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**CARING, VIRTUE THEORY, AND  
THE NURSE-CLIENT RELATIONSHIP**

by

**Marilyn A. Sutton**

**A Thesis  
submitted to the  
Faculty of Graduate Studies and Research  
through the Department of Philosophy  
in partial fulfillment of the  
requirements for the Degree  
of Master of Arts at the  
University of Windsor**

**Windsor, Ontario, Canada**

**1997**



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**ABSTRACT: CARING AND VIRTUE THEORY IN THE  
NURSE-CLIENT RELATIONSHIP**

by

Marilyn A. Sutton

The purpose of this essay is to investigate the use of caring as an ethical grounding for the nurse-client relationship. In the first chapter, some of the crucial components of an effective relationship are identified. Applying these components, three models of nurse-client interaction are reviewed: parental, technical, and contractual. Although all three are found wanting, the contractual approach is deemed the most workable, because it recognizes the values of both nurse and client. However, its view of them as equal partners in a non-legalistic agreement is not realistic, and is somewhat impersonal in its approach. Caring theory, which accommodates the major assumptions, principles, and convictions of the contractual model, is then presented as a viable alternative. In particular, Jean Watson's (1979, 1988) transpersonal human-to-human care theory is explored and discussed. However this approach also has its problems. Critics object to Watson's idealism, and cite burnout and loss of objectivity as serious threats to a caring relationship. Furthermore, the total lack of any inherent control within the concept of caring itself, poses a major difficulty. There is no way to know how or how much to care. Given the observed similarities between Watson's theory and the virtue theory expounded by Alasdair MacIntyre in *After Virtue* (1984), the MacIntyrian theory is suggested as a possible solution. This last section does not claim to have demonstrated that virtue theory is an appropriate response, but with the increased interest in the

character of the agent, it provides promise and merits further study. The conclusion is that Watson's theory is better suited to nursing relationships which extend over an prolonged period of time, for example, community health or psychiatric nursing. Caring itself is crucial to an ethical nurse-client relationship and may be more appropriately viewed as a moral imperative, a stance, or a virtue.



**For my "sonshine"**

**Jim, John, Mike, Matt, and Dan**

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## Caring, Virtue Theory, and The Nurse-Client Relationship

### **Introduction**

Not long ago, I had the opportunity to listen as a young man addressed a nursing conference about his struggle with a diagnosis of HIV (Human Immunodeficiency Virus). The news was devastating and he spoke with deep emotion about his fear and isolation, his desperation and the utter futility of his life. As each day passed he became more and more depressed. Finally the death of a close friend from AIDS drove him over the edge, and he began to plan his suicide.

In anticipation of his demise, he began to put his affairs in order and to say his goodbyes. One such task led him to the HIV Care Program to return some reading materials. It was there, he said, that something happened to change the direction of his life forever. One of the nurses took the time to look beyond the obvious, and she recognized his action for what it really was. Subsequently she invited him to her office "to talk a bit." As he told it that day, "She sat with me; she held my hand; she listened; she cared: and that has made all the difference."

I do not mean to imply that this one nurse-client interaction solved this young man's problem, but I do believe the encounter was the first step in his journey toward acceptance. There seems little doubt as to the outcome if the nurse had not intervened, and more importantly if that nurse had not "cared about" this client. This narrative serves to illustrate one of my strongest beliefs about the practice of nursing, it must be grounded in an ethic of care. Without caring, nursing is reduced to a task oriented profession, focused on the technological and scientific aspects of care.

Historically nursing has been associated with caring since its inception by Florence Nightingale (1860). However with the advance of science and technology in the 1960's, caring and the art of nursing took a back seat. In recent years, though, caring has enjoyed a resurrection. Many theorists now tout it as the essence of nursing (Fry, 1988; Leininger, 1984; Noddings, 1984; & Watson, 1979, 1988). The work of these scholars goes beyond nursing roles and functions to encompass an understanding of nursing grounded in the human care ideal. In particular, it is Jean Watson's (1979, 1988) Transpersonal Theory of Care which I promote and support.

In this paper I argue that Watson's model is not only a viable alternative to other models but that it is the most desirable one. It advocates a human-to-human approach to nurse-client relationships which I interpret as fundamental to ethics. Watson herself presents it as "a moral ideal of nursing" (1988, p. 74). This is not to suggest, however, that there is no place for other types of nurse-client relationships, I allow that they do have some application, albeit a limited one.

To begin, I review the major characteristics and components of effective nurse-client relationships. I accomplish this by investigating the meaning of the helping relationship, the balance of power between nurse and client, the holistic approach to health care, and the ethical component. I also take a look at the definition of health.

The next section comprises an inquiry into those types of nurse-client relationships not generally presented as caring models. Although caring can and does occur within such nurse-client relationships, the models themselves are not grounded in caring theory. My discussion centres on three categories of relations: parentalist, technical, and contractual.

I conclude that although there is a fundamental problem with contractual models, that is, nurse and client are seldom, if ever, equal partners, it offers the most potential for an effective nurse-client interaction.

Chapter III comprises some general thoughts about caring itself and its historical connection to nursing. A distinction is made between two senses of care, "caring for" and "caring about." Although both aspects are important to nurse-client relations, it is "caring about" which Watson promotes as the art of nursing.

This brings me to Chapter IV where I present an overview of Watson's notion of transpersonal human-to-human caring. She believes that the nurse-client relationship is central to nursing and that caring is fundamental to the relationship. The caring ideal elevates nursing to a higher plane. It also raises the awareness of both client and nurse and initiates their self growth and development. Key components of the model are also addressed, for example, life history, self, and phenomenal field. But Watson's theory is not without its problems and difficulties. In particular it has been criticized for its idealistic nature, and in general for its potential loss of objectivity and its tendency to burnout. Another objection is that the caring concept has no regulatory force within; there are no guidelines to tell us how to care or how much to care. A discussion of these objections completes the chapter.

In Chapter V, I offer a possible solution to the above criticisms through the application of Alasdair MacIntyre's (1984) virtue theory. It is perhaps by concentrating on the character of the agent that at least some of the problems delineated can be reduced. I suggest that nursing fits the MacIntyrian definition of practice and that caring is a virtue

in the MacIntyrian sense. It should be noted however that this section is merely a beginning, an introduction, if you will, to another thesis. Although I believe that MacIntyre's proposal to return to virtue ethics has merit for nursing, there is still much work to be done. Further investigation is needed.

## **Chapter I – The Nurse-Client Relationship**

The importance of the relationship between nurse and client for the healing process cannot be overemphasized. It is not only the vehicle for the application of the nursing process, it is the very foundation upon which nursing as a practice is built. Without this relationship nursing as such would cease to exist. This last statement appears so obvious at first glance it seems ludicrous to mention it all. However, it is for this very reason that it is worthy of note, the obvious often gets overlooked. Nurses and other health care professionals would do well to reflect often and much on the reason for their profession: the client.

Relatively speaking the focus on the nurse-client relationship is a fairly recent development. In the last two decades, as nursing matured as a profession and struggled to separate itself from its medical counterpart, a profusion of philosophies and theories appeared in the literature. It was during this time that the centrality of the nurse-client relationship rose to the forefront, and its healing influence took on a new depth and meaning. Both nursing and philosophical literature testify to a conscientious and fundamental interest in this interpersonal relationship (Aroskar, 1980; Benjamin & Curtis, 1985, 1987; Brock, 1980; Curtin, 1979; Gadow, 1980; Noddings, 1984; Smith, 1991; & Watson, 1979, 1988). Yet despite the quantity, and I might add, the quality of the research, the issue of the nature of the relationship between nurse and client remains controversial. How should nurses and clients relate to each other? Should nurses assume the role of parent, technician, partner, or a combination of all three? Should nurses "care about" those for whom they provide service or should they keep their distance?



What type of relationship most personifies the client's best interest? And who identifies these best interests? What about the best interests of the nurse? Should these be considered? Just what is the most ethical way for nurses to relate to their clients? These and other questions have plagued, and continue to plague, theorists and researchers in the field. As Smith (1991) points out, since assumptions concerning the character of the nurse-client relationship pervade the discussion of ethical dilemmas in nursing, their resolution is of prime importance (p. 144). I do not expect to solve these problems within the context of this essay; I propose however, that caring theory offers a viable solution.

Although I present caring as the most ethical way of relating to clients, I do not mean to imply that it is a magic ingredient. Caring is not just a thing out there; it is not something that can be added to a relationship like sugar to sweeten a recipe. Rather, it is a stance, a moral commitment, and as I suggest, a virtue that can be acquired. In itself it is a complex concept, and when coupled with the diversity of human beings becomes even more complicated. Every nurse-client relationship is unique. The specific "hows" and "whys" of each interaction require a certain amount of flexibility. This is not to say the terms of the relationship can simply be left to chance, for this would result in relativism. Whereas it is certainly appropriate to consider cultural norms, social traditions, and individual needs, it is also important that we have some understanding of what a caring nurse-client relationship entails. Without some objective, universal criteria, caring would be reduced to mere feeling and emotion. It would be virtually impossible to identify caring behaviours or activities. An act could be simply justified

by the claim "I felt it was the most caring thing to do." I knew a nurse who used this defense to explain why she had not informed a client that his blood count had dropped significantly. The nurse thought it would spoil his vacation. It did. The client became critically ill in a foreign country and has never quite recovered. There are certain theoretical and moral principles common to all effective nurse-client transactions, certain rights and responsibilities that must be upheld, while at the same time allowing for creativity and adaptation to specific circumstances. For example, such universals as respect for another as a person and informed consent should persist despite the circumstances. A viable model is one that incorporates these concepts and principles yet recognizes the peculiar qualities and idiosyncrasies inherent in every relationship. Although there are different ways of responding to clients the same rule or principle still applies.

In this chapter my main task is to explore the major considerations for an ethical nurse-client relationship. I elaborate on the holistic approach to health care as opposed to a strictly medical model. The importance of the "helping relationship" is emphasized within the context of a comprehensive view of health. The issue of the balance of power within the relationship is also examined with an eye toward its potential for positive influence by the nurse. Although all the aforementioned constructs have an ethical overtone, I spend some time discussing the specific ethical component of the relationship: the simple recognition and relation of one human being to the humanness of the other. This is what I call "real ethics."

Before I begin however, there are two items relating to terminology that I wish to

clarify. First of all, I have chosen to use the term "client" as opposed to the more traditional "patient" or the more modern "consumer" or "service user." One reason is that this usage is in keeping with the College of Nurses of Ontario (1995). More importantly though, the picture that the concept "client" evokes is more in keeping with the theme of this paper. According to Webster (1991) a client is "a person who engages the professional services of another" (p. 288). This interpretation suggests that the individual has some control over the situation and is an active participant in the relationship. Although it may be implicit at best, it is the client who actually initiates the relationship with the nurse simply by his/her presence. In direct contrast, one definition for "patient" cited by Webster is "someone who is acted upon" (p. 863). This translation clearly places the individual in a passive role, which tends to encourage feelings of helplessness and dependency. Whereas at times a passive, dependent client role may be unavoidable and even desirable, for example, during crisis or following some surgical procedures, prolonged adherence to this mode of behaviour can be detrimental to the resumption of client autonomy. It has been shown that clients who participate in the decision making process concerning their care and treatment, and who take a keen interest in their health and illness fare much better than those who do not (Brock, 1980; Gadow, 1980; Noddings, 1984; Rogers, 1971; & Watson, 1979, 1988). Lastly, nurse-client relationships tend to be quite intimate and the terms "consumer" and "service user" are simply too impersonal for my taste. I suppose though, in the final analysis the label is of little consequence: it is the manner in which the person who wears it is perceived and treated that really matters.

My second point relates to the complexity and diversity of nurse-client relationships. It is virtually impossible to write a thesis that will encompass all types of nurse-client interactions. Guidelines and assumptions differ depending on the situation. By this I mean that special consideration must be given for children, for those who are comatose, and those otherwise mentally incompetent. Therefore, in an effort to manage the following discourse, my discussion will assume a competent adult client. Even with this stipulation the diversity of relationships encountered is overwhelming. In any case, it is crucial to the argument of this paper that the client be perceived as capable of making his or her decisions, at least in principle. Now let me turn to some principal reflections about the nurse-client relationship.

### **1.1 Holistic approach**

Clients enter into a relationship with a nurse for a variety of reasons. Recent years have witnessed an increase in the numbers who seek some type of preventative or health promotional intervention, for example prenatal education and nutrition counselling. But for the most part the main reason for initiating contact with the nurse is therapeutic in nature. That is, the client has a need to be cured or otherwise relieved of some illness or condition. This concern with the curative aspects of care, with its corresponding scientific and technological foundation, has perpetuated use of what is called the medical model. Here the physician diagnoses and treats, the nurse follows orders, the client complies, and hopefully gets well. Although nursing is moving away from this type of disease - focused model, this image continues to be entrenched in many health care settings today (Aroskar, 1980).

Of itself, there is of course nothing wrong with attending to the client's therapeutic needs; after all these are usually the reasons for the client's entry into the health care system in the first place. The problem arises when the focus becomes selectively curative and medicinal to the exclusion of other needs. In contrast to the disease focused model, contemporary nursing ascribes to an holistic approach to health care (College of Nurses of Ontario, 1995; Gadow, 1980; Noddings, 1984; & Watson, 1979). In this model, the client is perceived as an integrated whole, with biological, psychological, sociocultural, spiritual, and intellectual components. Each part interacts with all others and ultimately has an impact on the client's total life process. Thus, to attempt to care for any one part in isolation is both self defeating and rash. The nurse must learn to relate to the client as a whole being, integrally part of family, community, and environment.

Ideally, holistic nursing aims at restoring the client to optimal health and function. Within the context of their relationship the nurse, "enables the client to attain, maintain, or regain optimal functioning" (College of Nurses of Ontario, 1995, p. 6). However, this does not mean that the nurse is always around to see this goal realized. On the contrary, since most nurses are hospital based, they are no longer in the picture when and if this occurs (Aroskar, 1980). Hospital stays are limited, and with the exception of accidental meetings nurses rarely see clients after discharge. It is only their nursing colleagues in community health or other long term care facilities who may actually witness a client's return to optimal health. Yet even this is doubtful, because current health care reform with its budget constraints, cutbacks, and reduced visitation schedules

has severely impacted on nurses' involvement with clients. Frustration and discouragement are common as nurses bitterly lament their lack of time for meaningful client interaction, and complain at length about bureaucratic demands. It is little wonder that they often feel like giving up, and sometimes consider compromising their ideals. But if these are difficult times for nurses, they are even more so for clients who struggle to find their identity in an overburdened and impersonal system. Tough times call for creativity and innovation that demand strong solutions. It is to this challenge that nurses must rise.

I believe that under such circumstances nurse-client relationships become more important than ever. Even though contact with clients may be limited by today's health care constraints, nurses still continue to have the most sustained client interaction when compared with other health care professionals (Gadow, 1980, p. 81). It is therefore crucial that every encounter is used to its fullest potential in order to create and maintain an environment conducive to recovery and healing. Clients must be continually apprised of what is going on, and be encouraged to participate in their care and treatment. The more information that is provided to clients, the more they and their families will understand what is happening, and the more they will be able to make good decisions. Nurses who are sensitive and responsive to clients' needs also play a critical role in alleviating negative emotions and reducing stress. Although there is limited scientific evidence to date, it is widely believed by health care professionals, that emotions such as fear, anxiety, and loneliness can have dire effects on clients' well-being and convalescence. (Anderson, 1993; Leininger, 1988; Noddings, 1984; Travelbee, 1971; &

Watson, 1979). Hans Selye (1975), a pioneer in the field of stress and adaptation has demonstrated the profound impact of stress on the immune system and subsequently on the clients' power to heal. It follows that nurses who are predisposed to recognize these symptoms, to respond positively and with sensitivity can greatly influence the healing process. In an interview concerning effective healing environments, Dr. Ron Anderson (1993) concluded that an atmosphere of trust, respect and caring is more important to getting well than any technology or medication. He is convinced that, "Caring is good medicine" (p. 26). But not only is it good medicine, it is also a fundamental need.

Madeline Leininger (1984), Nel Noddings (1984), and Jean Watson (1988) are among those who have identified caring as a universal need. Although the actual processes, expressions, and patterns of caring vary among cultures, Leininger's research of more than 30 cultures confirmed caring as a necessary phenomenon (1984, p. 5). Furthermore she concluded that care itself has biophysical, cultural, psychological, social, and environmental dimensions that must be explicated and verified to provide truly holistic care to people. A system of integrated health care must recognize humanity's need for caring. Watson agrees, "People need each other in a caring loving way; loving and caring are two universal givens" (1988, p. 50). Moreover she believes that these are things an individual cannot do without, at least not without deep suffering and a diminishing of one's nature. The need is so strong, that people will often sustain superficial or counterfeit relations in an attempt to give significance to their existence. It is crucial, therefore, that any holistic approach to health care should incorporate caring.

This is not to suggest that nurses can or should strive to meet this need for their clients, at least, not entirely. Rather, through their caring attitude and actions nurses can acknowledge and promote the significance of the client's friends and family. The nurse who inquires about an elderly client's wife and her ability to arrange transportation during visiting hours may do more to facilitate that gentleman's recovery than any dose of medication. As Noddings (1984) puts it, a seemingly small action performed generously and sincerely may be accepted nonchalantly but appreciated deeply.

The holistic model of health focuses on the entire nature of the individual, not just the specific components of human behaviour and physiology (Watson, 1988, p. 48). A client's physical status and psychological state are very important considerations but we must not neglect one's social mores: the political, religious, ethic, vocational, economical, and cultural norms and traditions. In addition, Watson cautions that the esthetic, spiritual and moral realms must not be ignored. It is critical to understanding of the holistic approach that the emphasis is placed on the interaction and influence among the various components and not on the components themselves. That is, we do not meet one need in isolation from all others. We may, for example, alleviate pain with an injection of narcotic, but it is not just the physical realm that is relieved. Because the person is an integrated whole, other components will be affected as well. A reduction of fear and anxiety could occur; a client may notice an improved attitude toward social interaction; or there may be an overall sense of well being and a feeling of hope. On the other hand, there could also be some negative changes in behaviour, for example, the client may be too groggy to visit with family or may experience muddled thought



processes. Nevertheless, the point to be made is, whether we recognize it or not, the total person is affected.

Holistic nursing is thus translated into a concern for the client as a unique psychobiological, social, and spiritual entity. What is not considered in this translation however is the health care professional. To what extent is the whole person of the nurse a necessary corollary for optimal healing of the whole client? Regarding the client as a "whole" would seem to require nothing less than the nurse acting as a "whole" person (Gadow, 1980; & Watson, 1988). This is a controversial issue. The traditional perspective maintains that the personal and professional roles of the nurse are mutually exclusive. A nurse's individuality is not allowed to enter his/her interactions with clients. I do not agree with this viewpoint. I have just been arguing that all parts of an individual impact and interact with one another. Therefore, it appears reasonable to assume that at least something of the nurse gets expressed in his/her professional behaviour. Whereas the personal and the professional aspects differ, they also overlap. Gadow and Watson advocate a softening of the distinction between these aspects and I support their view, although caution should be exercised so as not to completely cross the line. For the most part, parentalism should be avoided. I have more to say about this concern in the following chapter and in my discussion of caring theory.

### **1.2 The helping relationship**

The vehicle through which holistic nursing is practised is the helping relationship. It is maintained that optimal healing depends on the interaction of nurse and client as whole human beings (Gadow 1980; Leininger, 1984; & Watson, 1988). This notion that the

relationship between nurse and client is more important to outcomes than other traditional methods of care is nothing new. The well known psychotherapist Carl Rogers (1961) introduced this concept more than 45 years ago. Early in his career the question he repeatedly asked himself was, how he could treat, care, or change his client in some way. The answers eluded him however, but as he gained experience and matured as a therapist, he came to the realization that he was asking the wrong question. He reformulated his question to ask how he could best provide and encourage a relationship which would foster his client's growth and development (p. 32). This question profoundly affected his practice and his writing. His answer was the "helping relationship": a relationship, "in which at least one of the partners has the intent of promoting the growth, development, maturity, improved functioning and improved coping with life of the other" (p. 40). This same idea lends itself nicely to nursing practice.

The concept of helping offers several advantages over the practice of trying to find the answers for clients. First of all, it allows for expansion of a strictly therapeutic relationship, while at the same time including the therapeutic component. There is no reason why the nurse cannot "help" to treat or to cure disease. Secondly, although "help" as a concept carries a strong implication of advancement towards some objective or goal, helping simply means helping, nothing more, nothing less. Adopting this perspective removes a great deal of pressure from the nurse to attain the ideal, or to be solely responsible for meeting clients' needs. Lastly, helping invites and incorporates client participation. It challenges the client to assume responsibility for healing and self-

growth.

The helping relationship facilitates mutual problem-solving and decision-making - including ethical concerns. When the client perceives the nurse as "helper" an atmosphere of reciprocal trust and respect is created. The message is that the client matters and his or her autonomy is valued. Although, ultimately the client has the right to determine which type of care and treatment will be accepted, this is not an excuse for the nurse to abdicate all responsibility in the process. The nurse has an obligation to provide adequate and sufficient information to enable the client to make informed choices. On the other hand, it is unrealistic to think that all client needs can be met by the nurse, and here I would like to say a word about the difference between "wants" and "needs". Sometimes clients become upset because their "needs" are not taken seriously. This is often because nurses and clients do not share the same meaning of this term. How well I remember the angry client who admonished us for refusing to buy cigarettes, and then deliver them to him in a blinding snowstorm. He knew we subscribed to the client centered approach, and his interpretation of that concept indicated we should honor his request. To him it was a definite "need"; to us it was a "want". Whereas some people might disagree, the point is that "needs" should be determined and prioritized together. This is a function of the helping relationship. The nurse should have a fairly clear idea of how he or she can help the client heal and grow, as well as, how the client can get there. I say more about this when I discuss Watson.

In keeping with the tone of this paper "healing" seems a more fitting term than "curing". Although Webster (1991) indicates that both words can be interpreted as

rectifying an unhealthy or undesirable condition, they are often used differently. "Curing" usually implies recovery from an identified disease or condition but "healing" has a broader connotation, and is commonly used to mean "restoration to soundness" (p. 316). In other words, "curing" has a more specific orientation while "healing" suggests a broader connotation. "Healing" entails "curing" when "curing" is an option, but it also allows for those situations in which "curing" is not possible. When a client who is dying reconciles with his or her family we would consider that a form of "healing". However, we would not say that any "curing" had taken place. I therefore use these terms to indicate different things. One of the premises of this paper is that effective nurse-client relationships are those which incorporate the broader, more inclusive concepts of helping and healing. These, in turn, are more compatible with an holistic approach to health care.

### **1.3 Concept of health**

Nurses are synonymous with health care in one form or another. Nursing practice is an interpersonal process concerned with promoting health, preventing illness or suffering, and restoring individuals to their highest level of health, and when life can no longer be sustained, assisting persons to a peaceful, dignified death (College of Nurses of Ontario, 1990; Travelbee, 1971; & Watson, 1979). An understanding of health is thus crucial to the helping relationship: if health is the goal then we must have some idea of what we are seeking. But this is a difficult and perhaps unachievable task, that is, health is difficult to define. As I show below, health is a complex, elusive concept that comes with a multitude of variables. Moreover any adequate comprehensive interpretation must

allow for the inclusion of both subjective and objective criteria. At best, definitions tend to be quite general and ambiguous.

People use different criteria to determine what constitutes health. Subjective health has been described as an individual's perception of his or her health status based on several diverse factors. In other words, it is an individually defined phenomenon (Travelbee, 1971; & Watson, 1979). As well as being subjective, this definition is purely functional, many people consider themselves in good health if they can perform their activities of daily living to the satisfaction of self, family, job, and society. It is often the case that persons with a chronic illness, such as diabetes or hypertension, will continue to perceive themselves as healthy, especially if the condition is under control. I see no reason to refute this. There are varying levels of health, and some degree of high level wellness is certainly attainable under these circumstances. Alternately, some people with no discernable illness whatsoever, may perceive themselves as ill or unhealthy. Here I am referring to individuals who are repeatedly assured there is nothing wrong but who refuse to believe it. However, one could argue that since there must be something blocking the acceptance of this information, there is something wrong somewhere. Simply because no disease has been detected the possibility that the person is sick cannot be ruled out. For one thing, many individuals possess the ability to discern bodily changes long before these can be detected by any objective means. Furthermore, we do not always have the technology nor diagnostic skills to discover diseases or conditions in their earliest stages. Then too, objective appraisals sometimes differ. For these reasons, although objective criteria are important they are not always

the best indicators of health and illness. However, we tend to rely heavily on them today.

As Watson (1979) points out, there are often no clear distinctions between health and illness. She claims both states are relative ones and do not lend themselves to precise absolute interpretations. Whereas I agree that there is often a great deal of relativity in the meanings of these terms, I do not support her claim that they are entirely relative in nature. There are many times when individuals are diagnosed as unhealthy or ill on the basis of objective knowledge, for example, routine physical examinations and diagnostic tests. Health is not only a matter of subjective opinion; it is a complicated concept neither totally absolute nor totally relative. The importance of clarifying an idea of health and distinguishing between its various components is evident from the foregoing discussion. It is to this task I now turn.

Everyone agrees that health is more than just the absence of disease. As early as 1947, the World Health Organization recognized the wisdom of a more holistic approach to health care. In drawing up its constitution, it declared,

Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity (p. 29).

Although no one disputes this, the conception of health has undergone some fundamental changes as health care developed and became more sophisticated and comprehensive. Both nursing and philosophical theorists began to raise interesting questions and subsequently to formulate more extensive meaningful definitions.

In his article "Health as a Theoretical Concept," Christopher Boorse (1971) defends a functional view of health. From this standpoint, "health and disease belong to a family

of typological and teleological notions which are usually associated with Aristotelian biology" (p. 554). For Boorse, function and goal directedness are very useful concepts for modern health care. He bases his model on the very belief that, the normal is the natural. "Health [then] is normal functioning, where the normal is statistical and the functions biological" (p. 542). Whereas most theorists define the concept of health and then describe disease as an absence of one of its components, Boorse does the opposite. He proposes an analysis of disease and describes health as its absence.

A disease is a type of internal state which is either an impairment of normal functional ability, that is, a reduction of one or more functional abilities below typical efficiency, or a limitation on functional ability caused by environmental agents. Health is the absence of disease (p. 567).

Because of its focus on "absence" Boorse calls this "negative health". At the same time, he considers the prospects for a useful notion of "positive health". He theorizes that health care professionals should actively assist clients to maximize their quality of life, and to develop their full human potential. This takes function out of a strictly biological model, and the concept falls within the framework of his presentation. He views positive health as a type of functional excellence.

In comparing the two conceptions, positive and negative health, Boorse delineates three major differences. First of all, positive health is not just one ideal; it is a kind from which various ideals may be selected and pursued (p. 571). Viewing health as functional excellence instead of absence of disease changes it from a limited to an unlimited focus. There is no fixed path of perfect health at which to aim. Furthermore, neither is there any specific path to take us there. It is virtually impossible to determine whether one

way is healthier (better) than another (p. 570). Closely related to this second point is his last and perhaps most significant insight: the addition of values to positive health. The way for an individual to become healthier is no longer determined solely by the concept of health itself; values must be added (p. 571). As he explains, in the negative health model, decisions about health are really practical in nature and do not usually include consideration about what forms of human life are admirable or desirable. By contrast, positive health requires evaluative decisions about what life goals are worthy of pursuit. The ideals are not discoverable only advocable. In advocating for such ideals, many familiar ethical dilemmas emerge about the good life for man. Although Boorse does not elaborate, he does point out that these dilemmas cannot be resolved through any medical means. He concludes that we must be cautious about "confusing empirical questions with deep normative issues about the goals of human life and the role of health professionals in achieving them" (p. 572). Perhaps, as he suggests, ascribing some limitations to positive health is in order.

Jean Watson on the other hand, embraces the positive model of health in its fullest sense. She is not concerned with limitations, but understands the healthy person as being in harmony with the world and open to increased diversity (1988, p. 48). In her text, *Nursing: Human Science and Human Care*, she argues for a more extensive view of health. Health as such is defined as the condition of complete development of the individual's potential. In her words,

Health refers to unity and harmony within mind, body, and soul. Health is also associated with the degree of congruence between the self as perceived and the self as experienced (p. 48).



In this interpretation we begin to get a glimpse of Watson's metaphysical bent, whereby the concepts of nursing and health advance to a higher level of abstraction, as well as, a higher level of personhood. Watson refers to her model of health as eudaimonistic. I have more to say about Watson's principles and beliefs when I discuss her caring theory. At this time, though, I would like to comment on her choice of "eudaimonistic" to describe her concept of health.

*Eudaimonia* is a Greek word with roots in ancient Greek medicine and philosophy, particularly the philosophy of Aristotle. It is often translated as "happiness." However if we identify happiness with pleasure or contentment, as is commonly done today, we will fail to capture the essence and richness of Aristotle's concept. According to Aristotle happiness is the good for humankind; it is the supreme end or *telos* which everyone seeks (*Nichomachean Ethics*, 1095a 18). There are two crucial properties which the final end must possess, and happiness is the only good which meets both criteria. First of all, the ultimate good must be chosen for its own sake and no other, it is never selected merely as a means to something more. For example, health is the goal of medicine and although it is chosen for its own sake, it is also chosen as a means to some other pursuit: maintaining one's job, going to school, or travelling the world. Health contributes to happiness but unfortunately there are many healthy people who are not happy. We say therefore, that health is not a complete end, but happiness is (*Nichomachean Ethics*, 1097a 28). There is no further end which happiness can promote, it is the most comprehensive good. Happiness is also self-sufficient, says Aristotle, and herein lies the second criterion. Self-sufficiency means that the end is not

a component of some other state of affairs, nor is it merely one good among many. Of itself happiness makes life worthwhile, it lacks nothing (*Nichomachean Ethics*, 1097b 17). To justify some action by responding "Happiness consists in doing this" is always to give a reason which is self-explanatory. No further explanation is necessary. Yet, how do we reply to the person who defends a theft of money by saying that it will bring happiness?

Two points need to be made here. In the first place, the individual in question hasn't understood the concept of happiness. Money is always a means to another end, not an end in itself, or at least it shouldn't be. Although Aristotle argues that some external goods are necessary to one's happiness, they are not happiness itself. Secondly and more importantly perhaps, the exercise of the virtues is a condition for happiness. Aristotle's conception of virtue extends beyond moral virtue, and in some instances excellence is a better translation of the Greek *aretè* (virtue). It is from his notion of excellence in a craft that Aristotle develops his idea of a good person. The final end of a flute player is to play well, of a shoemaker to make good shoes, and of a nurse to provide excellent care. Each individual has a specific function which is discharged by performing it well (*Nichomachean Ethics*, 1097b 25). Humankind *vis-a-vis* plants and animals has a function all its own: that is, rationality (*Nichomachean Ethics*, 1098a 3). In the right and able exercise of these rational powers lies the specific human excellence. The good of humanity is thus defined as the activity of the soul in accordance with virtue (*Nichomachean Ethics*, 1102a 5). Although the practice of the virtues does not lead to happiness in the same way that practicing discus throwing leads to an Olympic trophy,

the virtues are necessary to one's happiness.

Virtuous choice is a choice in accordance with a mean, and this notion of the mean is perhaps the most difficult concept in Aristotle's *Ethics*. It might be better explained through an example. The virtue of courage is said to be positioned between two vices, one of excess called rashness and one of deficiency called cowardice (*Nichomachean Ethics*, 1107a 2). A mean then can be defined as a principle of choice between two extremes. The major concern is how to prevent oneself from straying too far in either direction. As Aristotle warns, it is easy to miss the target. The difficulty is, that there is no built in control or guideline to help us. I suspect though that Aristotle would respond that one becomes courageous and comes to understand courage by consistently being or acting courageous, whatever that entails. However, one courageous act does not make a person courageous, these acts must be repeated until they become habitual (*Nichomachean Ethics*, 1105b 13). In any case, I could spend the entire paper delineating this particular issue but this is not my purpose. For now, it is sufficient to know that virtues are intimately connected to happiness but do not of themselves create happiness.

There are several parallels between Aristotle's thought and Watson's conception of health. Health as the goal of nursing has a telic component, it is a final end toward which clients and nurses strive. However, for Watson it is not the supreme good, that distinction belongs to self-actualization (1988, p. 58). Just as for Aristotle we require health to pursue happiness, we also need health to pursue self-actualization. As I show later, Watson advocates a particular type of nurse-client relationship in order to facilitate

growth and healing for both participants. Although the values of the nurse hold prime importance, they are not the deciding factor in ethical decisions. The virtues of honesty, courage, and integrity are repeatedly promoted throughout her work, and she takes the moral character of the nurse into consideration.

#### **1.4 Balance of power**

One of the peculiarities with the helping relationship is that by its very nature, it implies the need of help or relief, and so imputes weakness to the one who is aided and strength to the one aiding. This raises the issue of power within the nurse-client relationship. Throughout the literature, theorists agree that the balance of power resides with the nurse. "At its core, the nurse-client relationship is one of unequal power, in which the nurse has: authority, knowledge, access to privileged information, [and] influence" (College of Nurses of Ontario, 1995, p. 25). Because the nurse attends the whole client during periods of sustained contact which often involve intimate personal procedures, Gadow (1980) contends that there is exceptional opportunity for powerful influence by the nurse (p. 82). Whether we like it or not, or whether we recognize it or not says Curtin (1979), nurses are in a position to exert enormous power over those for whom they care (p. 6). It goes without saying that this power must be used wisely and appropriately. How the nurse interprets and uses this position of power and influence will depend on several factors beginning with the first client contact.

Initially, it is easy to understand why a client might wish to turn over power and control to the nurse. After all, the reason for establishing the relationship is related to some type of health problem or concern which is anxiety provoking in itself. Life as the

client knew it is about to change dramatically. At this point it is quite common for clients to anticipate a loss of independence and control, and to experience feelings of fear and vulnerability. Indeed, anyone who has ever traded their clothes for a hospital gown can identify with these feelings of vulnerability. Under such circumstances, it is conceivable that the client might expect and even seek to play a submissive role. There is some comfort in letting someone else take over and make decisions for you. Yet this first meeting is also a time for building trust and establishing rapport. The client needs to know that the nurse can be of assistance and will provide support in times of stress and apprehension. However, as the relationship progresses, and the client's health status improves, it is reasonable for the nurse to expect a client to resume his or her independence and control. Through sharing knowledge, teaching necessary skills, and maintaining confidentiality, the nurse begins to equalize the balance of power and prepare the client to resume responsibility. In addition, such actions demonstrate confidence in the client's ability to retake control of his or her life. In like manner, the client's resumption of power and control usually signals an improvement in health status. The length of the relationship and the client's health status are two factors which influence the amount of power and control assumed by the nurse.

A third factor is the type of nurse-client relationship model practised. Since I will be discussing these models in greater detail in the following chapter, my comments here will be brief. The descriptions follow the basic characterizations of nurse-client models proposed by R.M. Veatch (1991). Parentalist models contend that nurses absolutely determine the best interests of clients. Here we will probably see a very strong parental

approach, with nurses making the balance of the decisions. In the technical or engineering model nurses adopt a more scientific factual approach to their relationship with clients. They deal only with the facts, divorcing themselves from all questions of ethics and value considerations in the decision making process. The role of nurses is to completely and dispassionately present the facts to clients, let the clients decide, and then proceed to carry out those decisions. Later, I argue that it is impossible to be completely value free in situations where choices about the quality of life must be made daily. Contractual models allow for the give and take between each participant: emphasis is on mutual decision making. Nurse and client establish a "nonlegalistic" agreement regarding general obligations and expected benefits for both. The potential for positive influence by the nurse is greater than in the other two types. Unfortunately, this power within the nurse-client relationship is sometimes abused, often unrecognized, and generally remains untapped. Even though the balance of power will continue to be tipped in favor of the nurse, it does not have to be as unequal as it once was. Nurses often fail to realize the difference they can make.

Another element that impacts heavily on the use of authority and power within the nurse-client relationship is the nurse's own moral character. Once a prime consideration in nursing, moral character fell to the background for a period of time. Lately, though, there is a resumed interest in the moral character of the agent and an emphasis on its impact within the nurse-client relationship (Brody, 1988; Benjamin & Curtis, 1985; Curtin, 1976; Fowler, 1986; and Salsberry, 1992). In Chapter 5, I will suggest a return to virtue ethics as a possible solution to some of the difficulties inherent in the caring

models of nurse-client relationships. For now it is enough to note, that the possession and utilization of such qualities plays a crucial role in ethical nurse-client relationships.

### **1.5 Ethical component**

The consideration of ethical issues is an essential component of the nurse-client relationship. The College of Nurses of Ontario (1995) emphasizes the primacy of ethical responsibility and generally spells out nurses' ethical obligations. Clearly, neither their personal nor professional values must interfere with clients' right to quality care. That is not to say these values are irrelevant, but only that it is clients' values which "are of primary consideration when planning care" (p. 6). It is not the case that whatever clients value and want is automatically acceptable and must therefore go unchallenged by nurses. Rather, this position underscores the importance of learning about clients' values and beliefs, so that we can better understand their attitudes and decisions. This knowledge will also be helpful in setting mutual goals and objectives, and to predict what outcomes clients expect or desire. Nurses and clients values often conflict. When this happens, caution should be exercised lest nurses attempt to impose their values on clients. Although I believe that nurses have a right and even an obligation to share critical values with clients, any undue influence would seriously damage the relationship. The College recognizes the needs of nurses, but is adamant that the relationship be based on the therapeutic needs of clients. Any action or behaviour is unacceptable if its main purpose is to benefit nurses (College of Nurses, 1995).

It follows then that the best types of action are those that benefit both client and nurse. There is a sense in which what is truly good for the client is necessarily good for the

nurse as well. Although this is a belief I hold strongly, I find it difficult to explain. It has something to do with nurse and client sharing the same goal as the client: the client's welfare. So, if the well being of the client is enhanced, attained, or maintained in any way, there is a sense of accomplishment for both. Yet it is much more than just feeling good about a job well done. Perhaps the reason is that through the experience of genuinely relating to another human being and sharing meaningful interactions, the nurse recognizes, develops, and takes her own humanity to a higher level. I maintain there are certain goods inherent in the nursing profession. In any case, I will raise this issue again when I discuss caring theory and its implications for nursing practice. The point I wish to make now is that the nurse-client relationship is reciprocal in nature.

Both nurse and client bring a particular set of values, expectations, and experience to the relationship. Each also has certain rights and responsibilities. Basically, clients expect that their right to quality care will be respected and the nurse accepts the responsibility for providing it. As might be anticipated, however, the beliefs, values, and expectations of each do not always coincide. When this happens both cannot be right, although, both could be wrong. The resulting conflicts present specific ethical dilemmas for the nurse. Occasionally, these conflicts are life and death situations, for example, whether to resuscitate a terminally ill client, but most often this kind of decision rests with the physician. Nurses are more likely to confront problems associated with routine practice. For example, when a client refuses an injection which would relieve pain and suffering but at the same time impair one's level of alertness, then the nurse is faced with a moral question. Should the injection be administered, thus benefiting the client, or



should the client's autonomy be preserved at all costs? This is more in keeping with the kind of ethical dilemma faced by nurses every day. The nurse's understanding of the nature of the relationship, sense of moral obligation, and moral character will all come into play in making this decision.

The moral considerations just discussed arise out of the particular relationship that is established between nurse and client. But ethics in nursing is not only about life and death situations nor about value conflict resolution, although these are important issues. There is another more fundamental ethical dimension that is philosophically prior to the nurse-client relationship and actually facilitates its existence. I am talking about the moral considerations, rights and duties held by both nurse and client simply as individuals, apart from their respective roles as nurse and client (Brock, 1980, p. 108). I refer to it as the coming together as human being to human being, the mutual recognition of each other's humanness. Leah Curtin (1979) puts it this way:

We [nurses] are human beings, our patients or clients are human beings, and it is this shared humanity that should be the basis of the relationship between us (p. 3).

Jean Watson (1988) calls it "the human to human care process" (p. 63), and Nel Noddings (1984) challenges us to care "in the deeply human sense" (p. 9). This is what "real" ethics is about, grounded as it is in human relationship. As far as I am concerned, any successful model of nurse-client relationship must embody this ideal. It is simple in theory but complex in practice.

In summary, an effective nurse-client relationship involves more than simply attending to clients' physical, biological, or medical problems. A holistic approach to health care

which considers the psychosocial, spiritual, and emotional needs of clients is preferred. The relationship should also accommodate a comprehensive view of health which includes the objective and subjective components. The concept of the helping relationship proposed by Carl Rogers facilitates respect for clients' autonomy and also facilitates healing. Nurses and clients should work together to determine clients' needs and to plan and prioritize clients' goals. Although the approach is client-centered, this does not preclude nurses' values, beliefs, and principles. These too should be acknowledged and respected. Whereas the balance of power in the relationship usually resides with nurses, care must be taken to ensure that this is not abused. Instead, nurses should become increasingly aware of their potential for positive influence.

## **Chapter 2 - Three Models of Nurse-Client Relationships**

As mentioned, I have classified the major models of nurse-client relationship into three categories: the parental, the technical, and the contractual. These categories are broad enough to incorporate the many variations within the models themselves. Although there is some overlap amongst them, each grouping is significantly different from the other. Moreover, each can be distinguished by the assumptions and conceptualizations it makes regarding clients and illness, about the ethical role of the nurse, and about the balance of power. The models can also be viewed along a chronological continuum because they have evolved as the demands and focus of nursing practice have changed. The progression of nursing reflects its development from its primary focus as an art, to a scientific approach with the advancement of technology, and more recently to a recognition of the importance of each of these aspects. These changes have greatly influenced the nature of nurse-client interactions.

### **2.1 Parentalist models**

In the early years of the nursing profession the role of the nurse was basically one of nurturing, tending to client personal needs, and carrying out the orders of the physician. There wasn't much to offer from a technical perspective and it was generally accepted that only the doctor needed to understand what was wrong with the client and the type of treatment required. The nurse was merely expected to have enough knowledge and skill to follow the physician's directions. Thus the traditional nurse was perceived as a steadfastly caring but minimally technical person whose trademarks became a devoted heart, disciplined hands, and tender loving care. I do not mean to minimized the

contribution of those pioneers in nursing for they were a dedicated, courageous group of women. Time and time again they put themselves at risk, for many of the diseases were highly contagious and incurable, for example, smallpox. However, at the centre of this image was the devoted mother caring for her children and family and managing her home appropriately (Aroskar, 1980, p. 21). This view of nursing with its maternalistic overtones, helped to facilitate the development of parental models of nurse-client relationships.

My use of the expression "parentalism" follows the lead of Benjamin & Curtis (1987) who coined the term in an effort to avoid the alleged sexist connotation of "paternalism" (p. 211). However, for all intents and purposes these two terms are interchangeable. Other parental types of nurse-client relationships include the "surrogate mother" (Aroskar, 1980), and the "parent surrogate" (Brock, 1980; Gadow, 1980). It should be noted that, although, there are subtle differences among the aforementioned models, these are not critical to my discussion. I have chosen to incorporate them under one umbrella: parentalism.

In its most general form parentalism means that a client is being treated like a child by a nurse acting with the authority and concern of a parent. Just as a parent can force an unwilling child to go to bed at a certain time or to swallow bitter medicine, so too, a nurse can force a client to get some rest or to take a specific treatment (Benjamin & Curtis, 1987, p. 203). In the child's situation, however, the parent's behaviour is probably warranted, but in the case of the client the nurse's actions are probably not. We can assume that the child lacks the capacity to comprehend what is really in his or

her best interests, but the same assumption does not necessarily apply to the client. Except in unusual circumstances, for example, coma or dementia, clients usually possess the ability to determine their best interests. They may need and appreciate some guidance in making decisions but for the most part they are capable of doing so, and should be given that opportunity. Parentalism can lead to total client dependence on the health care professional, and if maintained over a period of time, can result in dehumanization. Failure to accept at face value the choices, wishes, or actions of the client who is presumed to be autonomous and self determining, ignores the right of the client to be treated as a person. According to Benjamin and Curtis (1987), "To respect another as a person, ... is to take full account of his or her values and life plan and to give them as much consideration in determining the effects of one's conduct as one wants given to one's own values and life plan" (p. 204). In other words, the client is responsible for himself or herself. Strictly speaking parentalism does not allow for this.

A conflict arises when the client's judgement differs from that of the nurse. To act against the client's will, or to coerce the client to act against his or her will, is to act parentalistically. Even though the nurse ostensibly acts in the client's best interests, many theorists argue that this behaviour is not justified. For example, even if the nurse "knows" a certain medication usually cures an infection, the client cannot be forced to take it. It matters not that the nurse's intentions are benevolent or that the benefits incurred are great; parentalistic behaviour is unacceptable. The main objection is that it violates client autonomy and right to self determination (Brock, 1980, p. 207; Gadow, 1980, p. 83, & Smith, 1991, p. 145). These theorists hold the right to self determination

is inviolable.

Although I agree that clients have the right to make choices about their own bodies and lives, I hesitate to accept the strong position held by the above theorists. I have no quarrel with the notion that clients and their families are often better qualified to make decisions concerning their treatment, since it is their bodies and lives that are at stake. Many issues related to treatment are not strictly medical, and professionals are not always qualified to make these. Moreover, lay people today are often knowledgeable about their conditions, and even when they are not, they can be made to understand the nature of their problems. Although I believe these rights should be given high priority, they are not absolute. There are circumstances in which they may not be warranted: when the individual is a danger to self, to another person, or to the community. I would experience great difficulty accepting the decision of a pregnant woman with HIV infection, not to take prophylactic medication to prevent transmission of HIV to her infant. (Note: the argument, about whether her fetus is a person, is set aside in this example). Coercion and manipulation may be warranted in extreme cases. This brings me to a second important component of parentalism, the notion of coercion. Sally Gadow (1980) argues that coercion is the defining element in parentalism, and subsequently her parental definition is more explicit than most. She claims that parentalism is "the use of coercion to provide a good that is not desired by the one it is intended to benefit" (p. 82). I disagree with Gadow, coercion is not the defining feature. It has been suggested elsewhere that a client has the right to choose a parental type of relationship with the nurse, if that is what he or she desires (Smith, 1991, p. 147). Dan

Brock (1980) agrees; the key to his contracted clinician model is the client's freedom to select the kind of interaction that best meets his or her needs (p. 109). What is not immediately evident is how a relationship that is actively and willingly pursued can be considered coercive. Therefore, either coercion is not a necessary component of parentalism, or under such circumstances what we now have is something other than parentalism. Unfortunately detailed examination of this question is beyond the scope of this essay. For my purposes, I agree that at least some level of coercion is present in most parental behaviour.

Actions of a parental nature can range from the very deliberate and calculating to the manipulative and subtle. For instance, there is a difference in the degree of force between overriding a client's decision and injecting a dose of valium, and in hinting that the nurse will allow visitors to stay a little longer if the client complies and has the injection. Although both actions will likely have the same consequence, one is more blatantly coercive than the other, and will affect the relationship differently. From an ethical perspective, it is important to recognize the potential for force and manipulation inherent in parentalist models. The moral character of the nurse will be reflected in how he or she interprets and carries out his or her role within this model.

As stated, the assumption guiding paternal models is that the client is not capable of determining his or her best interests. It is believed that, illness with its accompanying fears and anxieties, somehow renders the client incompetent as far as decision making and problem solving skills are concerned. This is not my position. I believe that most clients are quite capable of making sound decisions, although professional input is often

required. However, with parentalism the supposition is that someone needs to take over this responsibility, so the role of the nurse becomes one of total commitment to, and involvement, with a helpless client. It is often true that the nurse does know what is best regarding health problems, but this does not transfer the right to insist on compliance with the nurse's judgement, nor does it warrant the violation of client wishes (except in circumstances similar to the above example). Moreover, it does not imply authority for ethical decisions.

In parental models the ethical responsibility of the nurse is defined by unlimited commitment to the client. It is the nurse's primary obligation to provide nursing care, to protect and to advocate, and to act in the client's best interests at all times. In other words he or she assumes the ultimate responsibility for all aspects of client care. This is an awesome task indeed. The values of the nurse carry great weight and critical decisions will be made in terms of these values (Smith, 1991). The power structure is imbalanced with decision making heavily tipped on the side of the nurse. Clients are perceived as victims and treated like mere objects with little to no recognition of their uniqueness as human beings. In Kantian terminology, this is to treat them as means to an end and not as ends in themselves.

Immanuel Kant (1724-1804) proposed that the supreme principle of morality is his "categorical imperative." Although several forms of the imperative are cited in the literature, one in particular applies here. It is the second formulation of Kant's categorical imperative which is relevant in parental models, "Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the



same time as an end and never simply as a means" (Grounding for the Metaphysics of Morals, p. 429). To paraphrase Kant: always treat persons as ends in themselves and never simply as means. Kant refers to this formulation as his "supreme practical principle." Clients are not merely objects to be investigated, analyzed, medicated, or operated on, there is a person who resides within, and it is essential that this person be treated with respect and dignity.

By the same token, the person of the nurse also merits recognition and respect, but in parentalism this component is given little, if any, attention. The nurse is prevented from enhancing and developing both personal and professional growth. In accepting full responsibility and displaying total commitment to the client, there is precious little left for the nurse. There may be a tendency to care too much and to be overindulgent. It is thus feasible to suppose that parentalism can lead to resentment and burnout. When the nurse assumes total responsibility, the task is overwhelming. I should point out that resentment can be experienced by both nurse and client. From the nurse's point of view, he or she quickly becomes depleted from the all-consuming responsibility, and from the client's perspective, the freedom for self determination is all but eliminated. In the short term, doing everything for clients may get things done but in the long term, we are not doing anyone a favour.

Can there be any place for paternalist models in nursing? I believe there is, albeit a limited one. Let me explain. Benjamin & Curtis (1987) cite three conditions for the justification of this model. Very briefly these include: significantly impaired capacity for rational reflection by the client, the belief that significant harm would result if no

professional intervention occurred, and when it can reasonably be assumed that the client would approve this intervention at a later date (p. 207). All three conditions must be met in order to justify parental behaviour. For example, consider the plight of a young man who has just learned he has the Human Immunodeficiency Virus, that is, he is HIV positive. He has indicated that if his test result was positive he would commit suicide. Does the nurse breach confidentiality and get him admitted to a psychiatric unit? Well, let us see if the three conditions quoted above apply. It could be argued that the client is not capable of making a valid decision at this time because of the impact of the devastating news. The chances are also very good that he would meet with irreparable harm if there was no intervention: he would kill himself. It is also feasible to believe he would approve of the decision to intervene at a later time in his life, especially if the nurse has experience in these matters. It is therefore reasonable to employ the model here.

I would also suggest that parentalism is acceptable in less dire circumstances. As has been pointed out, there is always anxiety and concern with illness or surgery. We would assume that these conditions will frequently be met, parentalism is a viable option, at least for a period of time. For a few hours or a few days in times of crisis and uncertainty it would often be beneficial that the nurse to assume this stance. However, it should only be employed with the understanding that as the client improves and is ready, responsibility for decision making should be returned.

## **2.2 Technical models**

Within the past few decades we have witnessed an incredible explosion of

scientific and technological advances in the health care field. As one new and more intricate technique after another appeared on the scene, the once-valued devoted heart and disciplined hands of the nurse were relegated to second place. In their stead, the need for theoretical mastery and technical precision rose to prominence. As the focus of nursing became increasingly scientific, a new class of nurse-client relationships began to emerge: the technical models.

These models also gained impetus through another source. At the same time that science and technology were coming into the forefront, a rhetoric of rights was taking hold across North America. Justice demanded that everyone had an equal right to health care; it should not be a privilege of the wealthy. The 1960's saw the rise of a clients' rights movement which generated increased public distrust of authority, especially when vested in such institutions as religion, education, and health care. The practices of health care professionals also came under increased scrutiny and clients demanded "higher standards of public accountability" (Yeo, 1991, p. 5). Ethical matters, once the jurisdiction of professional authorities, now became public concern. "Autonomy" was the catchword of the times and a new ethic based on autonomic principles began to emerge. As Yeo describes it, there was "a growing cultural and political pluralism in which the values of individual rights and liberties ruled the day" (p. 5). Within this environment of liberal individualism, parentalism, once firmly entrenched in health care professions, became the target of intense criticism. Clients demanded to know more about what was happening to them and requested more involvement in the decision making process regarding their health care. This phenomenon, coupled with the

advancement of technology, was instrumental in shaping those models of nurse-client relationships that the literature refers to as technical.

Technical models are based on a mechanistic conception of man as a complex physio-chemical system. Within this narrow view, it is the client's biological needs that receive prime consideration. Health is equated with absence of disease and consequently as in Boorse's terminology discussed above, a negative model of health prevails. Objective, scientific criteria determine who is healthy and who is not. The nurse, too, must be objective, and provide scientific care and treatment in a non-judgmental, and non-interfering manner. The major nursing concern is to apply skills correctly and efficiently; personal involvement is not encouraged (Smith, 1991, p. 45). When changing a dressing on a pelvic wound, for example, the emphasis is on sterile technique and the skill of the nurse.

Technical models focus on technique, skill, and efficiency. It's not that these things are not important; they certainly are, but the problem is that little attention is paid to what the client may be experiencing. For the client, the pelvic area may be viewed as an extremely personal part of the body, and he or she may be very embarrassed. For the technical nurse however, the pelvic area is just another part of the body and the client is assured that this is just a routine procedure that the nurse does every day. The nurse forgets that a person is attached to that wound and ignores this aspect. Moreover, the wound itself has a history. Perhaps it is the result of diagnostic testing and the client is awaiting news of a biopsy to rule out malignancy. Or maybe it was sustained during an automobile accident in which a family member was injured or killed. In any case,

changing the dressing is but a small part of the larger picture; it may help to heal the wound, but it won't necessarily heal the person.

Within the context of technical models, the professional stance of the nurse is paramount. It is ironic that in spite of clients' complaints that care is too impersonal, practitioners are constantly warned against becoming personally involved. Nursing students are instructed that personal interaction is unprofessional and must be avoided at all costs (Gadow, 1980; Travelbee, 1971; Watson, 1988). According to Gadow (1980) behaving in a professional manner entails the avoidance of any personal interaction, for example, behaviours expressing nurses' feelings, values, or peculiar characteristics (p. 88). The most that nurses are allowed to express is their scientific, technical, and managerial knowledge; the emotional, aesthetic, and contemplative must be confined to other areas of their lives. Recently, one of the nurses with whom I work was severely chastised for crying at the bedside of a young mother who was dying from AIDS. It was acceptable, though, when this same nurse became irate at the malfunction of one of this client's chest tubes. It is easier to deal with factual and scientific problems than it is to delve into the emotional, spiritual, and intellectual. Although nurses are getting better at it, many continue to be very uncomfortable with their colleagues who express emotion, and they are equally uneasy about expressing emotion themselves. The lesson has yet to be learned.

The taboo against personal involvement also dictates that nurses keep their values and beliefs to themselves. Consequently, they must adopt and maintain an ethically neutral position when relating to clients. They must neither impose their own values and beliefs

on those they care for, nor make value judgements about clients when administering that care. This model also demands that service be provided almost matter of factly, in an aloof, unbiased manner. Smith (1991) sums up the nurse's limited ethical role this way, "The extent of the nurse's ethical responsibility is limited to the correct application of knowledge and skills to meet the needs of the patient [*sic*]" (p. 145). I assume that the needs just referred to are mainly biological in nature, since that is the focus of this model. Nurses may indeed provide excellent technical care and may even surpass all expectations concerning skill and knowledge but as we will see client needs are not met when this model is singularly employed: not in the complete sense of that term.

The values of nurses are not considered in a technical approach to health care. Although, I agree that nurses should not impose their values on clients, this does not preclude their sharing of them when circumstances warrant it. Situations arise which would seriously compromise nurses' ethical beliefs and jeopardize their integrity, if they participate. One example is the nurse who is anti-abortion but is asked to assist with the procedure. Most theorists agree that the nurse has every right to refuse. I agree, the nurse must indicate his or her position in this circumstance.

Can nurses actually care for clients whose ethical beliefs are essentially different than their own, without any loss of integrity? Certainly the best way out of this dilemma is to resign from the case. Yet, this is not always possible. For one thing, the College of Nurses of Ontario stipulates that nurses must not abandon their clients. Current cutbacks and staff reductions also make it difficult to find replacements. However, I believe nurses must not compromise their ethical positions. Sometimes this can be

accommodated by sharing one's ethical concerns, and at others it is necessary to withdraw from the situation. When the latter situation occurs, there should be no personal affront to the client. It is helpful to focus on the act as wrong, not on the person as bad or evil. This is a difficult task.

In the technical models, client needs are identified by the client. In direct contrast to parentalism, it is assumed that illness neither impairs clients' ability to determine their best interests nor to make decisions concerning their health care. Nurses have little input into the decision making process and, as pointed out above, what input they do have is basically technical in nature. "Consequently, the patient [*sic*] retains ultimate responsibility for identifying needs and determining his [*sic*] best interests" (Smith, 1991, p. 146).

In response to clients' demands for increased autonomy, and perhaps in an effort to avoid some of the parentalist pitfalls, advocates of these models went a little too far in assigning decision making responsibility. The problem is not that the decision making process was left in the hands of clients, for that is where it should be. The difficulty is that so much of the process was taken away from the nurse. Gadow (1980) notes that whereas there is a duty for nurses to provide the technical information necessary for clients to make a selection amongst possible courses of action, this is where their contribution ends (p. 84). Nurses become no more than technical advisors whose responsibility stops short of recommending one option instead of another, lest that suggestion be interpreted as parental or coercive. Strangely enough, in so doing the very element of coercion that we sought to avoid, reappears under a different form. Clients

are now "coerced" into making significant personal and health care decisions with a minimum of assistance. Gadow (1980) points out that once nurses inform them of their options, the message to clients is "Do as you like" (p. 85). The nurse's attitude is one of indifference.

According to Smith (1991), a further consequence of this model is that regardless of the foolishness or the repugnance of the request, or regardless of the unsoundness of the decision, nurses' value judgements are irrelevant (p. 146). If I interpret Smith correctly, she is saying that what the client says or does is always acceptable; the nurse has no recourse but to provide the care requested. This position is not only extreme, it is impossible to maintain. There are client values and beliefs that clearly would not be condoned under any circumstance, and decisions that would be totally unacceptable. Child abuse is a prime example. There are clients who would argue that their pedophilia is a "healthy" choice for themselves and is merely an expression of love for the child. Parents sometimes argue that beating their child is good for both of them; the parent vents anger and the child learns a lesson. In both examples, clients may be unwilling to seek help or treatment and may even be unable to identify a need for it. They may in turn beg the nurse not to report their behaviour. Under such circumstances, it would be next to impossible for nurses to remain indifferent, to ignore their values and beliefs, and to fail to report the incidents (unless, of course, the nurse is of the same persuasion). It could be argued that since nurses are required by law to report all incidents and all suspicions of child abuse, that nurses' values do not come into play here. However, the decision to obey the law itself, requires the exercise values and beliefs.



The notion that nurses should remain ethically neutral is, therefore, ludicrous and unachievable. The fact that the major focus in the nursing process is people, indicates that moral choices are made everyday, often without thinking. Decisions to respect clients' values, to relate to clients as unique human beings, or to maintain confidentiality are examples. Moreover, ethical neutrality is detrimental to the nurse-client relationship and unhealthy for both nurse and client as individuals. In order to foster an atmosphere of trust, the values of each need a voice. I am not suggesting that nurses bare their souls to clients, only that there be an opportunity for expression of values, and beliefs when circumstances warrant it. The impact of non-verbal behaviour is well documented throughout the literature, so clients quickly perceive nurses' feelings and attitudes. The difficulty is that these feelings and attitudes may be misinterpreted, and unless some resolution occurs, nurses may be identified as uncaring, untrustworthy, or only in it for the money. The client too begins to build up anger and resentment and responds inappropriately.

To illustrate these points, I would like to consider the case of a young native Canadian mother, currently in treatment for drug addiction, who was hospitalized with an AIDS related infection. To support her drug habit, this woman had prostituted herself and either through sharing needles or through promiscuous sexual activity had contracted HIV. She is now making an effort to reconcile with her family and to provide for her three children after her death. For whatever reasons, two of the nurses assigned to her care adopted a purely technical approach to this client's care and treatment. Although, this may have been the only way these nurses could cope with the situation, in my

opinion their response was wrong. The dynamics of the relationship led to a missed opportunity for growth and development for the both client and the nurse.

The client perceived these nurses as impersonal, judgemental and neglectful and accused them of prejudice towards her disease and her race. She felt they were not supportive of her current commitment to her recovery program, or to her desire to reconcile with her children. Eventually her perceptions became exaggerated and generalized to the entire nursing staff on the unit. She became demanding and difficult and had nothing good to say about anyone. Interestingly, from a physical or technical perspective, she was improving, albeit slowly. What is clear, though, is that her other needs were not being met. Although it is true that her attitude was a factor, it is also true that the two nurses did not help the situation either. In failing to share their values and feelings with the client, they lost an opportunity to gain insight into her behaviour and subsequently to understand why people behave as they do. In essence, they could not get beyond the labels to the human being beneath them.

Nurses who guard against putting any of themselves into their work tend to become fragmented. Because of the exclusion of significant elements of themselves from their professional relationships, nurses experience a sense of self-estrangement (Gadow, 1980; Watson, 1988). The inability to be true to oneself alienates the nurse from his or her work and leads to a lack of ownership and pride in what one does. There is a feeling of separation from one's work and the nurse can no longer find himself or herself within it. It is as if all nurses are interchangeable. If none of their individuality is allowed into the interaction, then it would hold true that one nurse would be as good as another. I

once worked with a nursing director who ascribed to this notion. She believed that nurses should not put any of themselves into their work. She set out to design a comprehensive manual of community health which would include every procedure, policy, situation, and concern possible. Nurses would strictly adhere to the protocols within, and would be so consistent in their approach to care that it would not matter which one responded to a given situation. Presumably all nurses should be good-enough, and in that sense one nurse should be as "good-enough" as the other. However, in community health nursing, the bond which develops between nurse and client is significant. In part, this is due to the duration of the relationship, which often extends over weeks or months. Continuity of care, in terms of the same nurse visiting the client, is essential. Of course, this is not always possible but for the most part, it holds true. Therefore, when a client requests a visit from the nurse, it is not just any nurse to which he or she refers. Rather, a particular nurse is expected. Under such circumstances, one nurse is not as "good-enough" as another. There is no manual which can make it so. Let this serve as a caveat to all administrators and managers who become too far removed from the clients they serve.

Within the technical model clients also feel an estrangement of the self. When impersonal, technically based care and treatment fail to meet their needs, they feel lost in indifference, and unable to wade through the system to find what has been prescribed for them. They flounder in their attempts to identify their role within the nurse-client relationship and to determine their place within the routine of the institution. Furthermore, Gadow (1980) contends that the reluctance of the nurse to put himself or

herself into his or her work and the failure to act as a whole person, deters the client's participation as a whole being (p. 87). She promotes the involvement of the nurse's entire self in the relation but at the same time reminds us that the focus of the practitioner is directed away from the self and toward the other. The nurse is interested in the client's good more than in his or her own (p. 88). The traditional dichotomy between the personal and professional involvement of the nurse is softened somewhat by Gadow's proposal that a professional demeanor does not exclude personal interaction. She suggests that a professional approach is a deliberate synthesis of all types of involvement, such as emotional, esthetic, physical, and intellectual. All dimensions of the person "can and must be brought to bear as essential, positive elements in the professional relation" (Gadow, 1980, p. 92). For Gadow then, technical models, with their inherent lack of personal involvement and their promotion of ethical neutrality, are not viable.

It is reasonable to assume varying degrees of technical models. Some allow for more of nurses' personal involvement and ethical responsibility than others, but all emphasize the technical aspects of care and treatment. In the most extreme form, nurses would be concerned only with applying technical skills correctly and efficiently. In the truest sense of the concept, I doubt that many nurses are totally technical in their approach. Nurses are more than technicians and technical models do not accurately describe the job descriptions and role expectations of nurses. From the Greek word *technē*, meaning a skill or a craft, a technical task is one characterized by a predictable and patterned means-end relationship, a regular method of doing things or a set of instructions to

follow. It is therefore conceivable that an individual could be skilled in following the rules of the job without understanding why they apply. Someone could change a dressing, for example, and actually perform the task quite well by simply following instructions. It is not necessary that the individual have any understanding of sterile technique or germ theory. However, there is no fixed set of rules to follow when attempting to relieve a client's anxiety. Some knowledge of human behaviour theory is required. The term "technical" clearly applies to some nursing skills but not to others.

Without question the role of the modern nurse requires more scientific knowledge and technical expertise than ever before. Procedures have become increasingly complicated and invasive and usually involve mastery of some fairly sophisticated equipment. It is ironic, though, that this very technology which held such high hopes for better control of disease, relief from mundane chores, and more time for clients, now seems to be taking control. There is a need for more monitoring and maintenance of equipment and there is increased documentation and paper work. Nurses also rely on machines such as cardiac monitors to alert them to problems, and in the process they have lost some of their observational abilities. All of these consequences of technology remove the nurse further and further from the bedside at a time when we are becoming more and more aware of the importance of bedside manner to the healing process (Anderson, 1993). No machine can ever replace the specifically human art of healing.

Although I have been arguing against a purely technical approach, I do think that there is a limited place for such models in today's nursing practice. For one thing, clients may chose a technical relationship for some reason or another. They may be very business-

like in their interactions and may simply wish to get the job done without real involvement with the nurse. Other clients may be so difficult to get along with that it may be the only model whereby nurses can respond in order to save their own integrity, at least until the client's attitude changes. Then too, there will be clients who are so offensive and distasteful that it would be impossible to provide more than a technical response. For instance the young man currently on trial for the brutal rapes and murders of three adolescent females would present a major challenge to nurses. It may be difficult to provide more than technical, scientific service under these circumstances. Of course, much would depend on the nurse's ethical level of development. Some nurses may be able to get beyond the technical.

Our era is distinguished by its focus on technology. With such a profusion of machinery, testing, and technique it is often easy to forget that the nub of the health care system is really found within the interaction between nurse and client. Machines are not intrinsically anti-human, but the technological forward march needs to be balanced in such a way that an anti-human backlash does not occur. In the beginning, there was a sense of confidence and complacency in the power of science to solve all our problems, a belief that technological progress was not only inevitable but that it was ultimately beneficial. Today we are not so sure. The myth that technology, science, and reason can provide a cure for everything has been dispelled. In the words of Spicker and Gadow (1980):

It is a fundamental premise of nursing that a patient [*sic*] has the right to receive affirmation and acknowledgement as a human being. Human beings are so unique and so complex that each transcends the category of science (p. xvii).

What we need, then, is a model of the nurse-client relationship which will entail a proper balance of both the art and science of nursing and at the same time allow for a relationship of mutual respect and dignity between nurses and clients.

### **2.3 Contractual models**

As we have seen, there are serious problems with the parentalist and technical models, especially when these are used exclusively. In the former, the nurse so dominates the decision making process that the client's freedom and dignity are all but extinguished. It is the nurse who identifies client's best interests and the nurse's value system which influences decisions. The opposite position holds true for the latter. Here ultimate power and control reside with the client and the nurse is left with little opportunity to exercise moral integrity. The client is expected to make decisions unilaterally, with a minimum of assistance from the nurse. It follows that a model is needed which will equalize the balance of power, preserve the fundamental rights of both nurse and client, and at the same time pursue a common goal: the health and welfare of the client. Contractual relationships offer such an alternative.

The contractual approach views the nurse-client relationship as arising from an agreement between nurse and client. Each expects certain benefits from the relationship and each also assumes certain obligations. According to Dan Brock (1980), a strong proponent of the "contracted clinician" model, the client actually contracts specific care from the nurse and the nurse incurs the obligation to provide that care (p. 110). However, this is not to suggest that a detailed plan of care is laid out at the time the relationship is initiated, and subsequently executed under the terms of that agreement,

as in a legal contract. Although there are legal implications, we must not get too carried away by them. Usually there is a preliminary care and treatment plan, but it should not be grounded in rigidity and inflexibility. Any effective plan of care should accommodate the ever changing needs and conditions of the client. Needs are determined and evaluated as they arise and as nurse and client get to know one another during the progression of the relationship. The contract is thus one of continual, dynamic flux.

As the essence of contract implies, nurse and client both retain participatory roles and work closely together. They consult, discuss options, and mutually agree to certain terms, which will be evaluated and modified as necessary. The vulnerability and apprehension which usually accompany illness, as well as limited capacity to understand and evaluate proposed treatment choices, places clients in a position of considerable reliance on the nurse. Clients must feel confident that the nurse will always act on their behalf and in so doing will respect their wishes. For the nurse's part, there is a commitment to provide unqualified care, to protect, and to advocate for the client. The very presence of the nurse in the helping relationship implicitly promises a certain degree of knowledge and expertise (Brock, 1980; Smith 1991). The authoritarian and task-oriented postures of the nurse noted in the earlier models, are replaced by an attitude of cooperation, guidance, and concern. This position fosters the development of mutual trust and rapport.

Within this type of model, the right to determine what is done to and for the client, and to control within broad limits the course of treatment originates and generally remains with the client (Brock, 1980). The nurse neither determines clients' best



interests nor makes significant decisions for clients. The assumption is not only that clients are capable of determining their own best interests, but they are proper individuals to do so. However, this does not mean that clients are left alone to wade through complicated medical data in an attempt to become informed about their condition. The nurse must assist clients to comprehend their situations as much as possible and to understand their options. As noted above, this paper targets competent adults, but even so, there are occasions when competent adults have diminished capacities. Both medical and non-medical crises arise and sometimes quite suddenly. For instance, an individual can have a reaction to medication, receive devastating news, or experience depression, and as a result exhibit signs of decreased ability for problem solving and decision making. Under such circumstances it is the responsibility of the nurse to do everything possible to determine what the client's wishes are. Sometimes this can be accomplished by consulting family and friends or talking with the physician. The most important safeguard, however, is getting to know the client, by seeing the client's point of view or at least trying to. The point is that nurses play more of a supportive guiding role not a take over authoritarian one.

Treatment decisions and recommendations are made solely on how they affect clients' well being and should not be influenced by the interests or concerns of others (except of course in matters of public health or legal concerns). There are certain diseases that must be reported regardless of client objection, as well as specific requirements for reporting suspected physical and sexual abuse. It stands to reason that there must be some flexibility. There are a myriad of trivial decisions that nurses make every day

without conferring with clients, and clients, in turn, attempt to cooperate with institutional policy to accommodate nurses' schedules and workloads. For example, a nurse can choose to change a dressing at a more convenient time if the client agrees, and the client can request that the dressing not be changed during visiting hours, even if it is a "good" time for the nurse. Institutional constraints and nursing routines should not supercede client welfare.

The notion of contract renders this model more profound than the others. It recognizes client autonomy and right to self-determination, thereby helping to maintain client dignity. Nurse and client are provided with opportunities to realize the shared world of meaning between them, which personalizes their interaction. As they begin to learn from one another, the growth and development of each is enhanced and they can experience the human person behind nurse and client roles. At this height of communication, the relationship is raised to the level of an art and the agreement itself assumes a greater depth of understanding. In this context, the concept of contract is perhaps more akin to the rather antiquated notion of covenant, whereby each party solemnly promises or pledges a faithful fulfilment of his or her roles and obligations. Legalistic implications aside, this perception of contract emphasises the moral aspects of relationships.

The above view, with its moral ramifications, is consistent with Sally Gadow's (1980) conceptualization of nursing as "existential advocacy." Whereas she supports the contractual clinician models in their central features and agrees with Brock (1980) that the right to self-determination is the most fundamental and valuable of all human rights,

she goes one step further. She argues for a deeper, more philosophical involvement between nurse and client. The meaning of advocacy that she promotes is not to be confused with rights advocacy. Existential advocacy extends beyond the narrow realm of contract and its proscriptions to the realm of ideals. She maintains it is crucial that:

.... individuals be assisted by nursing to authentically exercise their right to self-determination. By authentic is meant a way of reaching decisions which are truly one's own -- decisions that express all that one believes is important about oneself and the world, the entire complexity of one's values (p. 85).

The nurse is indeed obligated to act in the client's best interests but it is clearly not the nurse's role to define what these interests are. The role of the nurse is one of clarification and support. The nurse creates a comfortable environment in which clients can identify and clarify what it is they really want to do. In this manner clients assume ownership for their decisions and receive the support they need to act on them.

Gadow includes two other features in her advocacy response which are worthy of note. Although my comments are not all encompassing, it is important to recognize these features as an integral part of the advocacy concept, since both play a significant part in nurse-client relationships. Their resolution is of major consequence. The first of these tackles the recurrent question of the professional versus the personal involvement of the nurse. Traditionally nurses have been discouraged from getting too close to clients; a professional stance was paramount. The sharing of oneself was viewed as a weakness to be avoided at all costs. It was as if nurses could seal themselves in some type of emotion-proof compartment. Many a nurse has been chastised for crying at the bedside of a dying person; Gadow argues against a totally objective approach. She claims that

regarding the client as a whole being, also entails the nurse acting as a whole person. It is absolutely prerequisite for the advocate (nurse) to participate in the relationship as a complete unity with no exclusion of any part of the self (Gadow, 1980, p. 93). I don't think Gadow intends nurses to reveal their detailed life stories, but relevant sharing is certainly called for. Not long ago at my place of employment, a client shared feelings of anger and frustration about the manner in which he was told about his adoption. The nurse responded by revealing that she was also adopted and had experienced a similar reaction. The degree of understanding communicated by this disclosure was extremely helpful and I think appropriate. Client feelings were validated and an atmosphere of mutual trust and respect was initiated.

The other characteristic of existential advocacy that merits comment is Gadow's distinction between what she calls the "lived body" and the "object body." Very simply the "lived body" is the "private, lived reality" of the client and the "object body" is that part which is "a public object, open to inspection" (Gadow, 1980, p. 92). These two concepts are not mutually exclusive. The "lived body" is not a thing so much as it is a mode of orientation. It is a complicated idea which includes "the immediate, prereflective consciousness of the self as capable of affecting its world as well as the consciousness of being vulnerable to the world's impact" (p. 94). The lived body is thus able to act and react, and is affected by the environment in which it finds itself. The "object body" on the other hand, is described as "an object with parts having only fundamental value, not emotional, esthetic or spiritual value" (p. 93). It is the "object body" that is the focus of technical models and to some extent parentalist ones.

At the heart of contractual models, including Gadow's existential advocacy, is the client as a person. In contractual relationships the ethical role of the nurse is defined by the client's *prima facie* right to determine the course of treatment. It is no longer acceptable to do something simply because the nurse determines that it is in the best interest of the client. On the other hand, neither is it acceptable to meet any and all client demands. Client centered care does not mean that clients get everything they want. As discussed earlier, a distinction should be made between needs and wants; there must be some guidelines, some type of structure, by which nurse and client work together to identify and prioritize needs. The nurse's right to act is both created and limited by the client's permission and consent (Brock, 1980; Gadow, 1980; & Smith, 1991). That is, the client's needs are the reason for the nurse's action and such action is restricted by the client's stipulations, and expectations. The client becomes the primary decision maker but this in no way implies that the nurse necessarily agrees with the decisions. By the same token, nurses have rights too; commitment to clients is limited by the nurse's own permission and consent. Because the relationship arises from a contract or agreement the nurse can refuse to enter into it or can opt out at some point if there is a danger of compromising his or her values. As mentioned above, a nurse who is against abortion can and should refuse to assist a client in obtaining this procedure. The case could be turned over to another nurse so as not to jeopardize client care. It is crucial that the nurse be honest with the client and with himself or herself when sharing his or her values and opinions. The value system of the nurse can thus be acknowledged, without imposing values on the client and without violating client rights.

One of the major objections to contractual models is that contracts or agreements seldom take place, explicitly or informally. In some cases the client originally contracts with the physician or with the institution and the nurse is an indirect party to the agreement. For the most part, though, it is true that contracts as such are not drawn up. Nurse and client are often inadvertently paired and the relationship begins rather matter of factly. However, neither of these situations rules out commitment on the part of the nurse, nor invalidates the notion of contract itself. Brock (1980) contends that although agreements may not be explicitly spelled out, they do entail implicit terms which are just as binding. He puts it this way:

These implicit terms are to be found primarily in the generally known and accepted understanding of the nature of such health care relationships, and in the warranted social expectations the involved parties have concerning who will do what in such relationships (p. 111).

Professional standards, codes of ethics, legal principles, nursing education, and community understanding act as guidelines and will influence the nature of these expectations. Although individuals may differ in their perspectives about nurse-client relationships, they do have some general idea about what these should entail.

The main objection to the contractual model is that it offers a false sense of equality. No matter how we look at it, nurse and client are not equal partners. By virtue of the nurse's superior knowledge base and familiarity with the health care system, he or she holds the most power. In addition, because the client is sick or otherwise incapacitated, he or she is in a more vulnerable position (Curtin, 1979). The relationship is established by chance and not usually by choice, as in the case of friendships, and its reason for being is centered on the needs of the client. These characteristics indicate that nurse and

client are not pals, friends, or colleagues in the truest sense of these concepts. Although the relationship can lead to friendship, at the time it is established this is usually not the case. Perhaps, then, this is not the sense of equality that proponents of this model are advocating.

The aspects of equality that are truly significant to this model, are to be found in the legitimacy of moral rights, and in the right of both parties to be recognized and treated as dignified, capable human beings. This type of equality arises from the rights that people have, simply because they are human beings. Reflecting Kant's notion that persons must be treated as ends only, not only as means to some end, this perspective is based in the presumption that human beings are inherently valuable as persons, regardless of anything else. There is a need to go beyond the nurse and client roles to acknowledge the person of the nurse and the person of the client. The nurse recognizes the rights of the client by imparting knowledge, orienting the client to the environment, and sharing decision-making.

Clients have the right to the information necessary to make choices, and to consent to or refuse care. The College of Nurses of Ontario (1995) believes that since clients know the context in which they live and their own beliefs and values, they can decide what is best for themselves. However, there are limitations to this choice. Clients cannot endanger the safety of someone else, they do not have the right to health care which is medically futile, and they cannot expect the nurse to perform acts which are illegal or which can cause harm (College of Nurses of Ontario, 1995, p. 8). Otherwise, informed decisions should be respected, even when the decisions are in conflict with the values of

the nurse. A client who refuses treatment should be allowed to do so, provided that it was an informed choice. Moreover, in cases when the nurse is certain the treatment would be beneficial, it should not be forced on the client. The nurse can continue to suggest the treatment at opportune times, and is always free to share his or her opinion in the hope that the client will have a change of heart. But to exert any type of force or to attempt to manipulate may only serve to further alienate the client. In my experience clients can and do change their minds, and if and when this happens and they accept the proposed treatment or therapy, they usually do so with a deeper level of commitment and conviction.

There is also an inherent danger in the contractual relationship that manifests itself in a tendency toward nonchalance, especially if the client has decided against a certain treatment. The nurse could be tempted to adopt a *laissez-faire* type of attitude: "I've done all I needed to do, it was the client's decision, he or she will have to suffer the consequences." However, I believe that this kind of response goes against the essence of the contract or covenant promoted in this model. This is not a legal type of contract; it is not the case, that once the terms of the contract have been met, the nurse is absolved of all obligation. The issue here is an ethical one, and the nurse should continue to provide opportunities for the client to change his or her mind, albeit in a non-coercive manner. To illustrate, suppose a client has refused an antibiotic which the nurse knows will cure the infection. For the next few days, the client's condition deteriorates. What is the role of the nurse under such circumstances? The efforts of the nurse, to get the client to accept treatment, should not cease. If anything, the nurse should become more



vigilant in his or her approach.

There is another consequence of contractual models that merits comment. As Smith (1991) points out, the nurse provides care because of the agreement or contract with the client, but the nurse is also obligated to obey the physician because of the physician's agreement with the client. Both client and physician expect that the nurse will carry out the physician's orders. However, the physician does not have a similar obligation to the nurse. This often complicates matters, especially when the nurse and physician have vastly different value systems. When such conflicts occur the nurse has several alternatives. For one thing, an attempt can be made to resolve the difference with the physician. Of course, this does not always work, but, it serves to alert the physician to the nurse's concerns. A second option is to assign the client to another nurse, a nurse who does not have the conflict with the physician. With current staff reductions, this is not always possible. Then too, if one nurse has a concern with a physician others frequently share that same concern. Another alternative is to refuse to follow the physician's directive. In this circumstance, the client continues to receive care, but not that particular aspect of treatment or non-treatment. Lastly, when all else fails, the nurse's ethical position is jeopardized, the nurse should remove himself or herself from that case. However this should not be done lightly. As the College of Nurses (1995) dictates, nurses must not abandon their clients. This dilemma is not an easy one, and requires the support and understanding from the institution where the nurse works.

#### **2.4 An ethical dilemma**

Although the above discussion may have been somewhat brief, I have attempted to

differentiate between three categories of models and their major characteristics. I have discussed their advantages and disadvantages and identified the underlying assumptions. Various beliefs about the ethical responsibility of the nurse, about clients and illness, and about the nature of nurse-client interaction have been delineated. In order to illustrate their impact on nursing practice and to encourage a deeper level of understanding, I want to apply these models to the following case. This example will serve to show both the essential differences concerning the nurse's responsibility with regard to the best interests of the client, as well as the place nurses' values and beliefs play in ethical decision making. This problem was selected because it is relatively simple compared to the major issues of euthanasia, abortion, and genetic engineering. It is in keeping with the type of question nurses expect to deal with on a daily basis.

Mr. S is a 31 year old client who is HIV+. He has been planning a long awaited trip to the east coast to visit family and friends. This is a special time for him and he is looking forward to a month away. He is determined that nothing will interfere with his plans.

His health status has been relatively good and he is not anticipating any problems. In preparation for his trip he has undergone a complete physical examination including a CD4+ count. This count is one of the laboratory markers for determining the progression of HIV. Current medical practice indicates that at CD4+ counts of 250 or less, prophylaxis for pneumocystis carinii pneumonia (PCP) must be initiated. PCP is one of the opportunistic infections often diagnosed in persons with AIDS.

Quite unexpectedly this young man's count has dropped from 410 to 235. He is now on the telephone requesting his test results from Nurse C. He states, rather jokingly, if its bad news he still wants to know. Nurse C has been providing care for this man for the past three months. The question is whether she should give the results as requested.

Although there may be several ways of resolving this question, there are basically only two options: either the results are given or they are not. The reasons for the nurse's

choice will also vary. Using the three types of models, let us examine Nurse C's response.

If Nurse C assumes a parentalist stance, she will take it upon herself to determine the best decision for her client's well being. She will undoubtedly realize the impact such news will have on Mr. S and his travel plans. Although the result of the CD4+ test by itself, does not signify a transition from an HIV positive status to an AIDS classification, it does indicate that this transition is moving closer. It is, therefore, very difficult for clients to learn of a drastic drop in CD4+ counts. There is a strong possibility that Mr. S will change his plans and either delay or cancel his trip. One of the strong points of this model is that it recognizes clients' vulnerability, fear, and need. Nurse C will feel sympathetic and understanding and want to protect Mr. S from the bad news, much the way parents tend to do with their children.

Nurse C's own preference as to whether she would want to receive this information just before leaving on vacation will greatly influence her decision. It is reasonable for her to postulate that prophylactic treatment could be delayed for a few weeks without any untoward effects. Then too, since Mr. S is not expecting his counts to drop so suddenly, he will not be suspicious if she does not give the results. Her tendency will be to let him enjoy his vacation and deal with the news later. She will regard the ethical commitment to Mr. S as a responsibility always to do what she believes is in his best interests. Consequently, she will most likely decide to withhold the information, even though Mr. S has requested it.

On the other hand, if Nurse C ascribes to the technical model, her decision and

subsequent action will be quite different. Her own views about the situation have no place in the decision making process, since she is required to be ethically neutral. The client determines his own best interests and he has requested the information. There is no further consideration to be made. Nurse C will give him the information.

Similarly, if Nurse C and Mr. S have a contractual type of relationship, she will probably give the information. In this model, her ethical responsibility is defined by Mr. S's right to determine his best interests and to control the course of his treatment. Nurse C must not impose her own value judgements on her client, and she will tell him.

It is important to note that although the end result of the technical models and the contractual models is the same in this situation, the reasons for acting are different. In the technical model the nurse's values are not consulted. The nurse simply responds to the client's request without much thought or deliberation. With contractual models, however, consideration is given to the client's need to take responsibility for and control his health care. Nurse C will discuss alternative solutions, explain how his decision may or may not impact on his health, and may offer her own perspective. She may also encourage him to take his vacation, but in the final analysis it will be his decision and his alone.

In reviewing the three categories of models, it appears that the relationship based on contract or agreement offers the most effective method of interaction. Parentalism may serve a limited purpose, for example, in times of crisis, but for the most part it is undesirable. For one thing, it endorses actions which violate clients' right to self-determination. It is ethically unsound for nurses to impose their values and beliefs on

clients, or to make important ethical decisions on their behalf. In this model, nurses determine the best interests of clients and act according to their own perceptions of what these are. Such actions promote dependence and prevent clients from accepting responsibility for their health care. They tend to keep the client in the sick role for a longer period of time.

Technical models are also inadequate. Whereas in these types of relationships clients have control over the decision-making and problem-solving processes, they receive little guidance or input from their nurses. Nurses' values and beliefs have virtually no place in the relationship. It has been suggested that nurses must take an ethically neutral stance. As argued above however, nurses are more than mere technicians. Except for completely amoral individuals, if there are such creatures, it is impossible to avoid any ethical involvement whatsoever. The mere act of relating to another human being has ethical implications and ramifications.

Contractual models recognize the ethical position of the nurse. Nurses are encouraged to share their values and beliefs to a point, and are also free to refuse to participate in a relationship if their value systems would be compromised. Clients' rights to self-determination are also honoured and recognized. The model promotes togetherness, sharing, and mutual agreement. Both nurses and clients have the opportunity to grow and develop personally and professionally and to pursue mutual goals. Contractual models have been criticized as being idealistic because there cannot be true equality between nurse and client, and that contracts in the literal sense do not occur. There is also an inherent danger for nonchalance and indifference on the part of the nurse once

the agreement has been carried out, for example, when client refuses treatment. However, for the reasons cited above, these models are preferable.

It is significant that in the literature reviewed concerning the three classifications of nurse-client relationships, there was virtually no discussion about the moral character of the nurse. The nurse's value system was alluded to several times, but there was no specific analysis of the nurse's moral characteristics. In retrospect, I suppose this is not so surprising. Whereas early professional nursing took the practitioner's moral disposition into account, the advent and subsequent adherence to scientific method brought a new focus. In an effort to provide a more concrete foundation for nursing ethics, the emphasis was placed on duties, obligations, and/or consequences. Lately though, there seems to be a renewal of interest in the moral character of the agent, that is, a return to an ethics of virtue (Benjamin & Curtis, 1985; Brody, 1988; Fowler, 1986; MacIntyre, 1984; & Salsberry, 1992). It is my belief that the moral qualities of the nurse play a critical role in relationships with clients, much as they do in any relationship.

From my perspective, the most important quality that the nurse can cultivate is that of caring. Within a helping relationship it seems inconceivable that one can "care for" effectively without "caring about" the individual who is helped. Yet, this is an area where there has been a great deal of controversy and uneasiness. Clients complain that nurses really don't care about them at all. This is reflected in such statements as, "You're only here because it's your job," or "You're just in it for the money." These comments generate a great deal of anger in nurses who are often overworked and

underpaid, and who want to be viewed as caring persons. Traditionally nurses have been cautioned about too much involvement with clients, and have been criticized for showing emotion. These beliefs have contributed to a great deal of confusion about caring and its place in nursing. In the following sections, I investigate caring theory as an alternative model of nurse-client relationship. It is my belief that caring incorporates the positive aspects of the models reviewed above, and also adds a dimension which greatly enhances the relationship.

### Chapter 3 -- General Aspects of Caring

The terms "care" and "caring" are not unfamiliar to the practice of nursing. Talk of caring, in one form or another, has pervaded nursing literature since the time of Florence Nightingale. But although caring has traditionally held a central place in nursing, there is little understanding about what it means to care, especially within the context of the nurse-client relationship. Caring was simply taken for granted as one of those things that nurses automatically do. The concept remained unexplored and unexamined. Within the past two decades, however, caring has become a popular topic for study and investigation. Nursing theorists and philosophers alike have begun to give voice to the depth, comprehensiveness and importance of this complex concept.

Staunch caring advocates like Leininger (1981, 1984); Noddings (1984, 1992); and Watson (1979, 1988) promote caring as the single most essential ingredient in nursing. They defend the position that it is so fundamental to nursing practice, that any attempt to disregard its primacy is tantamount to inviting the collapse of the profession. It is also their contention that human care models form the basis for ethical decision making within the nurse-client relationship. Watson (1988) calls caring, "the moral ideal of nursing" and claims nursing is fundamentally a caring relationship. These are strong convictions, and have generated much controversy.

In her article "Against Caring" Hilde Nelson (1992) charges that caring about clients carries inherent risks. She claims that it can cloud decision making, for example, a nurse may postpone a certain treatment because it is painful, and there is a desire not to cause the client discomfort. Caring is also "other directed" and can generate what Nelson



characterizes as "self effacement", something akin to burnout. Ultimately, she claims, "caring is not so well suited to nursing as it first seemed" (p. 11). In a similar vein Howard Curzer (1993) attacks caring models. Citing risks of burnout, favouritism, and loss of objectivity he alleges that caring is a vice rather than a virtue for health care professionals. These points are well taken: caring is not without its risks and limitations. I have more to say about them later.

Despite its problems and criticisms, it is interesting to note that caring is gaining momentum as a viable foundation for nursing. I believe that this is no coincidence; current times both demand and support a return to nursing's caring roots. Nurses have long expressed concern over the edging out of their human care role by the increasing number of technological advances and bureaucratic constraints in today's society. There is no doubt that great strides in science and technology have exerted a tremendous impact on modern medicine and nursing practice, but although these have often proven life-saving, there is also a down side. A high price in both time and money has been exacted. The vast array of technical procedures, complicated techniques, and specialized equipment has necessitated a high calibre of skill from nurses. All have impinged on the time nurses previously allotted to caring behaviours (Leininger, 1988). Paradoxically, the very technology that once held out such hope of saving time, finds itself now taking time away from the bedside.

As mentioned above, technology is expensive, which further complicates the situation. Escalating financial burdens have forced institutions to respond with cutbacks, lay offs, and bed closures in an attempt to remain solvent. Of course, this response only serves

to aggravate matters. Health care professionals become increasingly understaffed and overworked, and complain bitterly that they have no time to care for their clients. As feelings of dissolutionment and frustration intensify, job satisfaction plunges to an all time low. All of which adversely affects clients, who echo the same types of concerns. Clients experience feelings of depersonalization within the health care system and feel deprived of their basic rights and dignities. "Nobody cares anymore," they wail (Carper, 1979; Noddings, 1984; and Watson, 1985). It is a vicious circle.

Nursing is at a crossroads. A critical situation exists whereby human care ideals and caring ideologies are severely threatened by the convergence of science and technology. This does not mean that technology must be set aside, it has an important place. Rather, technology must be tempered by a humanistic value system. To paraphrase Nesbitt (1982), whenever nursing is confronted with a "high tech approach" there needs to be a counterbalancing human response that is "high touch". Leininger, Noddings, and Watson are convinced that this response is caring. I agree.

In this chapter I hope to provide some understanding of the meaning and scope of the caring in general, as it pertains to the nurse-client relationship. I spend considerable time distinguishing between the two senses of care: "caring for" and "caring about". Although both are important it is the latter concept which is primary to caring theory. I also discuss the notion of presence.

### **3.1 The meaning of caring**

Caring is a complex construct and, as such, eludes definition. Despite valiant efforts by nursing scholars to elucidate one, to date there has been no consensus about its

meaning (Huggins, Ganby and Kohut, 1993). The more one delves into the concept of caring, the more evident its profundity and mystery become. Caring is a dynamic complicated process, constantly changing in response to the needs of the individuals who comprise the nurse-client dyad. This in no way suggests it is a relative notion. Although there is a great deal of attention to particularity, it will be shown that there is a fundamental universality in the caring ethic. My point is that it has not been possible to capture the essence of caring in one precise definition. This is not necessarily a negative thing; it just means we must try harder. I look at the most common aspects and major components of this intricate concept. If I can impart some general idea of the type of caring I am advocating, then I will have accomplished much.

Nursing has used care as a mode of thought, action, and language for more than a century. It is one of those special terms that a discipline employs in order to communicate its distinctive features, interests, and attributes. In much the same way the word "cure" has come to be associated with the field of medicine. Nurses "care" and physicians "cure". Of course, it is ludicrous to believe that care or cure are the exclusive province of either discipline, but nevertheless these professional stereotypes have survived through the decades. Although I do not wish to enter a discussion as to whether these beliefs are justified, it is worth noting that the medical model of cure has greatly influenced and directed nursing practice. Many theorists contend that it still continues to be a dominant theme (Aroskar, 1980; Carper, 1979; Leininger, 1984; Noddings, 1984; and Watson, 1985). Aroskar's (1980) research indicates that the image of the nurse as handmaiden to the physician still prevails in the public's perception. In

an effort to shed this image and to establish the distinct identity of the nursing profession nurses have begun to reexamine and define their caring function. This attention to caring, however, does not eliminate the concept of cure. To achieve excellence, any model of nurse-client relationship must allow for both perspectives.

Nurses have been somewhat reluctant to become involved in caring research says Leininger (1988). One of the reasons for this hesitation, is the sheer complexity of the concept. Attempts to define caring have resulted in a myriad of both specific and diverse meanings. To further complicate matters, caring is both a noun and a verb; nurses care and also provide care. Ask anyone, who has been a provider or a recipient of care, to tell you what it means and you will receive as many different answers as people to whom you posed the question. Yet clients seem to know when nurses care about them; they are usually astute at recognizing nurses who care. However, they are often at a loss to put it into words. They usually find it easier to identify the specific caring tasks carried out by nurses. Nurses too have a tendency to equate caring with the so called nursing care activities, for example, providing palliative care, doing wound care, teaching prenatal care and formulating care plans. In addition, and in an entirely different context, nurses readily and even adamantly claim to care about those for whom they provide service. Unfortunately, these kinds of statements are made rather matter of factly, with little regard to their deep significance and meaning (Leininger, 1988).

### **3.2 Two meanings of care**

In the above paragraph two senses of care can be distinguished: one related to caring activities and the other to caring attitudes. Jecker and Self (1991) have provided a fairly

comprehensive analysis of the distinctions between these two senses and have subsequently labelled them "caring for" and "caring about." These same differences have also been noted by Leininger (1984), Noddings (1984), and Watson (1985) although they did not use the same labels. For example, Noddings talks about "caring from the outside" and "caring from the inside" (1984, p. 9). Jean Watson makes a similar distinction between what she calls "nursing trim" and "nursing core" (1979, p. xv). Although both aspects of care are crucial to nursing, it is the second type which is the springboard to the type of caring nurse-client relationship I advocate in this paper. Since I will often use these designations, it seems appropriate to further investigate the two senses of care, and to elaborate their differences.

The first sense of caring is designated "caring for." In this circumstance, the nurse takes care of, has the care of, or assumes some responsibility for the welfare, treatment, and guidance of a client. As Jecker and Self (1991) explain, "[caring for] implies an activity of looking out for or safeguarding the interests of others" (p. 294). Usually there is an objective action or task to be performed which, more often than not, requires the exercise of a particular skill or technique. Changing a dressing, completing an assessment, and teaching self-injection of insulin are examples of skills or techniques which fall within the scope of "caring for." The focus is on doing, and the doing regularly involves scientific, technical knowledge and know how. By definition, then, "caring for" requires direct contact between the health care provider and the person receiving this type of care. That is, to change a dressing or to complete an assessment, for instance, nurse and client must be together.

"Caring about" on the other hand pertains more to an attitude or feeling. From this perspective, it is the manner in which the nurse relates to the client, a manner which expresses concern, provides reassurance and attempts to gain the client's trust and confidence (Jecker & Self, 1991, p. 297). The nurse who "cares about" is very interested in the client as a person, often feels anxious and solicitous, and can be said to be in a subjective state of concern about those for whom he/she provides care. Hauerwas (1978) explains it nicely: "Caring about indicates an attitude, feeling, or state of mind directed towards a person" (p. 145). Yet this aspect of caring is not only about emotion, attitude, and feeling. "Caring about" calls for a high degree of involvement, personal interaction, and commitment on the part of the nurse. It requires that the nurse be totally and fully "present" to the client, not merely from a sense of duty but from a genuine desire to be there. The notion of presence is an important one, and merits additional explanation.

The concept of presence is abstract and difficult to put into words, yet, it is so crucial to the nurse-client relationship that some understanding is essential. "Presence" or "being fully present" to the client requires the nurse go beyond the reason for the relationship, for example, illness, health teaching, counselling. The client is not his or her diagnosis and must be viewed accordingly. That is, the client is a person, a unique human being with a peculiar set of circumstances, beliefs, and problems. To be fully present the nurse must recognize and respect the other, while at the same time giving himself or herself totally to the moment. Watson (1988) charges the nurse to both give time and take the time to approach the client as an individual, and to consciously convey

the will and intention to care (p. 34). In so doing the nurse should endeavor to feel what the client feels, as well as, share his or her feelings and experiences when appropriate. In the ideal situation, the nurse focuses on simply "being" with the client, and the client, in turn, is allowed and encouraged to be. Being fully present to the other allows us to experience the wonderful interconnectedness we share. Nurses who practice the art of presence have the ability to instill in the client the belief that he/she is the most important person in the world, at that particular moment in time and space. Perhaps this statement best describes the notion of presence.

There is also an element of continuity that prevails in "caring about" that is not evident when "caring for." In the strictest sense the latter is more task oriented. Therefore once the task has been carried out, that type of care is also completed, at least until it's time for the next activity or contact. However, when the nurse "cares about", the client can continue to feel "cared about" when they are apart. At any given moment the client can reflect upon and experience the calming presence of the nurse. In this manner, the nurse can continue to instill comfort, hope and well being. The nurse, too, can care from a distance. For example, the nurse can go beyond the call of duty to seek information about the client's situation, make an extra effort to contact family and friends, or plan a special dietary treat to please the client. These are the kinds of things that enhance and solidify the relationship. A different type of knowledge from the technical and scientific is required: the knowledge of oneself, of the other, and of humanity in general.

By now it is probably apparent that to assert Nurse A "cares for" my mother is to imply something quite different from saying that Nurse B "cares about" my mother. In

the first instance, caring is objective, is concerned with activity and doing, and usually requires that nurse and client be in direct contact. Caring in the second sense is subjective by nature, is focused on attitude and being, and boasts a continuity of presence that is lacking when "caring for." We could also say that the former is more science focused and the latter more arts oriented.

At first glance, then, it appears that we have done a fairly decent job of putting these concepts into two well defined packages. However, this is not the case. Both types of care are far more complicated than the discussion has indicated so far. Furthermore, their boundaries are not always that precise, in fact they often blur. It is often difficult for an observer to distinguish which type of care is being practised. As we will see, one does not necessarily rule out the other. In addition, there is often a tendency to relegate "caring for" to a position of little consequence because it is viewed as commonplace and routine. This is a grave mistake however, "caring for" has a lot to offer, and makes many demands on the nurse.

In elaborating the concept of "caring for" Jecker and Self (1991) classify it as "a deliberate and ongoing activity of responding to the [client's] needs" (p. 295). There is an emphasis on the notion of responding, but as the authors point out, the demands responded to are often complicated and involved. High levels of technical ability and proficiency in verbal skills are required to determine the client's particular condition and presenting needs. Competency in interviewing and observation techniques, active listening skills, and the ability to recognize and interpret non-verbal skills are critical to the nurse's success. To "care for" with any degree of effectiveness, the nurse must



possess a vast amount of knowledge, and master a multitude of intricate skills and procedures. We must not underestimate the value of this type of care. "Caring for" is an inextricable part of the nurse's role (Jecker & Self, 1991, p. 302). In emphasizing the values of "caring about" I do not mean to imply that "caring for" is a superficial mode of care.

On the other hand, "caring about" is the deeper, richer sense of care; it entails a broader, more comprehensive view, and greatly enhances the nurse-client relationship. With "caring about" there is, "a cognitive or emotional decision that the welfare of the [client] is of great importance" (Jecker & Self, 1991, p. 295). The emphasis is on the person, not the disease nor the activity. The total well being of the client is what guides and directs nursing practice. In other words, the client's best interests always take precedence. However, the issue as to what the client's best interest consists of, and how it is best achieved is not answered by Jecker and Self. The authors merely assert that prior to any nurse-client contact, there should be a predisposition to care in this manner (p. 294).

It is, also not clear just how or where the above predisposition comes from. It could be that this is a quality that most nurses possess or that somewhere along the way, perhaps in school, the nurse makes a decision to ascribe to this caring ideal. Jean Watson (1988) makes a similar claim. She contends that the type of care discussed in the sense of "caring about" requires "the will to care", and she views the commitment of the nurse as a moral one (p. 32). There must be "a recognition and acknowledgement of the value of human caring in nursing [that] comes before and presupposes actual

caring," says Watson (1988, p. 31). She strongly believes that her caring ideology can be and should be taught within the nursing education system. Such caring must be based on human values and a concern for the welfare of others.

Since we have been concentrating on the distinguishing characteristics between the two senses of caring, it would seem logical to assume that one does not entail the other. Jecker & Self (1991) argue this point quite well. A nurse can successfully "care for" a client without "caring about" that client (p. 296). The authors hold, for example, that dressings are changed using perfect sterile technique, nursing histories meticulously recorded, and medications distributed correctly, without the nurse "caring about" the client. The authors suggest that in these instances, the nurse is motivated by a set of different reasons. For example, the nurse may pride himself or herself on the efficient discharge of one's duties, may see the client as simply another puzzle to be solved, or may even be attempting to impress colleagues or supervisors. I realize this latter statement sounds somewhat cynical, but I do not think that is the message Jecker and Self are trying to communicate. Rather, the point they wish to make is that "caring for" is a viable option within the nurse-client relationship, it can stand alone.

There are at least three kinds of circumstances when "caring for" would be a prudent choice. Hopefully such situations are relatively few in number, but there are times when it is appropriate for the nurse to detach himself or herself from a given situation. The first relates to clients guilty of heinous crimes such as rape, child molestation, spousal abuse, or torture. Imagine if you will, the struggle of the nurse to provide service to Paul Bernardo, the convicted rapist, murderer, and mutilator of two adolescent females

in St. Catherines, Ontario. To "care about" in this situation is almost impossible, except perhaps for persons in the caliber of Mother Theresa. In reality, to be able to "care for" some clients is commendable in itself.

The second set of circumstances refers to clients whose behaviour is obscene or repulsive in some way, or whom we simply dislike for some reason. We cannot like everyone and to think that we can, is counterproductive. By this I mean that such a belief leads to moral obligation: I should "care about" this client. When the nurse, then, tries to muster this attitude it is necessary to deny his or her feelings, in order to subdue a negative response to the client. The behaviour is self defeating, because the feelings of the nurse are really not mitigated or changed: they are simply repressed or ignored. Subsequently, when the nurse finds it impossible to "care about" the client the difficulty is often compounded by guilt and conflict. It's a no win situation. Such considerations led Nel Noddings (1984) to reject the notion of universal caring (p. 18). The ideal of "caring about" everyone is impossible to actualize, says Nodding. She contends that attempting to uphold this ideal leads us to substitute abstract problem solving techniques and idle talk for genuine caring. Caring becomes superficial. There are times when "caring for" is the very best we can do. It is also possible that in "caring for" we learn to "care about."

The third situation has to do with burnout and vicarious trauma. Since burnout is one of the major criticisms lodged against caring theory, I discuss it more fully in the next chapter. For now, let me indicate that there are times and cases which are more overwhelming than others. During this age of rapid technological change, cutbacks, and

financial constraint the nurse often finds himself/herself understaffed and overworked. Some client situations are more disturbing and time consuming than others. Under these conditions it may be necessary to step back, to focus on activity and doing, and only do what needs to be done. This does not mean that the nurse can relax the quality of care provided. No matter which type of caring is practised, it has its own degree of excellence.

The last statement suggests that there are degrees of both senses of caring. Jecker and Self agree. Caring in both senses is a relational term, which refers to an attitude or skill directed to another. Within the context of the nurse-client relationship the other is the person receiving care. The nurse who "cares about" may do so with feelings which are more or less deep, and the nurse's skill at "caring for" may nurse more or less ability. In both instances, we speak of the quality of care to describe the depth of "caring about", and also how good or poor the nurse is at "caring for" the client. This notion of degrees of caring is useful because it allows for the growth and development of relationship. The type of relation advocated in "caring about" does not evolve overnight. If it happens at all, it takes time and work. It is also not unreasonable to presume that "caring for" can lead to "caring about." As nurse and client get to know and trust one another, and as the relationship progresses it is possible to "care about" someone whom the nurse only "cared for" in the beginning.

So far, I have shown that there are definite distinctions between the two senses of caring. There also appears to be adequate evidence that "caring for" does not entail "caring about", that is, it is possible to "care for" without "caring about". The question

which now arises is if the reverse is true: does "caring about" imply "caring for?" Jecker and Self (1991) argue that it does not (p. 292) and at least in a literal sense, I agree. They cite an example of a supervisor who may "care about" the clients without actually being engaged in the activity of "caring for" them. That is, the supervisor is not providing any hands on or direct client care. Here, I agree: "caring about" does not entail "caring for". However, within the context of the nurse-client relationship which is the focus of this paper, I beg to differ. If a nurse truly "cares about" a client, then it seems to me that "caring for" must necessarily follow. I cannot imagine a single instance in which "caring for" activities could not be demonstrated. There is always some activity or task to be performed even if it is as routine as giving a bed bath, monitoring vital signs, or putting client on the bed pan. For a nurse to "care about" a client yet fail to "care for" that client is to go against the very nature of caring. As Jean Watson (1988) contends, caring must manifest itself in concrete acts; otherwise it is futile (p. 32). To "care about" someone or something and do nothing does not make any sense.

Within the nurse-client relationship, both senses of care have an important role. Under certain circumstances, it is advisable and prudent to provide only "caring for" activities. On the other hand, "caring about" which, as explained above, entails "caring for", is the richer, more comprehensive alternative. It is the sense of care that Jean Watson expounds in her transpersonal therapy of care. "Both theoretically and empirically the concept of caring is not merely characterized by certain categories or classes of nursing actions, but as ideals, which persons desiring care and persons (nurses) doing those

actions hold before them" (Watson, 1988, p. 34). We get a glimpse of Watson's Platonic view of human care: it is a moral ideal. It is time to take a more detailed look at her theory.

## Chapter 4 - Watson's Caring Theory

### 4.1 Nursing "core" and nursing "trim"

In her first book, *Nursing: The Philosophy and Science of Caring (1979)*, Watson distinguishes between what she calls the "core of nursing" and "nursing trim." These two concepts respectively correspond to what has been described above as "caring about" and "caring for". Although the "trim" has a very definite role to play in nursing practice, Watson emphasizes the "core". The "core" elevates nursing to a higher, metaphysical plane. She views nursing as a human-to-human care process with spiritual dimensions, rather than merely a set of behaviours that conform to the traditional scientific/medical model.

"The term "trim" refers to the practice setting, the procedures, the specialized clinical focus, and the techniques and specific terminology surrounding diverse orientations and preoccupations of nursing" (Watson, 1979, p. xv). Nursing "trim" thus denotes those tasks and skills peculiar to the various spheres of nursing, for example, maternal, newborn, pediatric, medical, surgical, oncological, and geriatric. Each has its own language, its own collection of policies and procedures, its own set of techniques, and its own evaluation tools. By the same token, if we listen to the jargon, review the protocols, or observe the techniques, we can usually identify the specific realm of nursing being practised. The "trim" is therefore the more tangible and observable part of nursing. Like "caring for", the "trim" is more concerned with doing, with performing some activity, and tends to focus on the disease process or problem. That is, care and treatment are dictated by the client's diagnosis and not the client's rights as a person.

The characteristics cited above make the "trim" changeable and transitory part of nursing. Given today's rate of scientific and technological advances, the specific content of the "trim" quickly becomes outdated. The nurse is thus placed in a position which necessitates constant learning and relearning. If we stop and think about this phenomenon for a moment, we can gain some insight as to why nurses can easily get caught up in a technical model of care. If this is where the educational emphasis is placed, then, it is but a simple step to the belief that the "trim" must be the critical agent for effecting positive health change and providing quality care. Nurses may unintentionally be led to think that this is all there is to nursing practice. But, as Watson points out, when the "trim" becomes too elaborate and esteemed it does so at the neglect of the major component of nursing: the "core". Moreover, she charges that nurses who fail to effect positive health care changes in their clients are probably those who are too concerned with the "trim". This is in no way to suggest that the "trim" is expendable. Like "caring for", it has a very significant role to play. However nursing is more than the performance of a series of tasks and skills, no matter how intricate these may be.

Watson holds the "core" is the basic foundation of nursing practice. Unlike the "trim" it is remarkably similar for diverse groups of nurses and nursing fields. There is an element of sameness which permeates all nurse-client interactions. "The term core refers to those aspects of nursing that are intrinsic to the actual nurse-patient/client process that produces therapeutic results in the person being served" (Watson, 1979, p. xv). Thus, the potential for excellence is contained within every nurse-client relationship, waiting to be recognized and developed.



Metaphorically the "core" can be viewed as the common thread by which all types of nursing are woven into a tapestry of practice. Without it nursing disintegrates into isolated patches of highly specialized techniques, which causes us to lose sight of the whole picture, and subsequently a lack of meaning and comprehension. The "core" is considered to be the very heart of the profession, and as such, breathes life and spirit into nursing practice. Situated at the centre, the "core" radiates outward in all directions to encompass the "trim". In so doing, "core" and "trim" interact to produce a higher level of nursing care. But the "core" does not function automatically. It must be acknowledged and constantly nourished. For, just as the consequences of a poorly functioning heart are felt throughout the rest of the body so too are the effects of a poorly or non-functioning "core".

#### **4.2 Key components to Watson's theory**

According to Watson, this basic core is comprised of ten primary mechanisms which she has identified as "carative factors" (1979, p. 9 and 1985, p. 75). There is nothing unique or original about these factors; most nurses have used them at one time or another. Nor does Watson claim these factors are exhaustive. There are many different ways of categorizing the elements which facilitate therapeutic results in nursing, and colleagues may disagree with her list. However, the carative factors provide a starting point for Watson's theory, and at the same time, incorporate her major premises and beliefs. The term "carative" is used in contrast to the so called "curative" factors expounded by Yalom (1975). Watson explains, "Whereas curative factors aim at curing the client from disease, carative factors aim at the caring process that helps the person

attain (or maintain) health or die a peaceful death" (1979, p. 7). These factors are the fundamental interventions used by nurses in their delivery of health care.

A list of these ten carative factors is provided below (Watson, 1988, p. 75). This paper does not permit nor require a detailed examination of each one, however, some reference is made to these in the course of the following discussion. We would do well to note, though, the interconnectedness of the first three factors. These interact to establish Watson's philosophical foundation for her science of caring, and together formulate a value-laden orientation to her caring theory. For Watson, it is a given that caring is grounded on a set of universal human values.

**TABLE I**

**Watson's Ten Carative Factors**

1. Formation of a Humanistic - Altruistic System of Values.
2. Instillation of Faith - Hope.
3. Cultivation of Sensitivity to One's Self and Others.
4. Development of a Helping - Trust Relationship.
5. Promotion and Acceptance of the Expression of Positive and Negative Feelings.
6. Systematic Use of the Scientific Problem - Solving Method for Decision Making.
7. Promotion of Interpersonal Teaching - Learning.
8. Provision for a Supportive, Protective or Correction, Mental, Physical, Sociocultural, and Spiritual Environment.
9. Assistance with the Gratification of Human Needs.
10. Allowance for Existential - Phenomenological Forces.

Watson takes her carative factors and carefully blends them with a belief system firmly

rooted in human values. Such values include the belief that simply by their being, humans possess inherent worth, have purpose, and must be treated accordingly, that is, as ends in themselves, never only as means. Within the context of the interpersonal relationship, mutual respect and dignity are critical, without which nurse and client fail to attain a meaningful interaction. There is an assumption that people have unlimited potential for growth and change. This is crucial for Watson, otherwise she claims goals are unachievable, and the relationship lacks direction. In addition, she adds a high regard for the wonders and mysteries of life, and demonstrates a strong belief in the ability of human beings to live in harmony with nature, while at the same time having the ability to transcend it (1988, p. 55). These convictions are interwoven into what she calls "the moral ideal of nursing", in other words her transpersonal theory of human care. As she describes it:

... human care and caring is [sic] viewed as the moral ideal of nursing. It consists of transpersonal human-to-human attempts to protect, enhance, and preserve humanity by helping a person find meaning in illness, suffering, pain, and existence; to help another gain self knowledge, control, and self healing wherein a sense of harmony is restored regardless of external circumstances. (Watson, 1985, p. 54).

Her approach is non-parental. Nurse and client coparticipate in an intersubjective process which aims at facilitating self knowledge, self control, and self healing. Ultimately, she says, the goal is a deeper understanding of the meaning of life, and what it means to be more fully human. For Watson, the nurse-client relationship is the prime element in nursing practice.

The notion of a transpersonal human-to-human relationship is as simple as it is

complex. Very simply, nurse and client come together at the fundamental level of human being to human being: nothing more, nothing less. This is the starting point or foundation for the relationship; each person recognizes and respects the essential humanness of the other. Borrowing Watson's "core/trim" analogy, we would say that the participants are aware of and interact with the "human core" of one another. Just as the "core" is central to nursing practice, and serves to distinguish nursing from other disciplines, so too with humanity. The human "core" separates humankind from the other animals, and is the very heartbeat of the transpersonal relationship.

For the sake of argument it is necessary to accept the existence of an essential human "core" or as it is more commonly called an essential human nature. As I understand it, this "core-nature" is comprised of those elements usually considered as human qualities, for example, the ability to reason, to laugh, to choose, and to care. This potential should be recognized and nourished, and when that occurs, a person's individuality and separateness are allowed to manifest themselves. Nurses and clients who relate at this level have reached the epitome of caring. As might be expected, however, these types of relationships are rare, that is, the ideal is seldom attained. But Watson makes no apologies for her convictions. There is no reason to stop trying to achieve this ideal: it makes us better nurses, and ultimately better people. We see that although initially the notion of transpersonal caring may appear simple, the process itself is quite complicated. Therefore, to obtain a better understanding of Watson's theory, let's take a more detailed look.

Nurse and client come together at a particular time and place within each of their lives.

Each brings a specific set of baggage to the relationship, including a unique sense of self, a particular life history, and a frame of reference or phenomenal field (Watson, 1988, p. 58). These three components heavily influence nurse-client interaction and generate a completely new set of experiences and perceptions from the encounter. As is explained these incidents may be positive, negative, or any combination thereof, depending on the circumstances. According to Watson, however, the addition of transpersonal care into the relationship ensures a certain amount of success in a positive direction. The event is transformed into what she terms an "actual caring occasion" (Watson, 1988, p. 59). An entirely new experience is created and the transaction is greatly enriched. The event actually transcends itself, and in the process creates an occasion greater and other than the sum of the two participants' life histories, selves, and phenomenal fields (Watson, 1988, p. 59). This newly formulated "caring instance" produces an environment conducive to expanded human capabilities for learning and understanding. The more that human care is actualized the more potential that caring holds for self-development and self-healing (Watson, 1988, p. 75). In a very direct way transpersonal caring opens the window of opportunity for change and growth. Notice, however, that Watson focuses on opportunity only, she does not contend that growth and development automatically occur. Nurse and client are empowered to find meaning in the health-illness experience, and subsequently in their lives, but they must work for it. We begin to get a glimpse of Watson's penchant for the metaphysical and the ideal. Before taking a closer look at these, it is important to explore the three major concepts mentioned above: the life history, the self, and phenomenal field, if we are to gain further insight into Watson's

theory.

#### **4.3 Components of the human caring process**

Many factors influence the nurse-client interaction. From an individual perspective the culture, value and belief systems, education level, societal status, age, and gender are a few aspects that affect the relationship. From an institutional, health care point of view we are confronted with policies and procedures, standards of care, financial constraints, staffing patterns, legal and ethical guidelines. In an attempt to simplify her model, Watson categorizes these elements under three general headings. The life histories, selves, and phenomenal fields of each person in the relationship, are integral to the human care process. Although distinct, these concepts are closely related and often overlap. Each influences and is influenced by the other.

The life history or "causal past", as Watson sometimes refers to it (1988, p. 64), is the first concept to be discussed. Quite simply, and deceptively so, it means the sum of experiences and events that have contributed to and shaped one's life to date (1988, p. 47). Because people are unique, each person's life history is also unique. One's life history also impacts the immediate moment, as well as, each succeeding one. Watson explains: "Each successive moment of awareness is shaped by the previous moment and will determine the following moment" (1988, p. 55). However, this is not to suggest that life is a mere sequence of actions and episodes. On the contrary, human life is a dynamic process, continuous in time and space. Watson compares it to a river.

Reminiscent of Heraclitus, an early Greek philosopher who proposed almost 2500 years ago, that you cannot step twice into the same river (Nahm, 1964, p. 70), Watson

believes humans are in a state of flux. "The human is like a river that keeps a constant form, but not a single drop is the same as it was a moment ago" (Watson, 1988, p. 55). The power of human beings to change is critical to her theory. A person is continually writing and recording his or her life story.

Alasdair MacIntyre expounds this notion of life story in his text *After Virtue* (2nd ed., 1984). MacIntyre refers to the concept of narrative, or the narrative order of a single human life, as one of the stages in his account of the virtues. Whereas it is true that we are the main author of our own narrative, it is also true that individuals are no more than co-authors of their life histories. That is, our narratives are greatly impacted by those of others. Other people impose constraints on our choices. For example, I may want to continue my education, but my children and husband also need attention. I must, therefore, find a way of doing both or postpone the dream. We live the life we please only in fantasy, says MacIntyre (p. 213).

Another of MacIntyre's insights is that we often make the mistake of trying to understand the actions of others through the narrative of our own life (1984, p. 212). This of course does not always work; narrative histories are unique to each person. Therefore, to successfully identify and understand what someone else is doing, we need to place his or her action within the context of his or her particular narrative; we must look at the situation from his or her perspective. In this way, we render the action of another intelligible. Although we may not agree with the action, we realize that the action itself is based in the life history of the individual. In the way, a person's life story or narrative history also provides guidance in the present, as well as direction for the

future at the same time.

Persons coexist with the past, the present, and the future all at once (Watson, 1988, p. 60). Although she views the past as more objectively real than the present, it is often impossible to tell where one ends and the other begins. We think of past, present, and future chronologically and in that order, but they are not as sharply defined as we tend to believe. The present is very elusive. Before we actually finish thinking about it, the present has already become the past, and the future has come in to fill the void. Time is a successive process, a merging and fusing of the three tenses. From this perspective, a person's life history is visualized as propelling the individual forward to the next moment, and the next, and then the next. The moniker "causal past" makes sense. That is, one's past influences or "causes" present or future actions.

How nurse and client interact with one another will, in large part, depend upon the multitude of experiences and perceptions comprising their life histories. For the nurse, these specifically include, but are not limited to, educational background, previous experiences with clients, values and beliefs about humanity, and level of growth and maturity. We would expect, for example, that a recent graduate, who has been taught to keep his or her distance, would not respond with the same degree of sensitivity to clients as the more experienced nurse. Clients, too, possess the same types of perceptions, expectations, values and beliefs. A client who has never needed the services of a nurse, or one who has had a negative encounter with a nurse, will have far different expectations than one who has previously benefited from and even enjoyed interactions. We, therefore, begin to understand how life histories affect the nurse-client relationship.



In addition, the relationship itself influences the persons involved, and through the ebb and flow of life it takes its place in each of their life histories. As each new transaction/event is experienced, it lays the groundwork for the next, and influences its expression. This constant state of flux, combined with personal differences, ensures that no two encounters are ever exactly the same. The nurse meets the client ever new.

The self is the second component of the human care process which merits exploration. It is important to note, that although Watson makes a conceptual distinction between self and person, she often describes them as one and the same. For example, she defines a person as "a living growing *gestalt*" (1988, p. 54) and then on the following page also describes the self as "an organized consistent conceptual *gestalt*" (1988, p. 55). Given that the difference will not alter the outcome of this paper, I will use these terms interchangeably. For the most part however, my remarks will reflect Watson's exposition of the "self". The meaning of self is never easy to elucidate and Watson's explanation is no exception; her description is equally complex and abstract. I provide only a sketch of her interpretation, but when considered in the overall scheme of her theory, this should be sufficient.

Watson's perception of the self as a "growing *gestalt*" reflects her view of an individual as an organized whole, with qualities different from those of its components considered separately. She also denotes the self as, "the subjective centre that experiences and lives within the sum total of body parts, thoughts, sensations, desires, memories, life history, and so forth" (Watson, 1988, p. 55). One's self is really a process, ever fluid and changing, but at any given moment a specific entity. The nature

of its parts is determined by the whole. Any enquiry about humanity must begin with an examination of this whole, as opposed to looking at the parts, and then attempting to synthesize these into a meaningful whole. This notion has far reaching implications for nursing practice. Consider the case of Mr. B who is admitted to Emergency Room (E.R.) in severe cardiac distress due, in part, to his failure to comply with prescribed medication for his high blood pressure. In order to make sense of Mr. B's situation we must do more than merely attend to his circulatory problem. Although his illness is a part of who Mr. B is, it is not possible to discern its significance in his life only from objective observation. Mr. B is a complex, integrated, entity and must be treated accordingly. To understand his condition, and his behaviour regarding it, we must look to Mr. B's experience of it. His feelings and perceptions are crucial to interpreting the situation. Watson is a strong proponent of holistic health care and we also being to glimpse her propensity for existential psychology and phenomenology.

Sense perceptions are a major component of the self. How an individual perceives the characteristics of the "I" and the "me," or sees the relationships of the "I" or the "me" to other people and to various aspects of life are especially significant. In addition, the values attached to such perceptions also figure in Watson's concept of self (1988, p. 55). The "I" refers to the self as experienced and the "me" to the self as perceived. When these two aspects of self are aligned a state of harmony and health exists. However, when the "I" and the "me" are incongruent, when the self is separated from the self so to speak, a state of subjective turmoil or disharmony exists. When prolonged, this situation results in threat, anxiety, dread, and or illness (Watson, 1988, p. 48).

According to Watson a person's three spheres of being, mind, body and soul, are influenced by the self. Although we speak about these aspects as if they are totally distinct, they are actually inseparable. Watson denounces the mind - body schism, so prevalent in the Western world. As she explains: "A nurse may have access to a person's mind, emotions, and innerself indirectly through any sphere - mind, body, or soul - provided the physical body is not perceived or treated as separate from the mind and emotions and higher sense of self (soul)" (Watson, 1988, p. 50). The three spheres are so closely interwoven, that when something occurs in one aspect, it automatically affects all. Although Mr. B's hypertension may initially be diagnosed on a physical plane, we can be certain that there are emotional, psychological, and spiritual consequences as well.

Watson's work also has a definite spiritual flavour. She goes beyond other existential - phenomenological approaches to a higher sense of abstraction and personhood, to incorporate the concepts of soul and transcendence. The soul refers to one's inner self, essence, spiritual self, spirit, or *geist*, and she uses these terms interchangeably to represent the same phenomenon. It is the soul or spirit which enables a person to attain a greater sense of self awareness, a higher degree of consciousness, and to transcend the usual self (1988, p. 46). This ability to transcend the physical universe occurs within the mind, imagination, and emotions. Mr. B, for example, may be physically present on a cot in the E.R., but his mind and feelings may be located elsewhere, perhaps reliving his father's death from a heart attack twenty years ago. The ability to recall a past event and reflect upon its meaning provides Mr. B with the opportunity to find meaning and

purpose in his illness, and in his life. Whether Mr. B does this or not, depends on his willingness to engage in such an endeavor. But the nurse who "cares for" helps a great deal. By providing the opportunity and the atmosphere conducive to this type of reflection, the nurse encourages Mr. B to seek answers. Watson believes that Mr. B will naturally want to learn from his experience.

Watson shows an Aristotelian, teleological approach when she contends that all persons are born with one basic striving: to actualize the real self (1988, p. 57). "Every craft and every investigation, and likewise every action and decision, seems to aim at some good; hence the good has been well described as that at which everything aims", claims Aristotle in the *Nichomachean Ethics* (1094a). Human beings have a specific nature, and that nature is such, that they have certain aims and goals. By nature, persons move toward a specific *telos* or good. As noted in Chapter I, the highest good, that which is sought for its own sake and no other, is *eudaimonia* or happiness (*Nichomachean Ethics* 1097b 6). However, happiness is not to be equated with pleasure. Rather, happiness is a state of living well, doing well, and being well favoured with oneself or in other words, being self sufficient (*Nichomachean Ethics* 1095a 18; 1097b 7; 1140b 7). It is the highest good because it is sought only for itself; it is not a means to another end.

From Watson's perspective, the ultimate in self actualization is the actualization of one's spiritual essence (1988, p. 57). Since she believes that the highest sense of self is spiritual in nature, she thinks this is what brings about the much sought harmony of mind, body and soul. Self actualization is a process by which an individual gains increased knowledge and understanding of himself/herself. The talent and capabilities

thus discovered are cultivated and developed.

The belief that human beings possess some type of innate teleological process, some endeavour toward a common goal, is not generally accepted. Since the Enlightenment in the 18th Century philosophers like Kierkegaard, Kant, Diderot, Smith, and Hume argued against any teleological account of nature (MacIntyre, 1984, p. 54). These men all rejected the Aristotelian view of humankind as having an essence which defines their true end. In his attempt to maintain a teleological conception of virtue theory, MacIntyre also finds it necessary to renounce what he calls Aristotle's "metaphysical biology" or "biological teleology" (1984, p. 63). Human nature apart from culture cannot be known says MacIntyre. "A [person] with only a biological nature is a creature of whom we know nothing" (1984, p. 161). Notice, though, that MacIntyre does not deny the possibility, only that we cannot know its truth or falsehood with any certainty. Such concerns raise questions about Watson's claim that individuals have "one basic striving", to actualize the self, especially the spiritual self.

Although Watson does not refer to Aristotle directly, her claim can be interpreted in light of the Aristotelian biological teleology, that is, human beings by nature aim at a particular end. Whereas for Watson this end is self-actualization and for Aristotle it is a peculiar type of happiness, I believe that in essence these are one and the same. The question I wish to address is an obvious one: if we each possess a natural striving toward self-actualization why is it that so few of us attain it? Why do we have such difficulty with our choices? The debate over such issues is a lengthy one and is inconclusive. Several explanations come to mind that will allow us to retain Watson's

teleological perspective without resolving the entire issue.

Let us suppose, for the sake of argument, that human beings do possess some type of intrinsic teleological drive. How could we address the above concerns? First of all, I want to suggest that Watson does not mean this striving is an instinct in the literal sense of that concept. We do not automatically know what is good for us. There is no one, correct way to self actualization, we must each discover the way for ourselves. Other factors like culture, upbringing, social status, and education influence our judgement: sometimes in the right direction and sometimes not. Second, we sometimes make mistakes in deciding what is good for us often choosing external, tangible, and immediate rewards. It is not that these goods are "bad" for us, but of themselves they will not lead to self-actualization. To seek them to the exclusion of the others will be detrimental. For example, making money, accumulating things, and amusing ourselves often take precedence over study and achievement. Guidance and education are necessary to assist us in determining what will lead to self-fulfilment and happiness, and to help us make the right choices. This brings me to my final point. The end we allegedly seek is difficult and even impossible to envision. What does it mean to be self-actualized? Perhaps in the beginning the goal is purposively vague and undefined, like an uncomfortable twinge that begs to be noticed. The goal becomes clearer with practice and pursuit. As a person grows, and as another step is taken, the end gradually becomes more defined. Perhaps as Abraham Maslow (1968) contends, it is only after low level needs are met that we can identify and realize the higher order ones. In any case, the journey toward self actualization requires a great deal of individual motivation and

commitment.

All human behaviour can be interpreted as the goal directed attempt to fulfil needs experienced and perceived in the "phenomenal field" (Watson, 1988, p. 57). The phenomenal field, is the third major component of the caring occasion. The phenomenal field is comprised of everything an individual is experiencing at a specific point in time. Watson describes it as, "the totality of experience at any given moment" (1988, p. 51). If we were somehow able to take a split second snapshot of everything that was going on within and without an individual, we would have a picture of the phenomenal field. It would be a complicated photograph, because it would reflect the significance and meaning that an individual attaches to the various relations, experiences, and events in his or her past, present, and future. Watson also equates it to a person's frame of reference, and sometimes refers to it as a person's "subjective reality". Each person's phenomenal field is unique; it can only be totally known by the experiencing person. Although another person may make contact with this phenomenon through the strategy of "empathetic inference", it is not possible for another person to know it perfectly. Herein lies a real challenge for nurses: never to cease their efforts to know and understand their clients, even though the task is insurmountable. With the seeking comes understanding. A caveat to health care professionals, who may claim to have a client figured out; this is not necessarily so. In fact, according to Watson we never actually do so.

Watson claims that there are a variety of human needs but each is subservient to the basic striving toward self-actualization. One of the most fundamental needs is the need

to be loved, cared for and about. "Care and love are the most universal, the most tremendous, and the most mysterious of cosmic forces: they comprise its primal and universal psychic energy" (Watson, 1988, p. 32). In Maslow's hierarchy of needs caring is fundamental, yet ironically it is the one most overlooked in today's health care system. With the increase in technological and bureaucratic demands, the human care ideal receives less and less emphasis. Nurses claim to recognize the primacy of caring, but in reality they often give it little more than lip service. This is not necessarily a criticism of nurses themselves; I do not think they make a conscious decision not to care. Rather, they are often constrained by a lack of time and resources so that they can do little more than provide the "caring for" services described earlier. At other times, though, it appears that caring does get relegated to second place, in favour of the more intricate technical, scientific procedures. A change must occur, says Watson, human care without action is futile and senseless (1988, p. 32). As a caring profession, nursing must actualize its potential to promote and sustain the caring ideal.

The goal that Watson sets for nursing is an idealistic one, and is certainly related to her teleological bent. Since, as she claims, all persons possess a basic drive toward self-actualization, nursing must advance this end in some way. Watson proposes that nurses assist clients to attain a higher level of harmony within the mind-body-soul, which generates self-reverence, self-knowledge, and self healing (Watson, 1988, p. 49). Watson believes, the process by which unity is restored, brings about new insights and understanding; and individuals rise a higher level of being. However, such outcomes require a great deal of hard work, cooperation, and commitment from both people in the



relationship. It is not uncommon for individuals to come face to face with existential concerns during times of illness or crisis. Issues about the meaning of life often surface at such times and Watson contends that the more the threat to a person's existence, the more urgent the questions become (1988, p. 66). Because of the immediate, often intimate, and private nature of nursing, nurses are in a unique position to influence the client's pursuit of finding meaning in the health-illness experience.

This works well if client and nurse are of the same persuasion, that is, both are motivated to the same end. But what about the client who just wants to concentrate on his or her illness, get better (in a physical sense) and go home? This concern is answered in two ways. As earlier referenced, Watson has a strong conviction about the unity of the self. Mind, body, and soul cannot be separated. One aspect cannot help but affect and be affected by the others. Additionally, because of the human aspect of nursing, we should not ignore the spiritual, moral, and metaphysical components; these inherently operate, directly or indirectly, and should be acknowledged (Watson, 1988, p. 54). Although the client may not be aware of the interaction of these aspects, they are operating, none the less. It behooves the nurse to recognize their influence, and to reflect them to the client. This, of course, will not guarantee any change or recognition on the client's part. However, it may at some point give the client cause to think, if not now, perhaps later when the nurse is no longer in the client's life. In other words, the nurse should continue to "care about" the client.

Watson also allows for varying levels of care. Since every nurse and every situation is different, caring is not actualized to the same degree in all nurse-client relationships.

Nor should we expect it to be. If, as Watson advocates, the nurse is responding to the client as a unique individual, then this would account for and also encourage diversity. "Caring is influenced by multiple complex factors," says Watson (1988, p. 75). Personalities, values and beliefs, and cultural backgrounds are a few of the factors which impact upon the caring expression of both nurse and client. If the nurse ascribes to the transpersonal model of care, then this decision will have been made prior to any interaction with the client. "There must be an underlying value, and a moral commitment to care" (Watson, 1988, p. 32). So, the nurse enters the relationship in a state of readiness to care. However this "will to care" applies to clients in general, there is still a decision to be made about a client in particular.

At the time of the encounter nurse and client come together for the main purpose of assisting the client in some way. When the caring is truly transpersonal, two life histories, two selves, and two phenomenal fields merge to create an entirely new event with a field all its own. When the spirit or *geist* is acknowledged as a significant aspect of the relationship, then a union with the other occurs and a common bond develops (Watson, 1988, p. 59). The phenomenon is more than, and different from, the simple summing of the parts of two people. The interaction is no longer located only in the physical moment of time and space, but Watson contends that it extends beyond itself to touch the metaphysical and mysterious. This higher level of communication opens the door for addressing the deeper questions about the meaning of the health-illness experience, and subsequently the meaning of life itself. As we have seen, the experience becomes part of the life history or narrative unity of both persons involved. It also

impacts the future as well as the present. In this way, any learning, growth, or experience can be generalized to other aspects of life. This holds true for both nurse and client.

Contrary to other theorists, Watson emphasizes the opportunities for self growth and development available for the nurse. From her existential-phenomenological perspective, the day-to-day contact with the problems, struggles, pain, and suffering of clients creates an environment, whereby the nurse can discover personal meaning in the human predicament. The way that Watson portrays the transpersonal caring relationship all but compels the nurse to turn inward and connect with his or her inner self. In relating to the client, the nurse contacts the client's inner self, and begins to sense the client's feelings and emotions. Like a mirror the nurse reflects these feelings to the client, in such a way, that the client can experience them more fully. Watson claims that in attempting to comprehend the client and the client's situation, the nurse comes face to face with his or her own thoughts, feelings and concerns. "We learn from one another how to be human by identifying ourselves with others or finding their dilemmas in ourselves" (Watson, 1988, p. 59). Ideally, the nurse also benefits from the caring occasion and comes away with a deeper understanding of who he or she is, and develops an appreciation for the complexity of human beings in general.

To be successful in the art of transpersonal caring it is essential that nurses know and love themselves. Otherwise, claims Watson, it will be impossible to treat others with dignity, respect, and love (1988, p. 51). Simply stated this means that in order to demonstrate these qualities, nurses must first possess them. Caring, it would seem, is

a learned behaviour. We are not born caring. In fact, it is just the opposite. Babies are very self-centred and demanding, and only later learn to love their parents or guardians. Learning to care about ourselves and others is a life long process: we can always do it better. Watson's message is clear: the more that nurses care about and value themselves, the more they genuinely respond to and care about their clients. This is a recurring theme in Watson's work.

By this point the reader will have formulated at least some idea of Watson's caring relationship. For the most part, her transpersonal theory of care has been presented in a favourable light. I have shown that it accommodates the five basic characteristics of an effective nurse-client relationship delineated in Chapter I. That is, it is holistic in nature; is based on a broad although somewhat subjective view of health; takes a helping, healing approach; ascribes to a more equal balance of power between nurse and client; and is grounded in a strong ethical foundation. The advantages are many. Caring leads to increased self-knowledge, self reverence, and self healing. "Caring about" clients generalizes to a deeper understanding of human beings in general, and in addition it helps us to recognize the connections that tie us together. What I have not done, however, is to look at some of the criticisms and potential problems generally inherent in caring models and within Watson's model in particular.

#### **4.4 Objections to Watson's caring model**

In general critics of caring theory cite three major problems with these models: loss of objectivity, burnout, and something I call "lack of regulatory force", for want of a better label. Since these difficulties are very much interrelated they will be discussed

together. There is also an additional feature in Watson's theory which must be addressed. That is, the idealistic nature of her transpersonal theory of care. Watson places considerable emphasis on the way nursing could be if nurses sought to help clients attain harmony of the self, and ultimately to actualize their potential. I will begin with the specific objection to Watson's model.

There is no question that Watson's theory is idealistic. In fact, she characterizes it as the moral "ideal" for nursing, "My nursing views are of the ideal, what may be, rather than what is ...," but as she explains, "[these views] also acknowledge that what exists as the essence and power of nursing is underdeveloped and often overlooked" (1988, p. 38). She believes, we have become too oriented toward the technical and scientific components of nursing, and these should be blended with the artistic features of the profession. The art of nursing has been ignored for too long, and should be returned to its rightful place at the forefront. This is not to say that Watson discounts science and technology; on the contrary, she holds that these are crucial to nursing practice. She is seeking to elucidate and recognize other dimensions which are also operating (1988, p. 54). Her intent is to elevate nursing to a more complete level of practice and a higher degree of performance. Since we are all in the process of being and becoming, the ideal gives us something to reach for. But this response leads to the question: just how workable is Watson's model in today's health care system?

Some will no doubt answer "not realistic at all". Others like myself will claim that it holds some possibility. I must agree, though, that there are several obstacles to its application. One of the biggest problems today is the lack of contact between nurse and

client, especially in hospital settings. With the team approach to care, and the pressure to move clients in and out quickly, this is a real concern. Clients, too, just want to get their hospital stay over with and go home. How then can we expect nurse and client to forge the type of relationship expounded by Watson? The obvious answer is that it is not possible, at least not in an acute care setting. The relationship will not reach the level of intersubjectivity required to produce the enhanced levels of self growth and development. However, I think Watson might reply that it really doesn't matter, we just begin. Nurses can commit themselves to the caring ideal, and take from it what is feasible. Watson contends that caring is a particular attitude, a stance, or a starting point which is manifested in concrete acts (1988, p. 31). It is a way of interacting with the client as one person to another. Nurses can and should bring this caring manner to the bedside, no matter how long or how short the contact with the client. In a way, caring becomes more important than ever because of reduced contact hours with clients. One never knows how a little act of kindness, a gentle touch, a softly spoken word of encouragement, or a genuine interest will affect a person, if not now, perhaps later. If we don't take the first step toward helping clients toward self-actualization, there is no possible way to take the second.

We see that Watson's theory does offer some very real possibilities for hospital based nursing, although it does not apply totally. It is, however, especially suited to other areas of nursing, where we can expect sustained client contact. Such fields as chronic care, psychiatry, rehabilitation, public health, and home nursing fall into that category. At the HIV Care Program, where I work, we have easily adapted Watson's model.

However, we have a sustained relationship with clients that often extends over a period of years, and we get to know them quite well. Given their diagnosis, there are many instances of existential concern, and the ensuing discussions frequently lead to a higher level of self-knowledge and understanding. But the point I wish to make is, that discussions about the meaning of life and recognition of clients' search for answers would not happen without a will to "care about" our clients in the first place. A commitment to "care about" is a part of what we do. Nurses, too, find fulfilment, and grow both personally and professionally from their interactions with clients. Yet the model is not without its difficulties. Sometimes it is difficult to remain objective, and burnout is a constant threat.

Although not specifically directing their criticisms to Watson's transpersonal theory of care, Hilde Nelson (1992) and Howard Curzer (1993) cite the loss of objectivity as a prime concern in caring theory. Both charge that it is just too easy for the nurse to become emotionally attached, and there are no safeguards against it. When this occurs, the burnout, favouritism, or faulty decision making often follows. Although I agree that such issues do arise, I am not sure if they are as widespread as the authors indicate. I also question if these obstacles only arise within the context of the caring model, for I suspect not. There is nothing which will prevent a nurse from getting too involved with clients unless it comes from within the nurse himself or herself, and I refer to this later. In some sense, I believe that caring theory, Watson's model in particular, would be helpful in preventing the very problems it is blamed for generating. Watson clearly allows for objective problem solving and rational argument. What she disavows is

relating to the client as an object (1988, p. 58). Recognizing the personhood of the client, and interacting as one human being to another, creates an environment conducive to sound decision making. Interacting with clients as unique individuals also helps to avoid favouritism. If each client is approached according to his or her particular need, then, there is a better chance of those needs being met. Although it is a fact of nature that we will always like some people better than others, we can at least try to refrain from partiality. Moreover, "caring about" acts as a deterrent to burnout. There is a certain level of satisfaction, and feeling of accomplishment that accompanies the caring occasion. These are labelled "internal goods" by MacIntyre (1988), and are discussed in the next section. The nurse takes pride in doing the best that he or she could do under the circumstances, and to some degree this type of reward prevents burnout. Nevertheless the reality is that there are risks inherent to a caring philosophy, and the above objections are valid.

Another difficulty with caring, as delineated by Nelson is that, "there is nothing within the concept of care itself that can regulate its force" (1992, p. 9). In other words, it is difficult to know how to provide care, as well as, how much care is enough. Nelson is right. If she is looking for clear directives on how much caring is appropriate, there are none. How much to care calls for judgement and choice on the part of the nurse, but should be tempered with input from the client, directly or indirectly. General guidelines are also helpful. Because it is dependent on the recognition of the salient features and needs of the other; caring should be learned experientially. As has been repeatedly stated, every encounter is unique. The nurse learns by participating in nursing practice



how to apply its theoretical concepts. It is only in seeking a caring relationship that the caring relationship will be realized, or more succinctly: to learn to care, one must first care. As Watson points out, in the beginning we may have to impose our own will to care on our own behaviour (1988, p. 51). It is only then that the concept starts to become clear. The more experience one has, the more expertise that is developed. This parallels MacIntyre's assertion that "the good life for man is the life spent in seeking the good life for man" (1984, p. 219). Perhaps the MacIntyrian theory may hold a solution for the main objections to Watson's transpersonal care theory, especially with the renewed interest in virtue theory itself, and the moral character of the agent.

At first glance, it appears that Watson's caring theory and MacIntyre's virtue theory are compatible. A first read of the MacIntyrian definition of a virtue suggests that caring fits his conception. If caring can be viewed as a virtue, then, perhaps cultivating it as such, may prove "inherent control". That is, the objection that caring has no internal mechanism for gauging when a nurse cares too much or too little.

## **Chapter 5 - MacIntyre's Virtue Theory**

During the past few years there has been a shift in nursing ethics literature from a concern about ethical actions and outcomes to a broader concern about the character of the practitioner (Fry, 1989; Huggins & Approached, 1988; Packer & Ferra, 1988; and Yarling & McElmurry, 1986). This shift has also been accompanied by a recognition that traditional ethical foundations are an insufficient basis for ethical theory grounded in the character of the practitioner. Moreover, there is renewed interest in a nursing ethic that can accommodate an emphasis on the nurse-client relationship as morally fundamental (Cooper, 1988; Curtin, 19 ). Sara Fry (1989) also argues that traditional philosophical theory is not well suited to the development of an ethical theory for nursing. She maintains that such views do not fit within the practical realities of nurses' decision making in client care. In fact she charges that these views tend to deplete the moral agency of the nurse, not enhance it. Her argument has received considerable support from other theorists like Leininger (1984), Noddings (1984), and Watson (1985, 1988). These works have not only placed new emphasis on the nurse client relationship but have influenced the ethic toward a particular ideal. The moral ideal for nursing is caring and nursing is primarily a caring relationship (Watson, 1988). Some writers have begun to examine virtue theory as a way of grounding this new approach.

In the foregoing section of this paper I proposed Jean Watson's theory of care as the model which best exemplifies nursing's moral ideal. However, this ideal has many obstacles. Critics argue that caring leads to a loss of objectivity, to burnout, and to favouritism. In addition they contend that since caring is not regulated by any inherent

force, the nurse cannot know how to care or how to recognize when caring behaviour is deficient or excessive. As a result the nurse becomes too emotionally attached or remains indifferent. It is a vicious circle. If caring is going to be a viable alternative we must somehow rescue ourselves from this predicament. To do so requires that we rise above the problems or step outside of them, in order to look at things from a different perspective.

It has been suggested that one of the ways of responding to the aforementioned objections is virtue theory with its focus on the moral character of the agent. Since there are several parallels between Alasdair MacIntyre's theory of virtue and Watson's transpersonal caring theory, it seems logical to explore the possibility that MacIntyre's approach offers a solution. Nursing seems to fit the MacIntyrian definition of a practice and caring itself appears to meet the requirements for a virtue in the MacIntyrian sense.

### **5.1 Practices**

MacIntyre proposes no less than three stages in the logical development of a virtue, which must be identified in order, if we are to understand his core conception of virtue. Each stage also has its own conceptual background and includes practices, the narrative order of a single human life, and moral tradition. Since virtues are intimately related to practices the understanding of a practice is crucial to any discussion about virtues. MacIntyre has a unique and complicated description of a practice. He defines it as:

...any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and

human conceptions of ends and goods involved, are systematically extended (1984 p. 187).

By goods internal to practices MacIntyre means goods that can only be achieved by engaging in the practice; individuals who lack experience in a particular practice have difficulty identifying these goods. External goods on the other hand are things like money, social status, and power.

At first glance, it appears that nursing fits MacIntyre's definition of a practice. That is, it is "a socially established cooperative human activity," especially as outlined by Watson. Nursing was established out of human need and it continues to have an expanded social role (Watson, 1988, p. 32). It also accepts the authority of standards of practice and is partially defined by them. For example, the standards set by the College of Nurses of Ontario, the Canadian Nurses' Association, and the Regulated Health Professions Acts. These standards are under continuous revision and refinement. Most importantly, I think, nursing has particular internal goods. Benjamin and Curtis have identified a partial list of such goods which are associated with being a competent nurse: "Among these [internal goods] are satisfaction of using one's knowledge, talent, and skills to care for the sick, to help administer various treatments, and to teach clients how to maintain health" (1985, p. 258). Interestingly, these goods all focus on satisfaction from the performance of tasks. I would add the gratification of simply being with a client during an especially stressful time or the insight obtained when helping a client grieve.

It is difficult to explain to a non-nurse just what these internal goods entail. Unless one is in the health care field it is often impossible to grasp how one can obtain any level

of satisfaction from being with an ill person. I am frequently asked how I can continue to work with persons who have AIDS. It must be so depressing, people say. But people have little or no conception of the joy and serenity one finds in such a place. On the other hand my staff know exactly how I feel.

With MacIntyre's notion that in attempting to excel in a practice brings about the realization of internal goods we see yet another parallel with Watson. She claims that in executing the art of transpersonal caring, self growth and development occur and the individual experiences a higher level of being. Both writers promote the ideal. I also believe that the individual who reaches for the ideal for its own sake, will attain the goods referred to above. It cannot be otherwise.

Goods can be categorized as internal in two ways. MacIntyre explains that goods are internal to the practice itself, that is, within the practice of nursing there are goods specific to nursing which can only be realized by entering into the practice or one very much like it. As delineated, these might include a certain level of satisfaction or insight. They are rather vague notions which are only understood once obtained. But there is another sense, I think, in which we could speak of internal goods. Once I experience an insight or a certain degree of satisfaction it belongs to me. I have internalized it. Yet MacIntyre goes on to say that the achievement of internal goods benefits the entire community who participate in the practice (p. 191). What can he mean by this? If all my nursing colleagues benefit when I achieve an internal good how does this occur? One possible interpretation is that since I have grown or changed in some way this is now evident in the way I carry out my nursing duties, in the way I care, and perhaps in the

way I share my knowledge with colleagues. In any event it is the virtues which facilitate the realization of the internal goods.

In this primary conception of a virtue MacIntyre attends only to its relation to practices. His initial definition is partial and tentative.

A virtue is an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices and the lack of which effectively presents us from achieving any such goods (1984, p. 191).

At this point we begin to understand the role of virtues in sustaining practices. In Watson's theory, for instance, we could say that without caring there would not be any of the same degree of self-healing. There could be healing in a physical sense, and I suppose incidentally some psychological and emotional healing could occur, but according to Watson it would not be complete nor would this "good" advance the practice of nursing in the same way. We must be careful here because we must allow for those nurses who for whatever reason can only "care for" clients. Although Watson promotes her transpersonal human care model as an ethic of care, she still maintains that the nurse who acts only out of a sense of duty or moral obligation would still be an ethical nurse (1988, p. 31). If caring is a virtue, however, this would be problematic for MacIntyre.

## **5.2 Narrative unity**

Before addressing the question as to whether caring can be viewed as a virtue in the MacIntyrian sense, it is necessary to provide a brief explanation of the two other features of a virtue mentioned previously. The first of these is the "narrative unity of a single

life." For MacIntyre the unity of the self "resides in the unity of a narrative which links birth to life to death as narrative beginning to end" (1984, p. 205). Human life is more than a mere sequence of episodes. If his account of the virtues works, there is this requirement that the self be conceived in a narrative mode. As we see there is a telic connection between narrative and the good life. In addition MacIntyre also claims that virtues play a role in sustaining those traditions which provide both practices and individual lives with their necessary historical context. Thus the role of tradition must also be elucidated.

As we have seen, the notion of narrative is a prominent feature in MacIntyre's account of the virtues. He contends "that the unity of a virtue in someone's life is intelligible only as a characteristic of a unitary life, a life that can be conceived and evaluated as a whole" (1984, p. 205). Someone who possesses a particular virtue can be expected to manifest it in very different types of circumstances. MacIntyre reasons that if a person exercises a virtue in one situation, he or she will do so in other situations, or at least be more likely to do so. It would make no sense, for example to speak of Mr. C as an honest nurse but not an honest person. Once a virtue is acquired it generalizes to all aspects of one's life and influences one's behaviour. Now this does not guarantee that Mr. C will be honest all of the time, he could choose to act dishonestly. His being honest will however, significantly increase the probability that Mr. C will act honestly. I suspect, though, that MacIntyre believes people can develop virtues to such a degree that they cannot help but be virtuous. The more one practices the virtues the more one is motivated to practice them, and the more one learns about what it means to live a good

life. Virtue begets virtue. In this way virtues can be understood as dispositions which will sustain human beings in their search for the good. Virtues enable us to overcome the temptations, distractions and dangers we meet along the way. If we view the quest for a good life as a practice, the virtues help us attain the internal goods inherent in this practice.

MacIntyre tells us that we can see the proper narrative structure for our own lives only within the quest for a unified life; only as we develop the virtues do we recognize the good at which we should aim. "The good life for man is the life spent in seeking the good life for man" (MacIntyre, 1984, p. 219). Now this sounds very circular and abstract. What can MacIntyre possibly mean here? To answer this question we must examine what I alluded above as a "quest" for the good life.

The idea of "quest" is to be interpreted from a medieval perspective. In particular two key points about this notion need to be fleshed out. First of all, there is an inherent telic component. Without some idea of the final good or *telos* the quest cannot get started. We must journey to somewhere. At least some conception of the good for individuals is required. But it is not clearly defined; it is not like a trophy waiting to be won, and herein lies the second point. The medieval conception of a quest is not a search for something already characterized. It is only in the course of searching, in overcoming the dangers, temptations, and pitfalls of life that the goal will finally be understood. I agree with MacIntyre. It is a misconception to think we must have an explicit mental vision of the end before embarking on a path to it. It is often only as the path is travelled that the destination becomes clear. It is in dealing with the issues, problems, and concerns,



one makes the goal truly one's own. Guidelines can, however, be given if we become conscious of the moral tradition in which we are situated.

In direct contrast to liberal individualism, which MacIntyre claims is prominent in our society, we are never able to seek the good, or exercise the virtues for that matter, except in the capacity as an individual (1984, p. 220). There are two main reasons for his point of view. For one thing, what it means to live the good life varies from circumstance to circumstance even when we share the same conception of the good and are trying to embody the same set of virtues. The fact is people are different and live in different circumstances. What it meant for my parents to live the good life is not the same as what it now means to me, yet we share similar values. Moreover we all approach our circumstances as bearers of a particular social identity. I belong to a particular family and have a specific place in it. I am a Canadian, a student at the University of Windsor, and a member of the nursing profession. What I am in part is what I have inherited from the past history and traditions of these various settings. The story of my life is thus always embedded in the story of those communities from which I derive my identity. My past always exists, to some degree, in my present.

It is important to note that MacIntyre recognizes the fact that practices always have histories. At any given moment what a practice is depends in part on a mode of understanding which has been transmitted through those who have gone before. This is not to suggest a type of cultural relativism, but is only to recognize the importance of the historical aspect in determining the content of beliefs about what is and what ought to be the case. What constitutes a good nursing practice for instance, can be understood both

universally and philosophically even with the diversity of social environments. There are always certain principles that should be upheld, for example to treat a person with dignity and respect. "A practice involves standards of excellence and obedience to rules as well as the achievement of goods" (MacIntyre, 1984, p. 190). Virtues sustain the relationships needed for practices to thrive and grow. Since the past is an integral part of such practices MacIntyre reasons that the virtues also sustain the relationships to the past, and in a similar way, to the future.

### **5.3 Traditions**

To enter a practice is to enter into a relationship, not only with the current practitioners, but with those who have preceded us in that practice, especially those who have made noteworthy contributions. It is also to accept the authority and achievement of the tradition of that practice from which I must learn. When I entered the profession of nursing, I accepted my own inadequacies as a nurse and my education began at the point to which nursing evolved. Characterization of the good comes through the process of my living this tradition.

Tradition and the virtues are interrelated in a circular manner, not unlike Aristotle's account of how the virtues are acquired. According to MacIntyre, only on the basis of a tradition - manifested narrative can we actually know how to identify and access the status of various virtues, but without the virtues a vital tradition cannot be sustained. In this respect, MacIntyre's account is perhaps not sufficiently developed, since he wants to have it both ways. He wants to maintain that there is no way to possess the virtues except as part of a tradition, yet he also wants to maintain that virtues can, and perhaps

must, be known prior to and as necessary for the proper functioning of that tradition/practice.

By now the reader should have a clearer but certainly not complete understanding of the role of virtues as posited by Alasdair MacIntyre. In review, the virtues:

...find their point and purpose not only in sustaining those relationships necessary if the variety of goods internal to practices are to be achieved and not only in sustaining the form of an individual life in which that individual may seek out his or her good as the good of his or her whole life, but also in sustaining those traditions which provide both practices and individual lives with their necessary historical context (MacIntyre, 1984, p. 223).

We are now in a position to determine if caring fits the MacIntyrian description of virtue.

I believe that it does.

#### **5.4 Caring as a virtue**

In the previous chapter there was much discussion about the benefits of caring in general and of Watson's transpersonal caring theory in particular. We saw that caring differed significantly from technical skills and any type of procedural techniques. It was characterized as a manner, a stance, and a presence. It is more closely associated with being than with doing although caring as such must compel people into action. It would be ludicrous to claim to care but do nothing.

Within the practice of nursing, caring was presented as the moral ideal, that which will sustain the profession but not only sustain it, encourage and assist its development on a higher level. One way this is accomplished is through the nurse-client relationship. When that relationship is truly transpersonal both nurse and client achieve deep levels of understanding and attain high levels of being. Nursing is a helping relationship and the

nurse who helps a client grow, heal, understand or all the other things that nursing does, feels a great deal of satisfaction from that experience. The satisfaction felt at the level of caring is somehow different in context from the type of satisfaction achieved from the efficient completion of tasks. It is difficult to describe, but this is the very point that MacIntyre makes about internal goods; our language is inadequate to describe them (1984, p. 188). In any case, caring assists in the realization of such goods. From Watson's perspective, the highly particular level of satisfaction described above is not available without it.

Caring does not occur in isolation. By this I mean that a nurse who cares about clients will extend that caring to other areas of life. Again, to say that Mrs. S. was a caring nurse but not a caring person makes no sense. A nurse is embedded within other communities and social settings, he/she brings this identity to the bedside and in turn, what happens at the bedside is returned to the community. Moreover, we have seen that caring is a fundamental universal need. It is found in one form or another in all cultures of the world (Leininger, 1984, Watson 1988). From this perspective then, caring helps to sustain individuals as they seek the good life.

Lastly, nursing has traditionally held a caring stance. This was the major guiding force behind Nightingale's drive to found the practice (Nightingale, 1860). She believed that caring was paramount to healing and to cure. The rich traditions that have surfaced since her time cannot be maintained without it. Without caring nursing becomes shallow and loses its vitality.

From this initial review, I think we have gathered sufficient evidence to suggest that

caring à la Watson can be classified as a virtue à la MacIntyre. Yet I would caution that more investigation is required. There are many parallels between Watson's and MacIntyre's theory that have only been alluded to or not mentioned at all. These would present an interesting dialogue and I suspect would help to solidify the case for caring as a virtue.

### **5.5 Conclusion**

This paper has been basically a case for an ethic of care for the practice of nursing. As we have noted, the concept of caring is itself a complex ambiguous term. I have tried to address this problem by delineating between two broad aspects of care: "caring for" and "caring about". "Caring for" was designated as what is commonly referred to as hands on nursing; it is related to "doing". "Caring about", on the other hand is about the manner in which people care, an attitude or stance that results in a special type of presence at the bedside. The value of "caring about" involves a higher sense of spirit of self. It calls for a moral commitment toward protecting human dignity and individual regard.

Although I did not previously deal with the issue, at least not comprehensively, I do not want to give the impression that if nurses do not "care about" their clients that they are unethical. A nurse may perform actions toward a client out of a sure of duty or moral obligation, and would still be an ethical nurse. Sometimes as discussed above, it is the best a nurse can do. In cases of burnout, for example, the nurse may need to step back from the situation in order to "care about" herself. Moreover in cases where the client is a heinous criminal the most a nurse may be able to do is to "care for" that

individual. In itself this takes great courage and determination.

An inquiry into the main models of nurse-client relationships was undertaken. These models are not generally rooted in caring theory but I hesitate to call them "non-caring models." They include parentalism, technical, and contractual relationships. Since the paternalist relationship was dominated by the nurse and in the technical model the nurse was a neutral participant, it was concluded that the contractual type had the most to offer. It viewed nurse and client as a partnership. Ironically though this was also its major problem because in reality nurse and client are not equal partners. In the vast majority of situations the nurse holds the balance of power.

Jean Watson's Transpersonal Theory of Care was investigated as an alternative. This model recognizes the nurse-client relationship as central to nursing and advocates caring as essential to its practice. The relation between nurse and client is promoted as one human being to another - no more no less. Each person is unique and must be treated with the utmost respect and dignity. If the caring is truly transpersonal then both nurse and client benefit from the encounter. The relation is elevated to a higher plane where it meets the metaphysical and mysterious. It is here that self-growth, insight, understanding and self healing occur. Watson ascribes to a holistic view of health and holds that health is harmony of mind-body-soul. These aspects of self form a *gestalt* and although we speak about them individually they cannot really be separated.

Watson sees the goal for nursing as assisting clients to restore and/or attain higher levels of harmony. In so doing, the experience leads to self-healing, self-respect, and ultimately contributes to self-actualization. As discussed previously, her theory is very

idealistic. In today's health care system there is a lack of contact, or at the very least reduced contact, between client and nurse. It takes time to develop the type of relationship Watson is advocating - time plus commitment and hard work. I have suggested that the caring stance is still worthwhile however. There is something radically different between a nurse who "cares about" and one who does not, although it may be difficult to define clients sense the difference. In retrospect I don't think idealism is necessarily a negative position. It gives us something to reach for and a great deal of satisfaction can be gleaned from advancing in small steps. As I have also indicated one never knows how a little act of kindness or a gentle word will affect others.

Watson's model does not view nurse and client as equal partners, so in this way at least it eliminates that problem identified in the contractual model. There are other difficulties, however, as Nelson and Curzer point out, there is no built in mechanism to prevent nurses from caring too much, from losing their objectivity, or from experiencing burnout. I agree this is a problem and there is no easy answer. However, it appears as though the solution may reside within the agent, as opposed to establishing a set of rules or principles, although rules and guidelines have a place. I have suggested that the current revival of virtue theory might prove helpful. Since there were many parallels between Watson's caring model and Alasdair MacIntyre's theory of virtue, it was to his account that I gravitated.

MacIntyre characterizes three stages in the logical formulation of virtues which have to be identified in order if we want to understand his core conception of virtue. The first is an account of what he calls a practice; the second an explanation of the narrative order

of a single life and the third an account of moral tradition. Each of these stages has its own conceptual background and I have provided only a sketch of each. I have suggested, rather strongly, but have not demonstrated that caring is a virtue in the MacIntyrean sense. A more intensive investigation of this hypothesis is recommended. On the other hand, I believe there is enough to show that nursing fits MacIntyre's peculiar definition of practice. Here again though a more detailed treatment of internal and external goods would be helpful. MacIntyre also proffers a set of core virtues: honesty, trust, courage, justice, integrity and something called constancy, which should prove an interesting study regarding their relationship to caring.

In closing let me say that although I have become increasingly aware of the issues and difficulties with caring models of nursing, I am more convinced than ever as to their pride of place within the profession. Despite the objections, in this time of rapid change and technology it is for better to err on the side of caring. To those that say they do not have the time to care, I can only respond that you cannot afford not to.



## Bibliography

- Anderson, R. (1993). The healing environment. In B. Moyers (Ed.), Healing and the Mind (pp. 25-45). New York: Doubleday.
- Aroskar, M. (1980). Images in conflict: The fractured image: The public stereotype of nursing and the nurse. In S. F. Spicker & S. Gadow (Eds.), Nursing: Images and ideals (pp. 18-48). New York: Springer.
- Aristotle. (1985). Nichomachean ethics (T. Irwin, Trans.), Indianapolis: Hackett.
- Benjamin, M., & Curtis, J. (1985). Virtue and the practice of nursing. In E. Shelp (Ed.), Virtue and medicine (pp. 257-274). Dordrecht, Holland: D. Reidel.
- Benjamin, M., & Curtis, J. (1987). Parentalism. In R. Wright (Ed.), Human values in health care: The practice of ethics (pp. 203-212). Toronto: McGraw-Hill.
- Benner, P. (1991). The role of experience, narrative, and community in skilled ethical comportment. Advances in Nursing Science, 14 (2), 1-21.
- Boorse, C. (1977). Health as a theoretical concept. Philosophy of Science, 44, 542-573.
- Brock, D. (1980). The nurse-patient relation: Some rights and duties. In S. F. Spicker & S. Gadow (Eds.), Nursing: Images and ideals (pp. 102-124). New York: Springer.
- Brody, J. K. (1988). Virtue ethics, caring, and nursing. Scholarly Inquiry for Nursing Practice: An International Journal, 2 (2), 87-96.
- Carper, B. (1979). The ethics of caring. Advanced Nursing Science, 1, 11-19.
- College of Nurses of Ontario. (1990). Standards of Nursing Practice. Toronto: Author.
- College of Nurses of Ontario. (1995). Guidelines for professional behaviour. Toronto: Author.
- College of Nurses of Ontario. (1995). Guidelines for specific clinical practice situations. Toronto: Author.
- College of Nurses of Ontario. (1995). Explanation of professional misconduct. Toronto: Author.
- Cooper, M. C. (1988). Convenantal relationships: Grounding for the nursing ethic. Advances in Nursing Science, 10 (4), 48-59.

Curtin, L. L. (1979). The nurse as advocate: A philosophical foundation for nursing. Advanced Nursing Science, 1, 1-10.

Curzer, H. J. (1993). Is care a virtue for health care professionals? The Journal of Medicine and Philosophy, 18, 51-69.

Fowler, M. (1986). Ethics without virtue. Heart and Lung, 15, 528-529.

Fry, S. T. (1988). Response to "Virtue ethics, caring, and nursing". Scholarly Inquiry for Nursing Practice: An International Journal, 2 (2), 97-101.

Fry, S. T. (1991). Nursing ethics: Current state of the art. Journal of Medicine and Philosophy, 16, 231-234.

Gadow, S. (1980). Existential advocacy: Philosophical foundation of nursing. In S. F. Spicker and S. Gadow (Eds.), Nursing images and ideals (pp. 86-101). New York: Springer.

Hauerwas, S. (1978). Care. In W. T. Reich (Ed.), The encyclopedia of bioethics (pp. 145-150). New York: Free Press.

Heraclitus. (1964). Heraclitus. In M. C. Nahm (Trans.), Selections from early greek philosophy (pp 62-77). New Jersey: Prentice-Hall.

Huggins, E. A., & Approached, C. C. (1988). Limitations and alternatives: Ethical practice theory in nursing. Advanced Nursing Science, 10, 43-47.

Huggins, K., Gandy, W., & Kohut, C. (1993). Emergency department patients' perception of nurse caring behaviours. Heart and Lung, 22, 356-364.

Jecker, N. S., & Self, D. J. (1991). Separating care and cure: An analysis of historical and contemporary images of nursing and medicine. Journal of Medicine and Philosophy, 16, 285-306.

Kant, I. (1981). Grounding for the metaphysics of morals. (J. W. Ellington, Trans.). Indianapolis: Hackett.

Leininger, M. (1981). The phenomenon of caring: Importance, research questions and theoretical considerations. In M. Leininger (Ed.), Caring: An Essential Human Need (pp. 3-15). Thorofare NJ: Charles Slack.

Leininger, M. (1984). Care: The essence of nursing and health. Detroit: Wayne State University Press.

- MacIntyre, A. (1982). Intelligibility, goods, and rules. The Journal of Philosophy, 79 (11), 663-665.
- MacIntyre, A. (1984). After virtue. (2nd ed.). Notre Dame: University of Notre Dame Press.
- MacIntyre, A. (1988). Whose justice? Which rationality? Notre Dame: University of Notre Dame Press.
- Maslow, A. (1954). Motivation and personality. New York: Harper & Row.
- Nelson, H.L. (1992). Against caring. The Journal of Clinical Ethics, 3 (1), 8-15.
- Nightingale, F. (1860). Notes on nursing: What it is and what it is not. New York: Appleton - Century - Crofts.
- Noddings, N. (1984). Caring: A feminine approach to ethics and moral education. Los Angeles: University of California Press.
- Noddings, N. (1992). In defense of caring. The Journal of Clinical Ethics, 3, 15-18.
- Pincoffs, E. L. (1985). Two cheers for Meno: The definition of the virtues. In E. Shelp (Ed.), Virtue and Medicine (pp. 111-131). Dordrecht, Holland: D. Reidel.
- Rogers, C. (1961). On becoming a person. Boston: Houghton-Mifflin.
- Salsbery, P.J. (1992). Caring, virtue theory, and a foundation for nursing ethics. Scholarly Inquiry for Nursing Practice: An International Journal, 6 (2), 155-167.
- Selye, H. (1974). Stress without distress. New York: Lippincott.
- Smith, S. (1991). Three models of nurse-patient relationship. In T.A. Mappes and J.S. Zembaty (Eds.). Biomedical Ethics. (3rd ed.). (pp. 143-149). New York: McGraw-Hill.
- Travelbee, J. (1971). Interpersonal aspects of nursing. Philadelphia: F.A. Davis.
- Veach, R. (1991). Models for ethical medicine in a revolutionary age. In T.A. Mappes and J.S. Zembaty (Eds.). Biomedical Ethics. 3rd ed., (pp. 55-58). New York: McGraw-Hill.
- Watson, J. (1979). Nursing: The philosophy and science of caring. Boston: Little Brown.
- Watson, J. (1981). Some issues related to a science of caring for nursing practice. In M.

Leininger (Ed.). Caring: An Essential Human Need. (pp. 61-69). Thorofare NJ: Charles Slack.

Watson, J. (1988). Nursing: Human science and human care: A theory of nursing. New York: National League for Nursing.

Watson, J. (1989). New dimensions of human caring theory. Nursing Science Quarterly, 2, 175-181.

Watson, J. (1992). Response to "Caring, virtue theory, and a foundation for nursing ethics". Scholarly Inquiry for Nursing Practice: An International Journal, 6 (2), 169-171.

Webster's Encyclopedic Dictionary. (1988). New York: Lexicon.

World Health Organization. (1967). Manual of the international statistical classification of diseases, injuries, and causes of death. Geneva: Author.

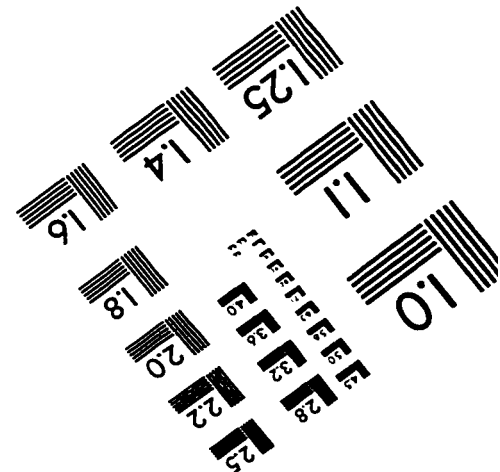
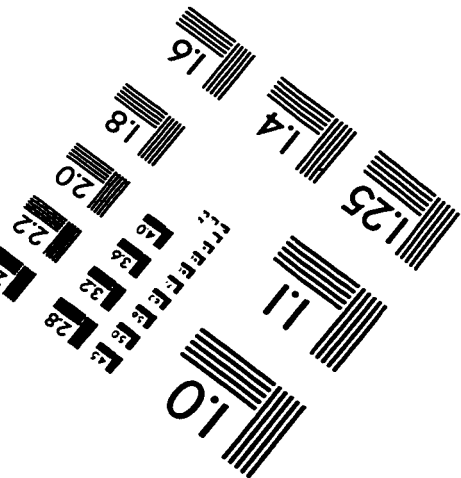
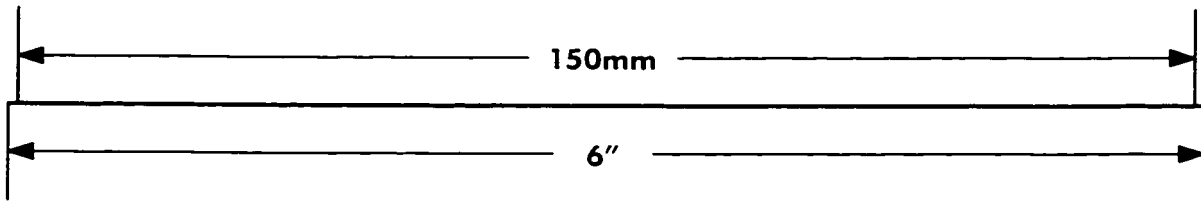
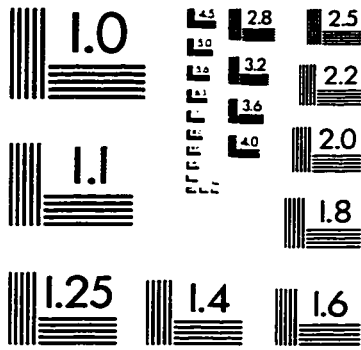
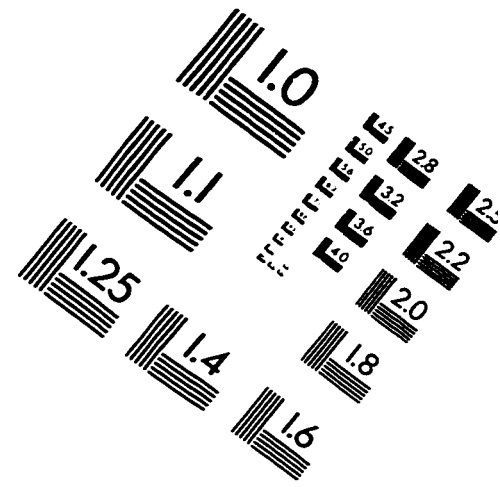
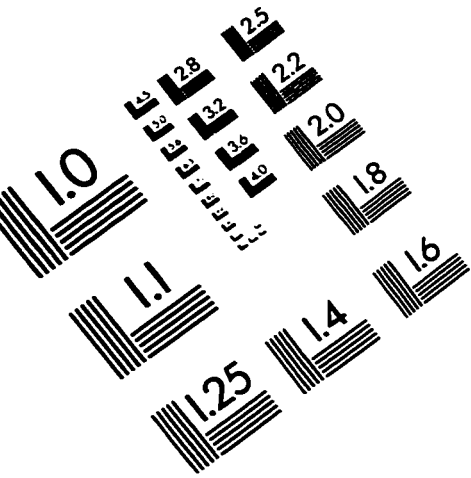
Yalom, I. (1975). The theory and practice of group psychotherapy, (2nd ed.). New York: Basic Books.

Yarling, R.R., and McElmurry, B.J. (1986). The moral foundation of nursing. Advances in Nursing Science, 8 (2), 63-73.

### **Vita Auctoris**

Marilyn A. Sutton was born in 1938, in Windsor, Ontario. She graduated from General Amherst High School, Amherstburg, Ontario in 1955. She then entered Hotel Dieu School of Nursing, in Windsor, where she received her Reg. N. Diploma in 1958. In 1974 she returned to school as a part-time student at the University of Windsor. In 1981 she graduated with a B.Sc.N. degree.

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