shift in the room"	RNP 17 "Just tell the patient what's happening…'I'll take good care of you…I promise I will'—that's a promise I don't take lightly"
Connectedness	RNP 5 "You have to have good listening skills…spend time with them…be willing to go that extra mile…be willing to take that time and go to bat for them"	RNP 19 "When you are ready…let me know and I'll be here…it seems to be a simple fact…if you say, 'May I listen to your heart"…maybe that opened her up that 'I, too, have a choice here and I'm not at your mercy"		RNP 19 "She really needed, if you talked to her for a few minutes, the attention to know that somebody cared…she wasn't forgotten…I took the time to sit with her…until she fell asleep"
Knowing	RNP 7 " It'd be easy to get 100 hours (CE) in a year—we did a cadaver lab—that was volunteer…learning's one thing, doing's another"	RNP 8 "Passion for your work…you gotta love what you're doing…a passion for your work, not only caring for your patients, but the yearning for knowledge and to be the best you can be"	RNP 17 "By making sure you stay in touch with them…talk to them…let 'em in on that world…let 'em know yes, you are somebody, you do recognize their presence…continually talk to them about it."	

RNP= RN Participant

Evolution of Caring Characteristics

Acquisition of caring characteristics, among the caring nurses who participated in this study, appeared to be multifactoral and multidimensional. Four themes concerning

how caring characteristics evolve were identified from the stories of the nurses, including (a) caring learned from within the family context, (b) caring instilled by one's faith in God, (c) caring learned from one's life experiences, and (d) caring as an innate quality.

Caring learned from within the family context resulted from having been cared for as a child or from having one's caregivers model caring for them as they related to and cared for others, including family, as well as non-family. Caring in this context was learned from having experienced caring. Noddings (1984) identified this as natural caring, evolving from having been the recipient of caring. One derives the motivation to care from loving relationships or having concern or a natural inclination for another. Many of the nurse participants described a loving childhood whereby they were the recipients of nurturing care from their families. Parents instilled in these caring nurses a caring ethic of putting others before one's own needs and in helping others in need. Parents were described as "wonderful," instilling into these nurses a sense of morals, acceptance of others, and kindness towards others.

Another theme of acquisition of caring characteristics pertained to one's faith in a loving God. The nurses spoke of their beliefs that God instills within one the ability to be caring, as well as providing the motivation for one to be caring in living out one's life in replication of God's ways of being. Caring nurses told of praying that they would do the right thing, know enough to help others, and make a positive difference in the lives of others. Having faith in God inspired the desire to help others and served as a basis for caring practices.

Caring learned from life's experiences emerged as a third theme of how caring characteristics are acquired. Both positive and negative life experiences were seen as positively shaping one's own caring practices. Positive life experiences modeled caring for the participants in this study; conversely, negative life experiences were just as powerful in modeling caring as RN Participant 8 said, "I don't want to be like that—I don't want to be uncaring." Caring nurses model caring for others and enable others to see the possibilities of caring. Role modeling has been described as a way of teaching caring in the literature (Nelms, Jones, & Gray, 1993; Kosowki, 1995; Paterson, Crawford, Saydak, Venkatesh, Tschikota, and Aronowitz, 1995; and Higgins, 1996).

The fourth theme of how caring characteristics evolved described caring as being innate. Some caring nurses believed caring was genetically acquired, saying that caring was a part of one's personality, and that some people were just more caring than others. Others believed caring's inherent nature was the motivation that makes them want to help care for others.

Consequences of Caring

Caring encounters led to positive outcomes for both patients and nurses. Patient benefits resulted in the accomplishment of a good feeling towards the care experience and the feeling that all would be done in their best interests. As a result of caring, the patient felt valued as a person, which gave the patient a sense of worth, decreased the patient's anxiety, and gave a sense of trust. Other patient benefits of caring may have included reduced recovery times and improved response to treatments.

Nurse benefits of caring included the feelings of a job well done, knowing one had made a positive difference in the life of another, and having the knowledge that everything possible was done in caring for the patient. From these, nurses gained a sense of self-worth and experienced personal growth. Mayeroff (1971) noted that a reciprocal relationship exists between the caring person and the person receiving caring. As one assists the other to grow and become actualized, the caring person also grows and becomes actualized as a result of the caring interaction.

The Grounded Theory

Caring nurses possess antecedent caring characteristics that enable them to act in caring ways. Caring nurses freely choose to act in these caring ways. Through their beliefs and convictions, these nurses possess a positive attitude and a positive intent to act in certain ways, and they feel compassion and kindness towards others. They are concerned for the needs of others, and feel considerate of others. Caring nurses hope for a positive patient outcome and instill this hope into their patients. They trust in the other to improve or to find comfort and instill trust in others through their honesty and respect. Caring nurses possess a desire and willingness to help others; for some, this expression arises from a sense of obligation and duty to serve God and others.

Caring nurses have integrity and possess the quality of honesty, as well as respect for all humans regardless of circumstances. Caring nurses possess humility and courage, noting that they are just a part of a team, which is what helps the patient improve. They also are willing to take risks in helping the patient, especially if it involves standing up for what they know to be right.

Caring nurses feel connected to others and possess the ability to show this attentiveness through authentic presence with their patients. They use time creatively and effectively in meeting the needs of their patients and are willing to spend the time needed in order to fully meet their patients needs. In connecting with others, caring nurses remain open-minded and are accepting of their patients' differences by remaining non-judgmental towards these differences. Caring nurses possess patience through the ability to endure with their patients.

Caring nurses value knowledge as they provide caring to their patients. Possessing theoretical and practical knowledge in order to meet the needs of their patients, as well as possessing self-knowledge enables nurses to provide informed caring for others. Knowing the other empathetically as well as intuitively also enables nurses to act in caring ways. Sharing one's knowledge with others extends one's caring to patients, families, and other healthcare providers.

The conceptual and categorical patterns illuminated within the four domains of nurse caring characteristics (see Table 6.1 and Table 6.2) have been further reduced to a theoretical model of nurse caring characteristics (see Figure 6.1). Centered upon one's intent to act in caring ways, the theoretical model represents the nurse caring characteristics that emerged from this study. Possessing a positive intent to be caring directly affects and is affected by one's integrity, a feeling of connectedness, and one's knowing of the other. Each domain interrelates with one another as shown in Table 6.2.

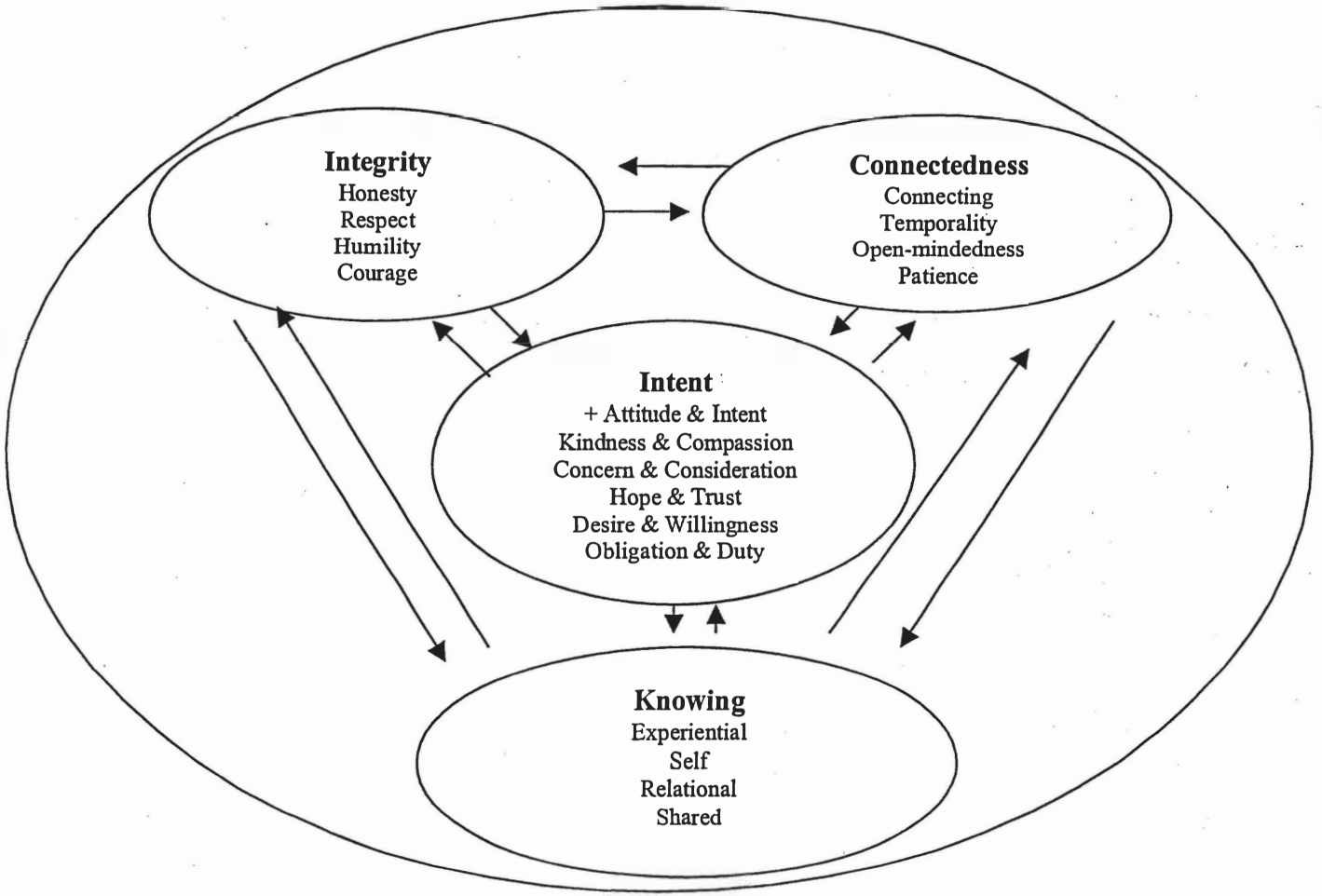

Figure 6.1. Theoretical Model of Nurse Caring Characteristics

Implications for Synthesis with Other Theories

Extant nurse caring theories can be used to examine this emerging work for the purpose of establishing theoretical relevance, potency, and fit. The grounded theory generated by this study can be synthesized into the works of Swanson (1999); Watson (1999); Wolf and Langner (2000); Hawley (2000); and Green-Hernandez (1992).

A Literary Meta-Analysis of Caring

Swanson (1999) reviewed 130 published works on the concept of caring including articles, chapters, and books, the majority of which were published between 1980 and 1996. Research findings were categorized into five hierarchal levels of caring knowledge including (a) Level I—capacity for caring, (b) Level II—concerns and commitments, (c) Level III—conditions affecting nurse caring, (d) Level IV—caring actions, and (e) Level V—caring consequences. These levels did not reflect order of importance; rather these reflect an order of level of assumption with Level V studies assuming that all previous levels had been satisfied.

Caring Capacities

Twenty-one qualitative studies with a total of 718 participants (e.g., nurses, patients and families, nursing students, and other healthcare providers) yielded information on caring capacities. From these studies, findings suggest that caring nurses are compassionate, empathetic, knowledgeable, positive, and reflective.

Descriptors within the compassionate capacity included compassionate, dedicated, possessing emotional warmth, connecting, giving of self, benevolent, committed, loving, involved, unconditional love, patient, warm, and possessing a caring

heart. Descriptors included within the empathetic capacity were understanding, empathetic, concerned, aware, perceptive, intuitive, sensitive, sympathetic, can see another's perspective, shows concern, being "in tune" (p. 35), and being receptive to patient's experience. Descriptors listed within the knowledgeable capacity included competence, knowledgeable, skillful, appropriately cautious, knows own limits, and achieves mastery. Descriptors within the positive capacity included courageous, confident, has personality, cheerful, enabling, personal qualities, self-worth, self-esteem, self-reliant, adaptive, flexible, pleasant, good self-concept, positiveness, feels good within self, and has a good mood. Descriptors listed within the reflective capacity included conscience, moral awareness, open, willing to share, balanced, visionary, looks inward, accepts and acknowledges own responses, quiet, calm, patient, constantly present in awareness of self, reflective, possesses ability to transcend ego, and genuine.

Evolution of Caring Capacities

Swanson (1999) reported that in two phenomenological investigations, questions were raised as to whether the capacity for caring is innate, taught, or a result of having been the recipient of care. Other studies provided evidence that the ability to practice expert caring improves with experience and may be linked with maturational readiness.

Caring Consequences

Watson has purported that through participation in a caring transaction, both the provider and recipient benefit, while Beck has asserted "caring is centered in authentic presencing where selfless sharing and fortifying support flourish and lead to uplifting consequences" (Swanson, 1999, p. 52). Only three studies were found that quantitatively

measured outcomes of caring. Of these, one demonstrated that certain patient conditions (e.g., self-esteem, age, and pain level) were associated with perceptions of nurse caring and sensitive and supportive nurse caring contributes to patient's coping effectiveness. A second study examined relationships between nurse caring and patient satisfaction, among other variables and demonstrated a statistically significant association between nurse caring and patient satisfaction, with caring accounting for 19% of the total variance in patient satisfaction. A third investigation of caring consequences demonstrated a significant association between administrator nurse caring and staff nurse job satisfaction.

Thirty qualitative studies were analyzed for potential outcomes of caring (Swanson, 1999). Consequences of caring from these studies included patient benefits such as enhanced well-being, including positive effects on self-esteem, mood, self-efficacy, satisfaction with care, and physical healing. Other patient benefits of caring included the recipient's feeling that he or she can count on the nurse, had less dependence, and feeling more secure in navigating the healthcare system. Nurse benefits of caring included increased feelings of well-being, both personally and professionally. Personal benefits included feelings of importance, accomplishment, purpose, awareness, integrated, whole, and confirmed. Other positive nurse benefits of caring were enhanced intuition, empathy, clinical judgment, capacity for caring, and work satisfaction, as well as a social benefit of an increased feeling of connectedness to both patients and peers.

Swanson (1999) noted that future studies should focus on how caring capacities originate, as well as examining the effects of nurturing and experience on caring capacity.

Additionally, measures need to be developed that can quantify caring capacities, as well as explore the relationship between caring capacity and caring practice.

The stories of the 19 nurse participants in this study showed similar characteristics or capacities for caring. Inherent in terms of compassionate capacity for caring, they spoke of caring interactions in which they felt that the patient's situation touched their hearts, which in turn moved them to desire to help them get better. They talked about love of others, and unconditionally loving even those who are most unlovable. RN Participant 2 believed that it was important for caring nurses to "have some type of kindness and loving in their hearts," while RN Participant 5 believed a caring nurse had "love for others as well as yourself." The nurses in this study identified ways of connecting with others as well as involving themselves intimately in their patients' problems as they used self therapeutically to resolve patient care issues. Comparably, the empathetic capacity evidenced by these 19 caring nurses included empathetic knowing, with their ability to perceive and understand the other's reality, being intuitively knowing, possessing concern and showing consideration for their patients, as well as being receptive to the patient's experience. RN Participant 8's intuitive understanding of her patient's need to go outside and see the fall colors in nature exemplified an empathetic capacity for caring.

That knowledge increased the capacity for caring was evidenced by all 19 nurses who addressed the need for knowledge in order to give the best care possible. Knowledge in this study included experiential knowing, which subsumes theoretical and practical knowing; self-knowing, which includes being competent and having confidence in one's

knowledge, as well as knowing one's own limitations; relational knowing, which incorporates empathetic and intuitive knowing; and shared knowing with patients, families, and other healthcare providers. Additionally, a positive capacity for caring emerged in this study within the domains of intent and integrity. Nurses in this study had a positive attitude, and possessed a positive intent to benefit their patients, as well as possessing a desire to help others, and possessing courage. Within the reflective capacity for caring, the caring nurses in this study demonstrated an honesty and genuineness; were willing to share their knowledge and time with others; and displayed integrity, humility, and patience.

Watson's Post-Modern Nursing and Beyond

Watson (1999) posited that it is one's consciousness that informs one's practices; caring nurses possess a caring consciousness and intentionality toward "healing, harmony, and wholeness…. Each act thereby potentiates healing" (p.230). Implementing one's caring consciousness draws on one's "feelings, emotions, inner processes, imagery, intuition, and into…the higher/deeper self—with increasing access to higher, universal consciousness" (p.231).

Watson argued that reconstructing nursing practice will demand a return to a feminist model that celebrates the integration of (a) feelings, including research and discourse on affective concepts; (b) receptivity, which involves listening, receiving, remembering, and relearning; (c) subjectivity/intersubjectivity, involving discovery through experiences, dialogue, and experiments; (d) multiplicity, which includes multiple ways of knowing based on our interactions in caring communities, with increasing

diversity in being, knowing, living, and evolving; (e) nurturing, which focuses on nourishing acts that provide comfort, ease, solitude and safety through the creation of a healing space, as well as nurturance of ideas and expanded consciousness; (f) cooperating, by instilling harmony and holism into our practices, relationships, and environments; (g) intuiting, through the use of imagination constructing a future that could be rather than accepting the reality of what is; (h) relatedness, through the construction of a exemplar of wholeness and connectedness, with "relational ontology of being, knowing, and doing" (p. 232); (i) loving and caring, which establishes the basis of being for caring practices; loving and caring are the sources for "inspiration, compassion, commitment, and energy" (p.232); and (j) peace, resulting from new possibilities of transpersonal caring, with a following hope for peace. The incorporation of these values into one's practices offers a holistic framework for nurse caring practices.

The caring nurses in this study addressed the need to maintain a positive attitude and intent in desiring to help others and in desiring a positive outcome for their patients. They addressed love and caring of others as reasons why they went into nursing, and spoke of caring exemplars that portrayed ways of nurturing and comforting others. In addition, the nurses in this study expressed their connectedness with their patients as being there for their patients, in authentic presence, spending time effectively, while accepting diversity and maintaining patience.

The Meaning of Nursing Practice

Wolf and Langner (2000) studied hospital-based nurses for four years in two urban hospital settings, using an interpretative phenomenological approach, in order to

derive meaning from the experiences of being a nurse who worked in a hospital setting. Themes that were identified included (a) becoming a nurse, in which concern over acquisition of skills was found to dissipate with time and experience, with a resultant shift in focus of the nurse's concern to that of the nurse-patient relationship as nurses learned to respect the individuality of the patient; (b) taking care of vulnerable strangers, where nurses focus on being the patient's advocate and become engaged with patients, through knowing them, learning the consequences of illness and hospitalization, which then becomes knowledge transferred to the care of others; (c) making a safe place for patients, including physical and psychological safety; (d) improvising, which includes experimentation with different ways of doing things until one finds a way that works; (e) being intuitive, and trusting one's premonition that something has gone awry with resultant quick action taken to avert any negative outcomes from happening; (f) worrying about not doing enough, including worry that the nurse lacks the necessary knowledge and skills to care for others, yet hoping that their nursing care does improve their patients outcomes; (g) witnessing the struggle, whereby nurses feel the suffering of their patients, joining with them in the struggle against disease and infirmity; (h) keeping the connections, including physical connections embodied by touching, as well as emotional connections through continued communication, even with patients in coma; (i) being sensitive to a patient's state of mind, which involves empathy and connecting with the patient in order to view reality from the patient's perspective, as well as going out of one's way in order to improve the patient's state of mind; (j) engaging in therapeutic dialectic, through maintenance of the nurse's intention for therapeutic care while

attending to the patient's demands; (k) caring for patients, physically and psychologically, using nursing knowledge and one's own humanity to assist patients in meeting their current crises; (l) caring for family members, sharing knowledge with them, supporting them, listening to them; (m) caring for dying patients, "nurses mourn the end of their patients' dreams as death comes…at the same time rejoice in their release from suffering," (p. 13); (n) supporting and recognizing each other, which supports a collegial environment in which everybody works for the good of the patient, as well as provides role models for socializing new nurses into patient care; (o) making a difference for patients and families, involving positive feelings of why one goes into nursing as well as motivating nurses to stay in nursing; (p) keeping memories, which are produced by nurses' and patients' interactions with one another, lasting a lifetime; (q) never knowing if patients have happy endings, which reflects today's healthcare environment in which short patient stays result in patients' early discharge before healing is complete, resulting in the nurse needing to trust in her ability to do all that is humanly possible to set the patient on the path to recovery during hospitalization; and (r) staying in hospital nursing, which based the great physical and mental stamina required to stay in hospital based practice may be surprising, yet affords the greatest rewards as nurses rely upon lessons learned in school to always give their best and go the extra mile, learning with experience that one often takes chances and breaks rules to provide the most meaningful intervention that provides comfort to the patient. Summing up the experience of hospital-based nursing practice, one of the study participants said, "Hospital nursing allows us, through sharing our knowledge, skill, intuition, and humanity, to change moments in people's

lives. In return patients give us so much, most of all, the permission to experience these moments with them" (p. 16).

Nurses share the experiences of hospitalized patients, families, and other nurses. The heart of nurses' caring protects patients and keeps them safe, while striving to know and understand the reality of patients' experiences, as well as witnessing and sharing their suffering, while continually providing expert care in an environment laden with uncertainty and unpredictability. Framed within Watson's (1988) work, being a hospital-based nurse is grounded in freely choosing to act and autonomy of action, as well as meaning of the perceptions and experiences of both patient and nurse. Nurse caring results in a caring transaction, with an outcome of caring being the "protection, enhancement, and preservations of the person's humanity, which helps to restore inner harmony and potential healing," (Watson, 1988, p. 58). The focus of nurse caring attends to the process of being human, the activities of caring, the intersubjective feelings between patient and nurse, and the personal individuality of nurse and patient. Nurse caring is a moral commitment freely chosen by nurses with attention placed on positively impacting another's life.

The stories of the 19 caring nurses in this study are congruent with the findings of Wolf and Langner. Similarly, the nurses in this study became engaged with their patients, and came to know their patients empathetically and intuitively. They connected with others to bear witness of their patients' struggles, successes, and failures, attending to them with compassion, honesty, respect, and patience. Caring nurses extend their caring

beyond their patients to families, as well as to other nurses, and truly hope to make a difference in others' lives.

Moments in Nursing

Moments in nursing practice were the focus of an interpretive study undertaken by Hawley (2000). Memorable experiences in the nursing practice of three nurses were analyzed for meaning; from this analysis, five themes emerged that reflect authentic encounters, which bring about profound changes in the lives of patients. These five themes included (a) a moment of understanding, which is founded upon intuitive empathy, or knowing the patient and having a feeling of connectedness, which facilitates the nurse's immediate understanding of the meaning of the experience for the patient; (b) a moment of being present, in which the nurse acknowledges the uniqueness of both patient and situation, while attending to the other with authentic presence through listening, and responding honestly and willingly, thereby implicitly communicating to the patient that both she and her well-being matters to the nurse; (c) a moment of comforting, whereby nurses explain procedures, through simple yet thorough explanations of the care activities that are necessary, thus, instilling trust in the patient that everything that can be done is being done, and at the same time, including the patient as a partner in his care; (d) a moment of touching, in the form of a grasp of a hand, a hug, or a touch on the shoulder, symbolizing an immediate participation with the other, conveying that someone is there to share the suffering, through the transfer of the strength, courage and hope of the nurse's touch; and (e) a moment of encouraging, through active listening, with respect for

patient autonomy, helping patients discover the possibilities of what might be, through this process, giving the patient the gift of courage to endure.

Nurses nurse in moments that surround genuine encounters. It is within these genuine moments that nurses succeed at nursing, when nurses respond to patients honestly and with tact, when nurses give courage to patients or families, when nurses comfort, when nurses touch others. A nursing moment as described by Hawley (2000) is "a relational encounter in which the vulnerable other is experienced as a call…to be authentic…to be present as a nurse. In recognizing the vulnerability, the nurse may experience an appeal to act responsibly to the patient's need" (p. 22). These moments of nursing may seem to some to be trivial; to nurses, however, these moments are the memories that nurses cherish. These meaningful moments bring a sense of fulfillment and satisfaction to nurses and supply the reasons nurses remain involved with their patients and families.

A few years ago, a local university had a nursing t-shirt fundraiser for the Nursing Students Association chapter. The t-shirt said something to the effect of, "Nursing, a career not measured in years, but in moments." When I began the interviews with the participants in this study, I asked them to tell me of a nursing encounter whereby they felt they demonstrated nurse caring to the patient or family. The nurses immediately all spoke passionately about a particular patient or incident, which they felt "touched their hearts," or where they "went above and beyond," or "went the extra mile," or "it was something I felt I needed to do." The caring nurses in this study had stories of nursing moments that were congruent with those described by Hawley. They experienced moments of

understanding, such as when RN Participant 6, after several hours, understood his head-injured patient's agitation was based on his need to know his child had survived the accident. These nurses spoke of moments of being present, in which their presence made a difference in the patient's experience. For example, when RN Participant 19 related a story of her patient who had a chronic pain syndrome, and who others shunned, she talked of spending considerable time with her, letting her know that she heard her concerns and that the patient mattered to her. These nurses spoke of moments spent comforting their patients, telling them honestly what would transpire and instilling trust in them. The nurses in this study addressed moments of touching, acknowledging the importance of knowing when not to touch as well as when to touch the other. RN Participant 7 related how she felt her touch on her blinded patient's arm, knowing the environment was hard to be heard in, helped calm and comfort him during a helicopter flight to the hospital. These caring RNs spoke of moments of encouraging their patients through their attentive presence, and through their display of respect for them. RN Participant 19 addressed the need to respect her patient's autonomy, by giving her choices and to have an active voice in her care.

Green-Hernandez' Professional Nurse Caring Model

Nurse caring arises from one's lived experience of having been the recipient of natural caring, caring which has been given because of love for another, often within the family context (Green-Hernandez, 1991). Nurse caring is an intentional process that includes physical and psychosocial nursing interventions, which promote healing and are based upon formal nursing education, acquisition of technical competence, and

professional experience. In explicating a professional nurse caring model, Green-Hernandez (1992) explored the concept of being there as the basis of the model and identified seven concepts, including being there, support, empathy, communication, helping, time, and reciprocity, all of which she designated as attributes of nurse caring and which guide the model. In the Professional Nurse Caring Model, a caring nurse is one who possesses a foundational knowledge base, the competence to act skillfully, and the confidence to act on the behalf of the patient.

As conceptually described within this model, being there and support maintain that the nurse exhibits a predictable, non-judgmental presence for the patient, demonstrating nurturance, advocacy, alliance, and access. The conceptual description of the concept of empathy infers that the nurse enters into the patient's reality in order to gain knowledge and understanding, thereby enabling the nurse to better meet the patient's needs. Communication is conceptualized as the nurse effectively communicating with the patient using all possible forms, including verbal, non-verbal, and tactile ways of communicating. Helping and time are interrelated concepts because the nurse must first perceive that time is available in which to help others. Reciprocity of caring addresses the growth and actualization of the nurse as a result of caring.

Congruence with these concepts was evident in the stories of the 19 caring nurses in this study who acknowledged knowing the patient, and knowing how to care for the patient, as well as being there for the patient while supporting the patient through non-judgmental acceptance were important caring characteristics. Caring nurses found ways of communicating with patients in order to meet their needs, from intubated patients to

head-injured patients to mentally ill patients, and caring nurses found effective and creative ways of managing time in helping others and in meeting the needs of their patients. Caring nurses acknowledged a reciprocity of caring, saying they positively benefit from being a caring nurse.

Implications for Further Research

The stories of the caring nurses who participated in this study can be used to develop quantitative instruments that will enable caring characteristics, capacities, or abilities to be measurable. To date, only one tool, the Caring Abilities Inventory, exists that purports to measure antecedents of caring behaviors and its structure measures only three of Mayeroff's caring ingredients (i.e., knowing, patience, and courage). Other caring tools focus on caring behaviors. It would be valuable to be able to measure precursors or antecedents (e.g., caring characteristics) of caring through use of a quantitative tool. Having the capability to measure caring characteristics could be used to assess a nurse's caring capacity, design methods for increasing caring capacity, and evaluate the acquisition of caring characteristics.

Having a reliable and valid instrument, which measures caring characteristics, could lead to a variety of studies in determining associations between caring characteristics and caring behaviors. In addition, such an instrument could be used with other existing instruments which measure caring behaviors, allowing for testing models of caring. Presumably, in the future, an instrument that measures caring characteristics could be used to predict caring capabilities, as well as predict caring behaviors and outcomes based upon one's caring characteristics profile.

Data from this study described caring characteristics of RNs identified as caring by supervisors or other RNs who were all employed at one suburban hospital. It would be a natural extension of this research to see if these findings hold up across settings, with potential replications in rural and urban settings, as well as non-hospital based settings in which RNs are employed.

Implications for Nursing

Nurses, nurse educators, and nurse administrators value nurse caring. Understanding nurse caring characteristics and how these evolve will assist nurse educators in designing appropriate teaching strategies to enhance students' acquisition of caring characteristics. In addition, experiences can be planned that allow students to practice in caring ways, thus furthering their acquisition of caring characteristics. Caring behaviors and caring practices result from antecedent caring characteristics, which can be learned from both positive and negative examples. Caring curricula influence students' acquisitions of caring characteristics and caring behaviors. While this study may not have uncovered all possible caring characteristics, it is a beginning.

In today's competitive healthcare climate, having caring nurses employed within a particular agency is seen as a positive benefit to both patients and other consumers of healthcare services. Nurse administrators may be able to use the knowledge discovered by this study to support caring nurses in the workforce. Previous studies that have examined nurse caring behaviors have shown a direct correlation between nurse caring and an increase in patient satisfaction with their care (Dingman, Williams, Fosbinder, & Warnick, 1999; Swanson, 1999). The identification of caring nurses who could be called

upon by administrators to serve as mentors and role models for nursing staff members could enhance the caring environment within an agency.

Nursing practice, as a result of this study, may have been validated as to the importance of nurse caring and the antecedent characteristics of nurse caring. Studies have shown that in addition to positive patient benefits, nurses also reap positive rewards from engaging in caring practices, as a result of connecting with others in authentic presence. This reciprocity of caring results in the growth and actualization of both the provider and recipient of care.

Conclusion

The findings of this study led to the generation of a theoretical model of nurse caring characteristics, comprised of four domains that are interrelated. These domains of caring characteristics include the central theme of intent, which directly influences and reciprocally is influenced by the themes of integrity, knowing, and connectedness. This emergent conceptualization of nurse caring characteristics has the potential for influencing how we might foster them in both education and practice.

The domain of intent includes the caring characteristics of possessing a positive attitude and intent to act caring, having kindness and compassion towards others, being concerned and considerate of others, having hope and trust, possessing the desire and willingness to act on the behalf of others, and feeling a sense of obligation and duty to act on the behalf of others. The domain of integrity includes the caring characteristics of being honest, respectful, and humble, while possessing the courage needed to act. The domain of connectedness includes the caring characteristics of connecting with others,

remaining open-minded and tolerant of differences, being patient with others, and using time effectively and creatively in connecting with others. The domain of knowing includes the caring characteristics of experiential knowing (i.e., theoretical and practical), self-knowing, relational knowing (i.e., empathetic and intuitive), and shared knowing.

The 19 caring nurses who shared their time and stories with me allowed me to learn from their lived experiences what characteristics constitute a caring nature. They unselfishly gave their time in telling me their stories and in doing so, modeled many of the characteristics about which they spoke. They were humble, respectful, courageous, and honest in their depictions of nurse caring. They modeled their knowledge and spoke of the importance of knowing as it relates to patient care. They spoke of connecting with others and being tolerant of others as well as maintaining a positive attitude, and always desiring positive outcomes for their patients. The nurses in this study shared priceless caring nurse moments with me, to which I am most grateful.

As a nurse educator, I am always fascinated with the reasons why people go into nursing, believing that most still choose to go into nursing in order to help others. These nurses supported that belief. A surreptitious result of this research was the witnessing of the excitement and passion for nursing and caring that was evident in these nurses' stories. These nurses live caring practices, and upon telling me about their nurse caring, they seemed to leave the interview energized by the exchange. As a result of my hearing their stories, I became excited and passionate about nursing all over again, remembering the reasons why I went into nursing, and why, almost thirty years later, I am still proud to be a nurse.

In conclusion, it is my sincerest hope that this study's product illuminates an area of nurse caring that had not yet fully been explicated. I also, with my deepest desire, hope that I have remained true to the nurses and their stories represented in this study.

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APPENDIX A

Interview Guide

Interview Questions

1. What does caring mean to you?
2. Describe a situation or incident in which you exemplified caring in your nursing practice in meeting the needs of your patient
3. How do you know that you are a caring person?
4. What characteristics do you think you need to possess in order to be caring? How did you develop the caring characteristics that you possess?
5. Do you find that one of these characteristics is more important in order for you to be a caring nurse than the other characteristics? If so, which one and why?
6. What beliefs do you have about caring in nursing?

Demographic Information

1. Age.
2. Gender.
3. Educational preparation and number of years in nursing.
4. Brief description of nursing work experience.
5. Cultural heritage/ethnic background.

APPENDIX B

Institutional Review Board Approval

TEXAS WOMAN'S
UNIVERSITY

DENTON / DALLAS HOUSTON

HUMAN SUBJECTS
REVIEW COMMITTEE
P.O. Box 425619
Denton, TX 76204-5619
Phone: 940/898-3377
Fax: 940/898-3416

March 12, 1999

Ms. Deborah Davenport

Dear Ms. Davenport:

Your study entitled "Generation of a Theory of Courage to Care" has been reviewed by a committee of the Human Subjects Review Committee and appears to meet our requirements in regard to protection of individuals' rights.

If applicable, agency approval letters obtained should be submitted to the HSRC upon receipt. **The signed consent forms and an annual/final report (attached) are to be filed with the Human Subjects Review Committee at the completion of the study.**

This approval is valid one year from the date of this letter. Furthermore, according to HHS regulations, another review by the Committee is required if your project changes. If you have any questions, please feel free to call the Human Subjects Review Committee at the phone number listed above.

Sincerely,

Jerry D. Wilkinson

Chair
Human Subjects Review Committee

cc. Graduate School
✓Dr. Gail Davis, College of Nursing
Dr. Carolyn Gunning, College of Nursing

West Texas A&M
UNIVERSITY

Division of Nursing

May 14, 1999

Deborah Davenport

Dear Ms. Davenport,

The Institutional Review Board has reviewed your proposal entitled "Generation of an Explanatory Model of Human Caring in Registered Nurses." I am pleased to inform you that your study has been approved. This approval is extended for one year. Should data collection extend beyond one year or if there are any changes in methodology as it affects human subjects, we ask that you resubmit the study to the IRB.

Thank you for your cooperation with this committee and we wish you well with your research project.

Dr. Vaughn Nelson
Dean, Graduate School

Dr. Rebecca Robinson
Chair, IRB

xc: Nelson
Robinson

A Member of The Texas A&M University System

WTAMU Box 60969 • Canyon, Texas 79016-0001 • 806-651-2630 • Fax 806-651-2632

APPENDIX C

Agency Approval Letter

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Northwest Texas Healthcare System

GRANTS TO Deborah Davenport, RN, MSN, CCRN
a student enrolled in a program of nursing leading to a Doctoral Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

CARING CHARACTERISTICS OF REGISTERED NURSES

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Date: 4/14/95

Signature of Agency Personnel

Signature of Student

Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original - Student: First copy - Agency. Second copy - TWU College of Nursing.

APPENDIX D

Subject Consent to Participate in Research

TEXAS WOMAN'S UNIVERSITY
SUBJECT CONSENT TO PARTICIPATE IN RESEARCH

Tentative Title of Study: *Generation of an Explanatory Model of Human Caring in Registered Nurses*

Investigator:

Deborah Davenport, RN, MSN

806-655-8255

Supervising Professor:

Dr. Gail Davis
PO Box 425498
Denton, Texas 76204
940-898-2409

I understand that I have been asked to provide a name of a person I consider to be a caring registered nurse to the study's principal investigator, Deborah Davenport, who is completing doctoral course requirements at Texas Woman's University in Denton, Texas. The purpose of this study is to examine caring attributes and characteristics in registered nurses.

By my return of this request, I agree to allow my responses to be used for research purposes in this study. I understand that my name will not be used in the study, although the investigator may identify me to the potential participant as the one who recommended her/him. The information of the attached questionnaire will not be identified with me in any other way. I have been informed by the investigator that the information I provide will be coded with a number for confidentiality purposes and that this information will be kept in a locked file cabinet in the investigator's home. After completion of the study, the information I have provided with be destroyed by shredding.

I understand that by participating in this study, I will be helping to contribute to knowledge development that will further of understanding of caring in nursing. I understand that my participation will not be financially reimbursed.

The researchers will try to prevent any problem that could happen because of this research. I should let the researchers know at once if there is a problem and they will help me. I understand, however, that TWU does not provide medical services or financial assistance for injuries that might happen because I am taking part in this research.

*Signature of Participant*_____ *Date*_____

The above consent form was read, discussed, and signed in my presence. In my opinion, the person signing said consent form did so freely and with full knowledge and understanding of its contents.

*Signature of Investigator*_____ *Date*_____

ID#____

The name of the registered nurse I consider to exemplify caring characteristics is:

_____

The reasons I believe this nurse is a caring individual are: (discuss characteristics you feel this nurse possesses and give any description that you think might be helpful):

TEXAS WOMAN'S UNIVERSITY
SUBJECT CONSENT TO PARTICIPATE IN RESEARCH

Tentative Title of Study: *Generation of an Explanatory Model of Human Caring in Registered Nurses*

Investigator:

Deborah Davenport, RN, MSN

806-655-8255

Supervising Professor:

Dr. Gail Davis
PO Box 425498
Denton, Texas 76204
940-898-2409

I understand that I have been invited to participate in a study conducted by Deborah Davenport, who is completing doctoral requirements as a student in the College of Nursing at Texas Woman's University in Denton, Texas. The purpose of this study is to examine caring attributes and characteristics in registered nurses.

I understand that my participation in this study is strictly voluntary. If I decide to participate in this study, I understand that I will be interviewed by the investigator for approximately one hour. During this interview, I will be asked to describe a situation or situations in which I felt I was a caring nurse, along with other exploratory questions that will enable me to fully describe my caring in my nursing practice. I also understand that the interview will be audiotaped in order to develop a written transcript of my interview for data analysis purposes. I have been informed by the investigator that the audiotape and transcript will be coded with a number for confidentiality purposes; no other identifying information will be kept. Both the tape and the written transcript will be kept locked in a file cabinet in the investigator's home. After completion of the study, or at the end of three years, both the audiotape and the transcript will be shredded.

I understand that I may withdraw from the study at any time without penalty prior to the preparation of the final report.

I understand that I will be allowed to review the transcript of my audiotape and/or the investigator's interpretation of my transcript for accuracy. I have been informed of how to obtain a copy of the results of this study if I wish.

At any time during my interview and upon completion of it, I understand that I may feel free to ask questions. It has been explained that I may encounter some emotional feelings during my memory of events that I will be asked about. The investigator and I will have a chance to talk about these feelings and any concerns after the interview. This is called "debriefing," and I will be allowed to fully express my feelings during this time.

Participant Initials: _____

I understand that my participation will be kept strictly confidential and will not be discussed with anyone. Portions of my transcript, minus identifying information, will be shared with dissertation committee members periodically during the analysis of the data.

By participating in this study, I will be contributing to knowledge development what will further our understanding of caring in nursing. I understand that my participation in the study will not be financially reimbursed.

I understand that if I have any questions about the research or my rights as a participant, I may call the investigator or her supervising professor at the phone numbers listed above. If I want to report a problem with this study, I may call these same individuals or Ms. Tracy Lindsay in the Office of Research and Grants Administration at 940-898-3375.

The researchers will try to prevent any problem that could happen because of this research. I should let the researchers know at once if there is a problem and they will help me. I understand, however, that TWU does not provide medical services or financial assistance for injuries that might happen because I am taking part in this research.

I release Texas Woman's University and the undersigned party acting under the authority of Texas Woman's University from any and all claims arising out of such taking, recording, reproducing, publishing, transmitting, or exhibiting as is authorized by Texas Woman's University.

By signing this consent form, I am giving permission for my voice to be recorded onto audiotape by Deborah Davenport. I understand that the material recorded during my interview will be used for research purposes and give permission for such use.

I have been given an explanation about this study and the opportunity to ask questions about this research. I have also been given a dated and signed copy of this consent form to keep.

*Signature of Participant*_____ *Date*_____

The above consent form was read, discussed, and signed in my presence. In my opinion, the person signing said consent form did so freely and will full knowledge and understanding of its contents.

*Signature of Investigator*_____ *Date*_____