

Feasibility, Acceptability, and Benefits of a Humanistic Educational Intervention: A Qualitative Secondary Analysis of Two Datasets (Quebec and Switzerland)

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Abstract: A French-language humanistic educational intervention aimed at strengthening nurses' caring attitudes and behaviors was first developed in Quebec, with rehabilitation nurses, and then used in Switzerland, with hemodialysis nurses. In both projects, phenomenological interviews explored the feasibility, acceptability, and benefits of this intervention. This article presents the results of a secondary analysis of both datasets regarding its convergence and divergence. A strong thematic convergence underlined that nurses adopted a shared language with respect to caring and reinforced their humanistic clinical practices. Consequently, such intervention could prove itself useful in fostering a more humanist nursing practice within today challenging healthcare system.

Keywords: humanistic educational intervention; Watson's Human Caring theory; secondary data analysis; phenomenology; rehabilitation; hemodialysis

Background

Since the 1980s, humanistic nursing practice has made constant headway in the world thanks in particular to the publication of works on the caring approach and to the vitality of the scientific community (Boykin & Schoenhofer, 2001; Cara, 2010; Cara & O'Reilly, 2008; Cara et al., 2016; Hills & Watson, 2011; Leininger, 2013; Liu et al., 2012; Newman, Sime, & Cororan-Perry, 1991; Perry & Cara, 2017; Roach, 1987, 2002; Swanson, 1999, 2013; Watson, 1979, 1988, 1999, 2008, 2012). This has contributed to singularize nursing thought and practice. Numerous authors (Andersson, Willman, Sjöström-Strand, & Borglin, 2015; Boykin & Schoenhofer, 2001; Brilowski & Wendler, 2005; Cara, 2004, 2010, 2017; Duffy, 2009; Finfgeld-Connett, 2008, 2013; Leininger, 2013; O'Reilly, 2007; Perry & Cara, 2017; Roach, 1987, 2002; Sargent, 2012; St-Germain, Blais, & Cara, 2008, 2009; Swanson, 1999, 2013; Watson, 1979, 1988, 1999, 2008, 2012; R. Watson et al., 2003), especially in the United States, acknowledge that caring is at the core of nursing and recognize it as an approach for ensuring the safety of care, preserving human dignity and, more broadly, defending humanity. In this regard, Watson (1997, 2013) underscored, on the strength of observations she made over the course of her travels around the world, that caring conceived as a deeper human-to-human involvement and connection between nurse and patient emerged as a universal phenomenon in nursing. Watson's Theory of Human Caring (1979, 1988, 2008, 2012) places the emphasis on the quality of the relationship between patients and nurses, a relationship which should allow nurses to develop favorable to compassion, active listening, being there, and understanding, which are sources of healing for patients and of satisfaction for nurses. In this regard, many studies have documented the therapeutic effects and benefits of this caring relationship for patients in terms of greater autonomy, independence and hope (Lucke, 1999), a stronger sense of the safety of care delivered (McNamara, 1995; St-Germain et al., 2008, 2009), improved quality of life and maintenance of that quality over time (Delmas, O'Reilly, Iglesias, Cara, & Burnier, 2016; Erci et al., 2003; O'Reilly, Cara, Avoine, & Brousseau, 2010, 2011), not to mention a higher level of satisfaction with nursing care received across different cultures (Lee, Tu, Chong, & Alter, 2008; Rafii, Hajinezhad, & Haghani, 2008). Moreover, some studies have also evidenced that the caring relationship has beneficial effects on nurses

in terms of a heightened sense of self-esteem, wellness, self-fulfillment, and accomplishment (Dinç & Gastmans, 2013; O'Reilly, 2007; O'Reilly & Cara, 2010), and empowerment (Cara, 1997, 1999) and that it raises their quality of work life (Brousseau, Alderson, & Cara, 2008; Brousseau, Blais, & Cara, 2017; Brousseau, Cara, & Blais, 2016, 2017a, 2017b) and their job satisfaction (Beck, 1992; Euswas, 1993; Kosowski, 1995; McNamara, 1995). Finally, according to Duffy (2009), a caring nurse–patient relationship has been found time and again to be strongly associated with specific patient outcomes, notwithstanding the many limitations owing to sample size and methods used that must be taken into account when interpreting research results. In the face of the growing body of evidence supporting the usefulness of caring as the fundamental basis of nursing discipline and profession, a number of nursing administrators, according to Duffy (2009), have adopted or suggested adopting a professional caring practice as the foundation of nursing practice in their healthcare establishments.

Problem

Notwithstanding the definite value-added of the caring relationship between nurses and patients, in the past few decades, some works (Avoine, 2012, 2016; Avoine, O'Reilly, & Michaud, 2012; Avoine, O'Reilly, Michaud, & St-Cyr Tribble, 2011; Beagan & Ells, 2007; Boykin, Schoenhofer, & Valentine, 2014; Brown, McWilliam, & Ward-Griffin, 2006; Cara, 1997, 1999, 2008, 2017; Duffy, 2007, 2013; Graber, 2009; Halldorsdottir, 1990; Létourneau, Cara, & Goudreau, 2016, 2017; O'Reilly et al., 2010; Perry & Cara, 2017; St-Germain et al., 2008, 2009; Swanson, 1999, 2013; Turkel, 2014; Varcoe et al., 2004; Watson, 2005, 2012), have raised awareness of the difficulties that nurses face when they seek to exercise their profession according to a caring approach, difficulties that include the presence of uncaring care practices in their clinical environments. In this regard, Enns and Sawatzky (2016) pointed out that, although the caring relationship was at the core of nursing, in emergency settings, its practice by nurses on an everyday basis was truly jeopardized. This is no trifling observation given that, according to the results of a meta-analysis of the literature undertaken by Swanson (1999, 2013), patients exposed to uncaring attitudes and behaviors feel humiliated, frightened, powerless, and vulnerable, which can prolong their physical healing. Furthermore, for nurses, uncaring nursing practices can lead to burnout, depression, and

a sense of going through the motions perfunctorily (Brousseau et al., 2016, 2017, 2017a, 2017b; , 1997, 1999, 2017; Cara, Nyberg, & Brousseau, 2011; Hall-dorsdottir, 1990). In other words, uncaring nursing practices are harmful as much to their health as to that of the patients in their care.

Context of the Secondary Analysis Study

Though most of the articles published on the subject derived from the United States, a few studies conducted in Quebec have reported similar results (Avoine, 2012, 2016; Avoine et al., 2011, 2012; O'Reilly & Cara, 2010; O'Reilly et al., 2010). More specifically, in a phenomenological study carried out with 23 Quebec rehabilitation inpatients, Avoine (2012, 2016) reported that a dehumanizing nursing practice corresponded to a practice qualified as unethical (shoddy, abusive, degrading, and unacceptable), disengaged (centered on minimal technical task, egocentric, indifferent, inattentive), insidious (sporadic and silent), and potentially contagious for team practices. As a result of these outcomes and in partnership with the Director of nursing of that rehabilitation institution, a grant-based educational intervention was developed in Quebec in 2011 by Drs. O'Reilly and Cara, predicated in large part on the fundamentals of Watson's Theory of Human Caring (1979, 1999, 2005,

2008), in the aim of reinforcing the caring attitudes and behaviors of nurses working with a vulnerable population (Cara & O'Reilly, 2011; O'Reilly & Cara, 2011). After obtaining a grant and a research ethics certificate for each of the pilot studies, the educational intervention (see Figure 1) was first offered in the fall of 2012 to a population of Quebec rehabilitation nurses working with patients suffering from a spinal cord injury (O'Reilly, Cara, & Delmas, 2015, 2016; O'Reilly, Delmas, & Cara, 2012) and then, to a population of Swiss nurses working with patients under hemodialysis (Delmas et al., 2016). Articles have been published on the content and results of the educational intervention (Delmas et al., 2016; O'Reilly et al., 2016).

A more refined analysis of the qualitative results obtained in the two studies mentioned above revealed a strong thematic convergence. This suggested that, following the educational intervention, the participating nurses adopted a common vision and language regarding caring and raised the level of their humanistic care practice, which constituted a definite value-added benefit in a bureaucratized healthcare system (Delmas, O'Reilly, & Cara, 2014, 2015). Subjecting these updated results to a secondary analysis (Heaton, 2004; Heaton, 2008) seemed like a worthwhile endeavor in order to shed further light on the centrality of the concept of caring for nurses and to reinforce the no-

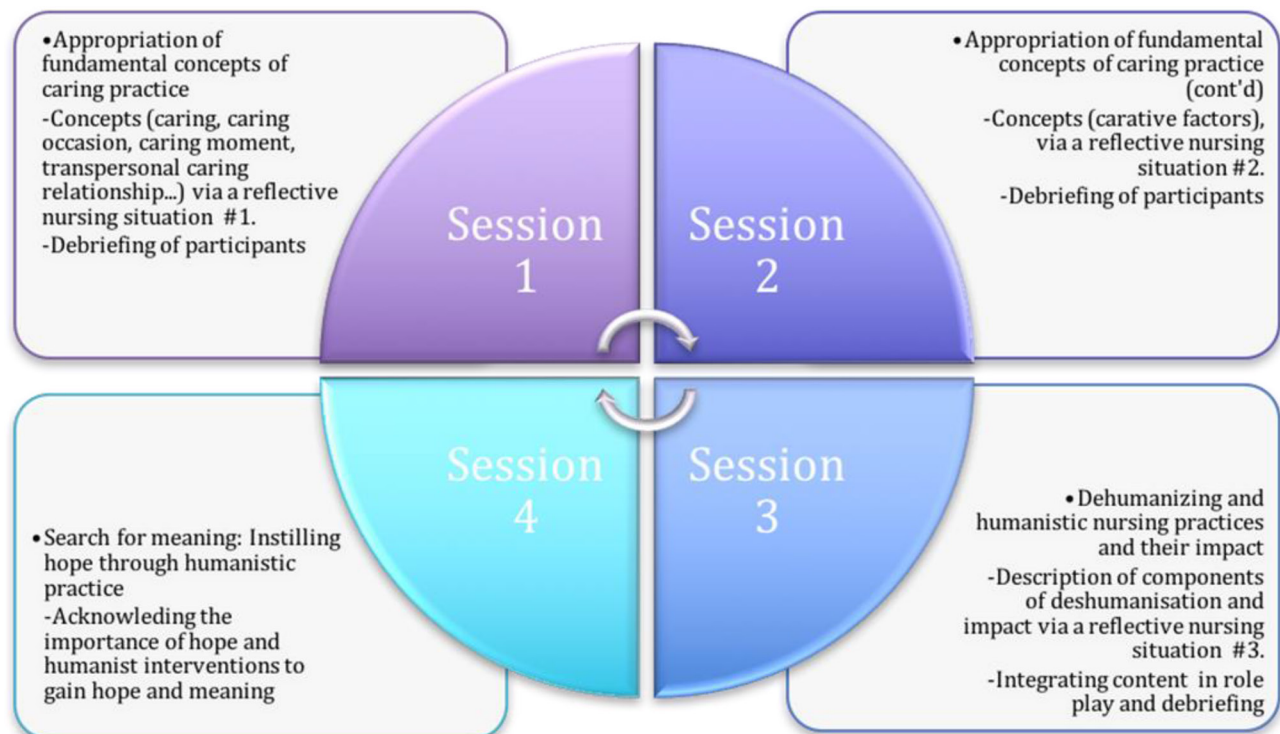


Figure 1. The humanistic educational intervention (O'Reilly et al., 2015, 2016).

tion of the universality of caring (Leininger, 2013; Watson, 1979, 1988, 2013) as a topic of reflection and practice in the field of nursing care.

Consequently, this article presents the results of a secondary analysis (Heaton, 2004, 2008) of both datasets (phenomenological interviews with French-speaking nurses in Quebec and Switzerland) regarding its convergence and divergence in terms of the intervention's feasibility and acceptability and its benefits for nursing practice (rehabilitation or hemodialysis).

Method

This section will first present the secondary analysis method used to reanalyze both qualitative datasets. A brief description of the original humanistic educational intervention will follow. The phenomenological method used to identify the convergent and divergent themes will then be explained. Finally, scientific rigor will be addressed.

Secondary Analysis Method

We wished to reanalyze the datasets from the above-mentioned pilot studies to investigate additional research questions that emerged after concluding the data analysis of each study. To this end, we used the secondary analysis method proposed by Heaton (2004, 2008). The choice was congruent with the purpose of a secondary analysis, which, according to Heaton, is "the re-use of pre-existing qualitative data derived from previous research studies in order to investigate new or additional research questions or verify the findings of previous research" (Heaton, 2008, p. 35). Heaton (2004) was previously used by Avoine (2012), which we mentioned earlier, in a phenomenological study of dehumanizing care carried out with French-speaking spinal cord injury patients.

The new research question that we wished to explore in this secondary analysis was the following: How do the perspectives of French-speaking nurses in Quebec and Switzerland converge and diverge regarding the feasibility and acceptability of a humanistic educational intervention and post-intervention benefits for their practice? In this context, *convergence* (Convergence, n.d.) meant that the datasets of the two pilot studies tended towards similar results regarding the intervention's feasibility, acceptability, and benefits for nursing care, and *divergence* (Divergence, n.d.) meant that each set shed a different light on these topics.

To answer the new question, we reanalyzed the qualitative datasets of the two pilot studies using

Heaton's amplified secondary analysis, which, of the three types of secondary analyses proposed by Heaton (Heaton, 2008), was the one that best corresponded to the objective stated in the previous paragraph. The first dataset derived from a pilot study where a qualitative phenomenological design was used with a population of 16 nurses working in a rehabilitation center in the Montreal area (O'Reilly & Cara, 2011; O'Reilly et al., 2016). The purpose of this study was to explore, from the nurses' perspective, the feasibility and acceptability of the educational intervention and post-intervention benefits for caring clinical practices. The Relational Caring Inquiry (RCI) phenomenological approach (Cara, 1997, 1999, 2002; Cara, O'Reilly, & Brousseau, 2017; O'Reilly & Cara, 2014) was used to analyze and interpret the qualitative data. Of the 16 nurses, 10 were interviewed individually shortly following the educational intervention delivered by the researchers. The second dataset derived from a mixed method study (Delmas et al., 2016) that combined quantitative and qualitative approaches in examining the feasibility, acceptability, and benefits of the educational intervention delivered to nurses ($n = 9$) working in a hemodialysis unit in the Canton de Vaud, Switzerland. Only the qualitative data were reanalyzed via the RCI phenomenological method (Cara, 1997, 1999; Cara et al., 2017; O'Reilly & Cara, 2014). The nurses in Quebec ($n = 16$) and in Switzerland ($n = 9$), respectively, had a mean age of 42 ± 8.3 and 48 ± 10.6 years and a mean number of years working with patients of 19 ± 9.3 and 12 ± 4.3 . In both studies, the nurses met the following inclusion criteria: (a) at least 6 months' experience working in the unit selected; (b) willingness to participate in a study; and (c) ability to understand and write French. The only exclusion criterion was not being available for the training sessions. The researchers noted the following contextual differences between the two studies: care unit (rehabilitation vs. hemodialysis), service users (person living with a spinal cord injury vs. persons subjected to hemodialysis), specific nursing care needs of service users, role of nurses in meeting their needs, work organization within care unit, problems faced by care unit and, finally, particulars that arose over the course of the study.

Description of the Educational Intervention

The development of this educational intervention rested primarily on Watson's Theory of Human Caring (Watson, 1988, 1999, 2006, 2008). In order to create the intervention, O'Reilly and Cara (2011),

focused on the choice and definition of the theoretical concepts to be taught and on the creation of learning activities, which were deemed indispensable to foster optimum appropriation of the selected concepts and their applicability within the clinical care context of spinal cord injury rehab (Quebec) and hemodialysis (Switzerland). For example, according to Watson, the aim of a humanistic or caring nursing practice is to protect, improve and preserve the patient's human dignity (Watson, 1988, 1999, 2005). It refers to the nurse's "moral ideal," which is to be the best nurse possible to engage in promoting patient healing and health (Cara, 2003; Cara & O'Reilly, 2008) by establishing a specific type of relationship with patients, that is, one steeped in humanist values (Cara, 2004, 2010; Watson, 1988, 1999, 2008, 2012). In this regard, Watson proposed a set of "carative factors" to guide nurses in their humanist practice (e.g., faith and hope; sensitivity to self and others; helping-trusting human relationship; expression of positive and negative feelings; assistance with gratification of human needs). Accordingly, inspired by the carative factors, nurses accompany patients in exploring their significant beliefs and values in order to help them give meaning to their health situation and suffering (Cara, 2003; Cara & O'Reilly, 2008). Operationally, the intervention

was partitioned into four sessions (see Figure 1), each 3.5 hours long, spread over a period of 3 weeks (O'Reilly & Cara, 2011; O'Reilly et al., 2012, 2016). A detailed description of the educational intervention has been published elsewhere (O'Reilly et al., 2016).

Phenomenological Method for Data Analysis

Though Heaton (2008) provides a detailed description of the different types of secondary analysis, she stressed that there was no consensus regarding the method to be used to conduct such analysis. Under the circumstances, we opted to go with the same qualitative analysis method used in the two pilot studies, namely, the RCI phenomenological approach (Cara, 1997, 1999; Cara et al., 2017; O'Reilly & Cara, 2014). The RCI approach (see Figure 2) is a phenomenological method grounded in Husserl's philosophy of science and Watson's Theory of Human Caring. This method consists of the following seven dynamic, inter-related steps: (a) Acknowledging the Researcher's Worldview; (b) Seeking Participants; (c) Being Present to Participants' Stories; (d) Discovering the Essence of the Participants' Stories; (e) Reciprocating the Participants' Stories; (f) Relational Caring Process; and (g) Elucidating the essence of the phenomenon.

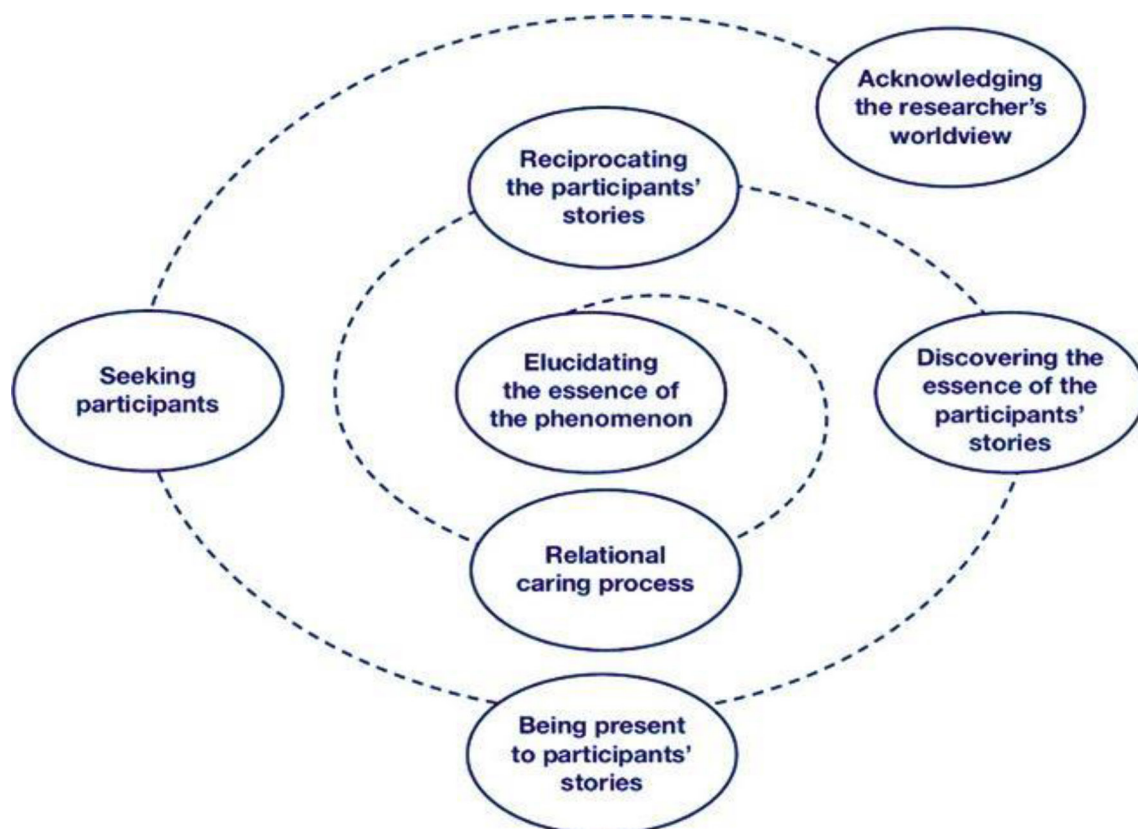


Figure 2. The process of the Relational Caring Inquiry (RCI) (Cara et al., 2017).

Elucidating the Essence of the Phenomenon (Cara, 1997, 1999; Cara et al., 2017). It is essentially a caring, transformative, relational phenomenological method (Cara, 1997). Some of the steps (namely, steps 2, 3, and 5) followed in the pilot studies did not apply in the secondary analysis given the absence of contact with participants.

In terms of actual operations, for the purposes of the secondary analysis, we compared the subthemes, themes, and eidos-themes of the two pilot studies to determine where they converged and diverged. Subthemes corresponded to descriptive elements that best reflected the content of the interviews with the study participants, whereas themes expressed a convergence between ideas expressed by the participants (O'Reilly & Cara, 2014). Then, an in-depth analysis of the elements of convergence and divergence, together with the use of free imaginative variation, enabled us to identify the eidos-themes, that is, the core or essential structures of the phenomenon under investigation (O'Reilly & Cara, 2014). Free imaginative variation consists in questioning where each element belongs within a data set, which facilitates the organization of data (Giorgi, 1997; O'Reilly & Cara, 2014). This in-depth analysis enabled us to identify new eidos-themes related to the intervention's feasibility and acceptability, as well as to post-intervention benefits perceived by nurses in their practice. The results of this analysis were validated by consensus by the three authors of this article. All three were experienced in the delivery of the intervention and two were acutely familiar with phenomenological analysis. Moreover, the fact that all three researchers analyzed the primary data of both pilot studies mitigated the potential risk of misrepresentation (Thorne, 1998) when data are reanalyzed outside of their initial context.

Scientific Rigor

The researchers ensured scientific rigor, including authenticity, credibility, criticality and, to some degree, the transferability of results to other care programs and departments (Cara, 1997; O'Reilly, 2007; O'Reilly & Cara, 2014; Whittemore, Chase, & Mandle, 2001), throughout the two pilot studies and the secondary analysis. *Authenticity* was ensured by adhering to the RCI phenomenological method (bracketing and phenomenological reduction), doing multiple readings of interviews/narratives, and relying on the researchers' intuition (in phenomenology, it means to use various modes of consciousness in order to be open-minded)

(Cara, 2002; O'Reilly & Cara, 2014). *Credibility* was ensured through the data interpretation method used (free imaginative variation and eidetic reduction) and recognition of the phenomenon by readers and experts (Cara, 2002; O'Reilly & Cara, 2014; Whittemore et al., 2001). The *criticality* criterion was met by adhering to the analysis and interpretation method (phenomenological reduction and use of free imaginative variation) throughout the research and by holding discussions with persons considered experts in the field in order to assure dependability throughout the study (Cara, 2002; O'Reilly & Cara, 2014). *Transferability* was ensured as best possible by providing a detailed account of the results (O'Reilly & Cara, 2014) to evidence the convergence of the datasets of the two pilot studies towards the centrality of caring. This might make it possible for other settings to undertake similar studies.

Results

The results of our secondary analysis of the datasets according to Heaton's approach (Heaton, 2004, 2008) are presented below by topic, that is, the feasibility, acceptability, and benefits of the educational intervention. Excerpts from interview transcripts are presented in support of the results.

Feasibility of the Educational Intervention

For Sidani and Braden (2011), an intervention's feasibility depends on the availability and quality (expertise) of trainers/researchers, physical resources, the recruitment process, assiduous attendance at training sessions and, finally, level of participation by study participants. Though the notion of feasibility is often illustrated through quantitative data, it can also be described via the analysis of qualitative data, as was the case in our study. Thus, the secondary analysis of the qualitative data from the two datasets allowed us to identify an eidos-theme associated with feasibility entitled "*General satisfaction with the educational intervention*" (see Figure 3). This eidos-theme concerned the overall satisfaction of all participants (Quebec, $n = 10$; Switzerland, $n = 9$) with the organization and structure of the training, as well as their participation.

Regarding the organization of the educational intervention, the Quebec participants deemed that the activity, on the whole, was well structured, that the content covered suited participants. The following excerpt from an interview transcript illus-

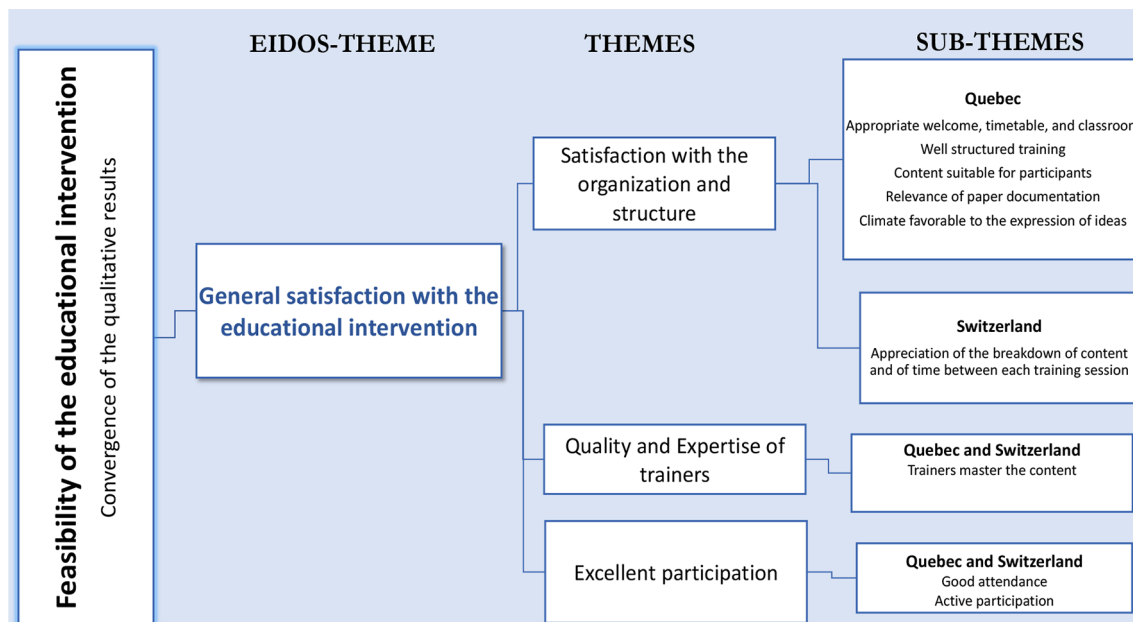


Figure 3. Secondary data analysis regarding the feasibility of the educational intervention (Adapted from Delmas et al., 2015; O'Reilly et al., 2015).

trated the point: "They were better able to connect it to their practice, it made more sense, it took concrete words to link it, it made sense in their reality in the field, I found that interesting in that regard" (Quebec, Charles, bloc 4). The Quebec participants also mentioned that the hardcopy documentation handed out (research articles, PowerPoint presentation, clinical vignettes, reflexive exercises) during the training sessions were appreciated, specifying that they would be able to refer back to them after completing the training. Moreover, the pleasant ambiance that reigned during the training sessions was conducive to the mutual expression of perceptions and stimulated exchanges. The Swiss participants expressed their satisfaction with where and when the intervention was offered. They also expressed satisfaction with the interval between sessions, which to their eyes, was indispensable to appropriating the theory taught. The following comment relates that the training was offered at the right time for the nurses in the care unit: "Well, I think so, it was then or never, because there was a minor crisis situation in the department, which meant that everyone was a little on edge" (Switzerland, Éléonore, lines 29–31).

Where participation is concerned, all the nurses (Quebec and Switzerland) attended all four sessions of the educational intervention. After receiving the intervention, all of the Swiss nurses and 10 of the 16 Quebec nurses took part in a qualitative interview. These two points bear witness to a high degree of feasibility.

Acceptability of the Educational Intervention

According to Sidani and Braden (2011), an intervention's acceptability depends on the participants' perception of the treatment in question (i.e., the educational intervention in our case), as their perception will influence their interest in the training, their adherence to it, and their expected outcomes. In other words, is the intervention appropriate for and useful to the participants? (Feeley et al., 2009). In this regard, the secondary analysis allowed us to identify two eidos-themes that reflected a thematic convergence between the two pilot studies (see Figure 4).

The first eidos-theme, "*Educational intervention enhances a humanistic nursing practice*," referred, for the participants on the whole (Quebec and Switzerland), to the relevance of the content (knowledge, know-how, people skills) covered and of the pedagogical strategies used in the educational intervention (see Figure 4). Regarding the relevance of the content covered to promote a humanistic nursing practice, the Quebec participants indicated that the intervention reminded them of the importance of recognizing the uniqueness of each person cared for and of not objectifying patients. The following excerpt from an interview transcript illustrates the point: "I learned a lot of things, such as, for example, knowing that each patient lives a unique everyday reality, that they have a unique history of illness, that we must take this into account when delivering care and treatment, that

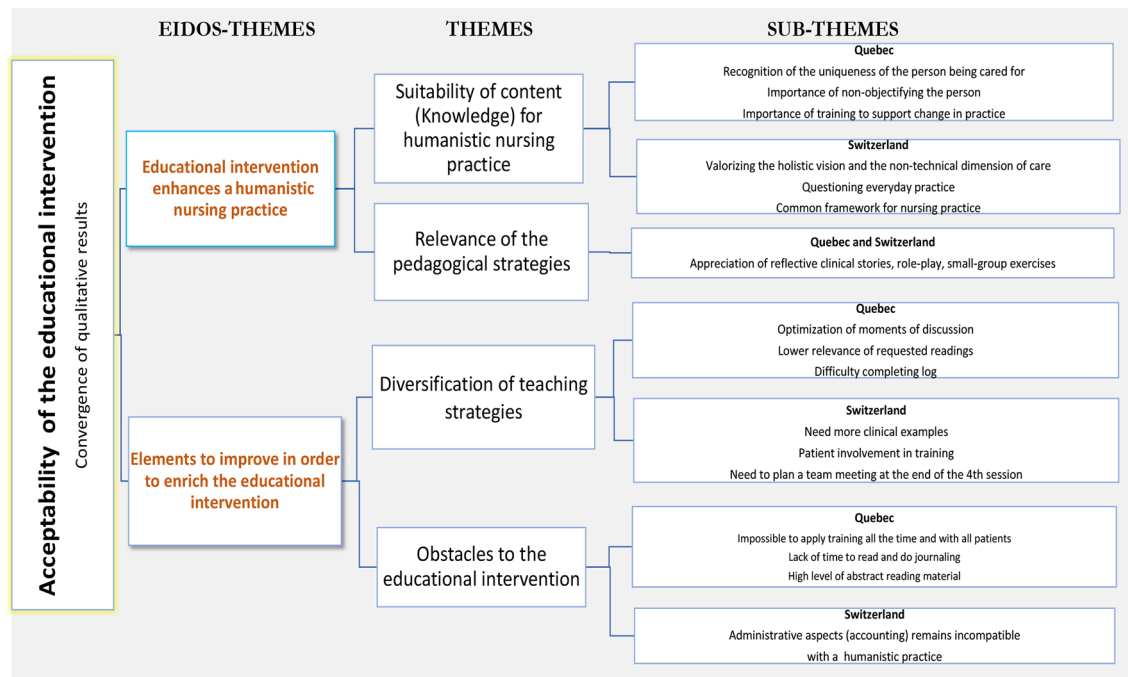


Figure 4. Secondary data analysis regarding the acceptability of the educational intervention (Adapted from Delmas et al., 2015; O'Reilly et al., 2015).

we must try to penetrate their phenomenal field a little, if I'm remembering things correctly, and the proper terms" (Quebec, Frédérique, bloc 9). For their part, the Swiss participants mentioned that the training valorized a holistic vision of the person, the nontechnical side of nursing, that it questioned their everyday practice, and provided a common framework for nursing practice. Two transcript excerpts speak to this point. The first deals with the holistic approach to people: "Yeah, I'm pretty much sold on that because, anyway, it's been a while now that I've been thinking that you have to treat people in their entirety, and that it's wrong to look at a pathology in and of itself, you know? Patients are individuals with a history of their own, a life of their own, and their disease gets tagged on to this later... It's a better way of looking at it" (Switzerland, Albert, lines 35–41). The second refers to the fact that the intervention offered a common outlook and vocabulary to the nurses of the unit: "If we speak the same language, it's like having a common denominator, I think, so to speak, that should ensure that we are all normally pulling together in the same direction" (Switzerland, Hélène, lines, 78–81).

Regarding the pedagogical strategies used, all of the participants (Quebec and Switzerland) gave these an ample passing grade, specifying that they were conducive to appropriating the content covered. More precisely, most of the comments expressed a positive appreciation of the use of reflex-

ive clinical vignettes, role-play, and small-group exercises. Here are two excerpts in this regard. The first concerned the use of vignettes: "Absolutely, the vignettes, I loved because they were really concrete examples. All the more so that most of the vignettes involved patients we'd known" (Quebec, Isabelle, bloc 37). The second related to the use of group exercises: "We worked in small groups, it's important that they stay small, I found that it went ways toward fostering exchanges, working in groups, not too big, smallish. It added a little... zest. That's it, because it allowed us to speak up. When we're a dozen or more, there are always one or two who don't talk, they don't say anything, they don't get involved" (Switzerland, Denise, lines 137–143).

The second eidos-theme, "*Elements to improve in order to enrich the educational intervention*" covered, according to some participants (Quebec and Switzerland), adjustments to be made to some of the pedagogical strategies and obstacles the educational intervention must overcome (see Figure 4). Where the pedagogical strategies are concerned, some Quebec participants mentioned the need to optimize time set aside for discussion and the difficulty of keeping a log. Here is an excerpt in this regard: "The log was something that had to be done. But you don't necessarily remember everything you've done, so you had to go through your sheets to see how it was exactly. Now, I don't want to have to take along all my sheets all the

time. Whereas the exercise with the articles, everything was already there! I didn't necessarily have to refer back to anything because it was all there before our eyes" (Quebec, Angélique, bloc 60). The Swiss participants expressed the need to have a greater number of concrete examples, to involve patients in the educational intervention, and to plan a team meeting at the end of the fourth session. Here is an excerpt in this regard: "It can become tense at times, which is why I'm saying that it's too bad that we didn't have a moment together at the end to air our opinions and confront one another, a moment to be able to say 'there, we talked about it'" (Switzerland, Denise, lines 144–151).

Despite the fact that the participants (Quebec and Switzerland) mentioned the possibility of generalizing the educational intervention to other units, they all highlighted important obstacles to take into consideration. The following excerpt refers to adapting the intervention to different care units: "You might consider making some changes because as far as training goes, it's quite particular. In some departments, for example, where patients are there for short stays, it might require a little more adapting. We don't all have the same expectations, it depends on the department, so it also needs to be adapted in that sense" (Switzerland, Francine, lines 5–10). The second excerpt refers to the many things to be learned from the intervention and the possibility of offering it to all practitioners: "I think that it should be offered to everyone, to all staff members involved in nursing care, orderlies, nurse's assistants, everyone, including managers. I think it would be interesting, I do. I think they would stand to learn a great deal, though, sure it would require a little more time" (Quebec, Charles, bloc 80). As for other obstacles to delivering the intervention, Quebec participants mentioned that the content of the training could not be applied at all times and that it was not possible to put this theory into practice with all patients. Here is an excerpt that explains the difficulty to apply it at all times: "Me, in my opinion, seeing how we're always rushing, it like makes sense that we had the training, but with all that we have to do, we don't really have time to say I'm going to apply it" (Quebec, Elyse, bloc 85). Swiss participants, instead, stressed that an administrative "bean-counting" logic remained incompatible with a humanistic practice. Here is an excerpt in this regard: "And, on top of that, you're always being told 'one nurse to three patients', which is to say that one patient is just the same as another and that one nurse is just the same as the next.

That alone, it's not human, for starters, because it's bean-counting, it's all bean-counting, and so the moment that it's bean-counting... this one time there's this patient who's not well, we were four of us around him, so there you go, that's that. And everybody knows it, patients aren't beans" (Switzerland, Béatrice, lines 101–110).

Benefits of the Educational Intervention

According to the Cambridge Dictionary, the term "benefit" refers to a good effect (Benefit, n.d.). For the researchers, it corresponded to documented and perceived changes in behavior and practice following reception of the educational intervention.

For all participants (Quebec and Switzerland), the eidos-theme "*Educational intervention to transform individual and collective nursing practice*" corresponded to the enhancement of humanistic practices, at both individual and collective levels, following the educational intervention (see Figure 5). Regarding the enhancement of everyday clinical practice, participants (Quebec and Switzerland) indicated that nursing care was more centered on the care receiver by allowing them to speak, by taking the time to be with the person, and by offering a genuine presence. The following excerpt touches on the idea of care being centered more closely on the person cared-for: "For me, that activity allowed me to really refocus [draws her hands to her heart], and to observe myself, and I found that stimulating because it allowed me to really focus more on the patient" (Quebec, Guylaine, bloc 5). All of the participants (Quebec and Switzerland) also indicated that they reflected more acutely on their practice. More precisely, the participants reported questioning themselves more intensely about their relationship with each patient, about their way of being and of doing things, and about their way of talking and asking questions. The following transcript excerpt relates to this: "I think that I might now be more inclined to question patients a little, especially when I sense that something is bothering the patient. When this happens, I might seek to push things a little further and see what happens" (Switzerland, Albert, lines 28–34).

All participants (Quebec and Switzerland) reported beneficial changes following the educational intervention. In Quebec, participants referred more to individual changes, such as greater confidence in their own practice, lowered stress on account of the knowledge gained, sharpened moti-

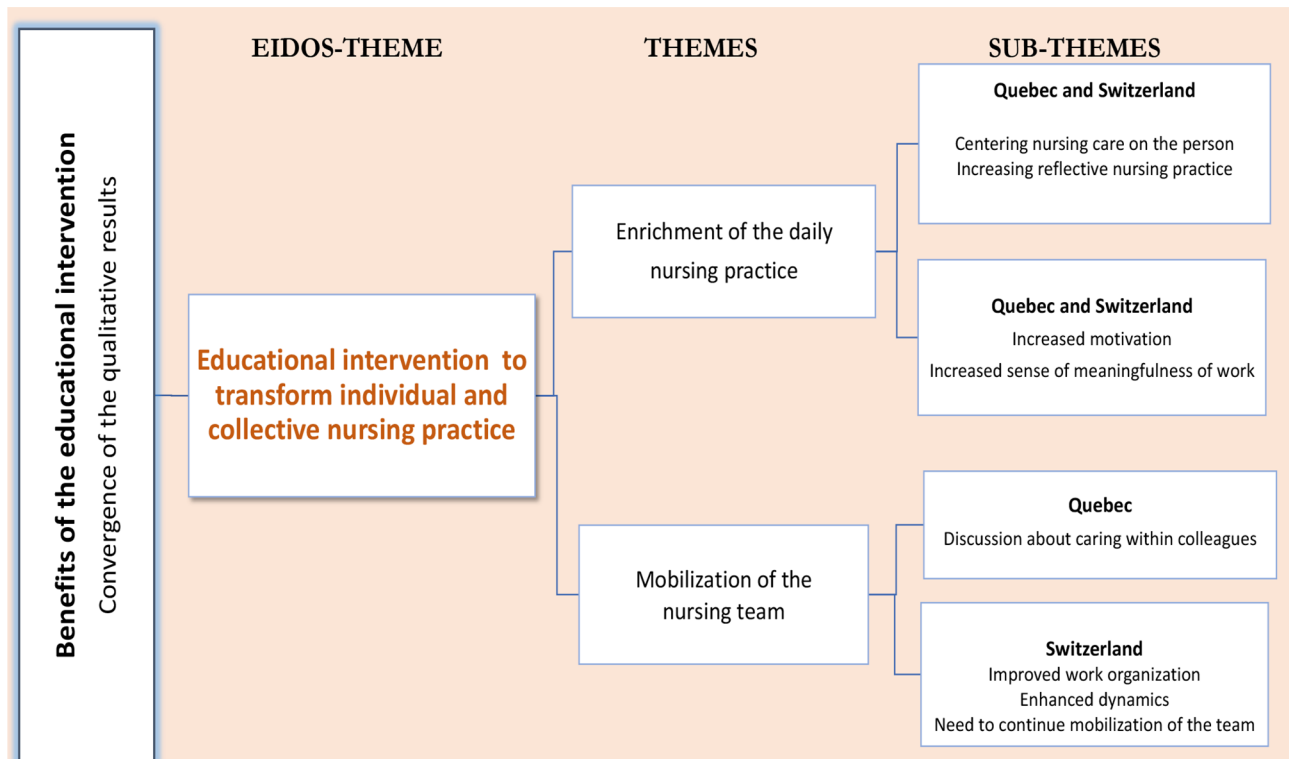


Figure 5. Secondary data analysis regarding the benefits of the educational intervention (Adapted from Delmas et al., 2015; O'Reilly et al., 2015).

vation, heightened sense of the meaningfulness of their work, and moral satisfaction. The following excerpt is illustrative of this: “I’ve never worked in a rehabilitation center and I’ve never worked with persons with spinal cord injuries. This is the first and only department I’ve ever worked in, so yeah, when I started out, I tried to do the work properly and all, like my colleagues did. This training also gave me the chance to learn a lot of things, to discover that—what do you know?—that’s how it should be, above and beyond the technical tasks, that’s how we should deal with patients to really do our job right, because I say to myself that, sure, there the financial satisfaction that comes with nursing, but we also expect a moral satisfaction” (Quebec, Frédérique, bloc 33). In contrast to their Quebec counterparts, Swiss participants placed the emphasis primarily on group changes. Some talked about work organization, greater energy within the care team, and the need to keep mobilizing the team toward further changes. Here is an excerpt that indicates how the intervention benefitted the care team: “Me, I’m basically satisfied with the training because it’ll allow us to advance and change the organization’s mentality a little, how patients are managed” (Switzerland, Denise, lines 218–221). Another comment touched on the team’s enthusiasm at work: “And then it injected a little vitality in the department, just changing

the organization, it’s true, it brought fresh energy” (Switzerland, Éléonore, lines 26–29).

Discussion

As mentioned earlier, the aim of this secondary analysis of the two datasets derived from phenomenological interviews conducted in two pilot studies was to explore the convergence and divergence in the qualitative data obtained following the delivery of a French-language educational intervention to nurses working with spinal cord injury patients (Quebec, Canada, 2012) and hemodialysis patients (Canton de Vaud, Switzerland, 2013) intended to promote a more humanistic or caring nursing practice. Despite the difference between the two clinical settings, the secondary analysis showed that results in large part converged regarding the intervention’s feasibility, acceptability, and benefits for nursing practice. We discuss the results of this secondary analysis as they pertain to each of these three points in the following paragraphs. Some limits will then be described at the end of this section.

Feasibility of the Educational Intervention

Regarding the feasibility of the educational intervention, the results of the secondary analysis tend

to show that participants were generally satisfied with all the material and pedagogical aspects of the training and with the competence of the trainers. Moreover, all the nurses who participated in the two pilot studies attended all the sessions offered, which is in itself an important point to consider. Furthermore, all the nurses were assiduous over the course of the two pilot studies with respect to their participation in the qualitative interviews, which denotes a strong level of engagement in the research process despite the fact that their participation was entirely voluntary and that it was solicited in an era of care rationalization, which might have led us to expect a greater degree of attrition. According to Sidani and Braden (2011), these elements are at the core of the feasibility of an intervention, which is a prerequisite that must be met before undertaking studies on a larger scale. Finally, the interest demonstrated by the nurses in this project might also be tied to the issue of humanistic care, which, as Watson (1999, 2008) has underscored, is at the heart of nursing practice and of nurses' reflections on their practice.

Acceptability of the Educational Intervention

Regarding the acceptability of the educational intervention, the suitability of the content covered during the educational intervention justified the choice of content, particularly using Watson's Theory of Human Caring (1988, 2005, 2008) to guide our teaching of humanistic nursing care. In this regard, the participants specified that recognizing the uniqueness of the person cared for, avoiding the objectification of patients, and valorizing a holistic approach to care corresponded, in particular, to content congruent with a humanistic nursing practice. These results corroborate those of a case study (Durgun Ozan & Okumuş, 2017) carried out in Turkey involving a woman living an experience of infertility and her spouse. Their results demonstrated that the nurse's application of Watson's Theory of Human Caring was useful in guiding the nursing care delivered and in meeting the specific needs of persons living such an experience (Durgun Ozan & Okumuş, 2017). The results of our study also support Watson's (2008) statement to the effect that the science of caring corresponds to the essence of the discipline of nursing and that, as such, it constitutes the disciplinary foundation of the profession. As stated by Duquette and Cara (2000), "caring allows us today to affirm our professional identity at a time when humanist val-

ues are frequently and intensely questioned and shoved aside" (p. 11; free translation). Along these lines, Watson (2009) suggested that practitioners (e.g., nurses) and healthcare systems realized that a radical change was needed in order to reverse the non-caring practices experienced in various care settings. In fact, if we consider caring to be at the heart of nursing care and to represent its essence, a conscious effort must be made to defend this humanistic and relational approach to care in clinical practice (Cara, 1997, 2003, 2004, 2017; Cara & O'Reilly, 2008; DiNapoli, Nelson, Turkel, & Watson, 2010; Turkel, 2014). According to Watson (2009), nurses who practice humanistic caring in care settings constitute the most fundamental and most precious resource for turning around the situation mentioned above. This statement by Watson lends weight to the idea of offering continuing professional development (CPD) activities to nurses working in different care settings in the aim of supporting such caring practices.

Still on the topic of the acceptability of the educational intervention, the second result regards the relevance of the pedagogical strategies used. It informs us, in particular, on the positive contribution of reflexive clinical vignettes (which were created from real-life clinical situations) to the learning of humanistic practices. This result corroborates what Benner, Sutphen, Leonard, and Day (2010) have written regarding the benefits of using significant real-life clinical situations to gain a better understanding of theory. In this connection, Cazale et al. (2006) reported that clinical vignettes "allow taking account of the complexity of phenomena under investigation and facilitate the proposal of significant experiences for respondents" (p. 407; free translation). Moreover, this selfsame result bears witness to the relevance of reflexivity in the pedagogical strategies and in exercises completed with participants. For example, each training session began with an exercise in introspection (10 minutes) that allowed the participants to be at peace with themselves and with the others, thus creating a space conducive to openness where the expression of ideas, reflections and emotions was encouraged and welcomed. Similarly, the manner in which the content was broken down and the skills targeted in the educational intervention afforded the participating nurses moments to reflect upon their professional practice and thus, mobilize their reflexivity. The importance of reflexivity in one's professional life was underscored by Johns (2009), who wrote: "reflection is learning through our everyday experiences

towards realizing one's vision of desirable practice as lived reality. It is a critical and reflexive process of self-inquiry and transformation of being and becoming the practitioner you desire to be" (p. 3). Finally, the proposed educational humanistic intervention seemed to contribute to reinforce the reflexive practice of the participating nurses. This allowed them to enact significant transformations in their clinical practice by making the quality of the relationship they can develop with patients the focus of their concerns. In the same vein, Horton-Deutsch and Cara (2017) indicated that reflection develops the capacity for openness, wholeheartedness, and a sense of responsibility, and helps promote the development of self-consciousness and interpersonal relations. In fact, these authors considered reflexivity as fundamental to patient care: "Effective nursing practice [...] require[s] systematic and careful thinking acquired through caring reflective practices to achieve meaningful and successful outcomes" (Horton-Deutsch & Cara, 2017, p. 145).

Benefits of the Educational Intervention

Finally, as for the results regarding post-intervention benefits, they evidence the transformation of nursing practice in terms of enhanced humanistic practices and illustrate advantages at both the individual and the group level. Generally speaking, numerous authors (Cara, 2008; Cara et al., 2016; Duffy & Hoskins, 2003; Finfgeld-Connett, 2008, 2013; Graber et al., 2012; Létourneau et al., 2016, 2017; O'Reilly, 2007; O'Reilly & Cara, 2010; O'Reilly et al., 2010, 2011; Schoenhofer & Boykin, 1998; St-Germain et al., 2008, 2009; Swanson, 1999, 2013; Watson, 1988, 2012) have discussed the benefits associated with a caring practice. Our result – *Enrichment of the daily nursing practice* – also discussed how reflexivity can contribute to improve humanistic nursing practice. This result corroborates the point of view of various authors, including Boykin (1998), Boykin et al. (2014), Cara and O'Reilly (2008), as well as Horton-Deutsch and Cara (2017), who indicated that reflexivity contributed to a caring practice by helping nurses meet patients' needs more effectively. Finally, this educational intervention allowed nurses to refocus their view according to a person-centered care approach and thus participate in the enhancement of care quality and safety. For their part, individual benefits, particularly a heightened sense of the meaningfulness of their work and moral satisfaction, corroborate what Cara and O'Reilly (2008) wrote, namely,

"that by grounding their care in caring values on an everyday basis, nurses can transcend the perception that their work is meaningless and acquire a more gratifying perception of their professional practice" (p. 38; free translation). Indeed, according to Brousseau et al. (2017b), caring appears to provide major benefits in terms of personal empowerment and job satisfaction. Our results also pointed out that, following the educational intervention, the team was spurred on to strive towards a common goal, thereby generating a fresh sense of cohesion. These results evoke the concept of team cohesion, which can be defined as "a dynamic process which is reflected in the tendency for a group to stick together and remain united in the pursuit of its goals and objectives" (Carron, 1982, p. 124). Consequently, it is not unreasonable to think that, in this context, the educational intervention will encourage nurses to communicate more among themselves and to share knowledge and values, and will promote greater team cohesion, which, in turn, will bolster the nurses' sense of the meaningfulness of their work. These observations are supported by Boykin et al. (2014), who pointed out that the implementation of caring would promote communication and teamwork as well as a collaborative practice. In other words, implementing humanistic and altruistic values in a work environment "could help humanize care and the health establishment and promote job satisfaction, well-being, empowerment, and both the personal and professional growth of caregivers" (Brousseau et al., 2017b, p. 3; free translation).

Limitations

Although our secondary analysis showed that results converged in terms of feasibility, accessibility and benefits for nurses, it is important to point out some of the study's limitations. First, both pilot studies had a small sample size, as is often the case in qualitative studies. A larger sample size might have yielded different results from the two datasets. A second limitation arises from the fact that the two pilot studies involved French-speaking nurses, which might limit results to that population. A third limitation stems from the fact that the pilot studies focused on nurses' perspectives. It would have been interesting to document the perspectives of the patients cared for by the nurses in order to explore the intervention's benefits regarding care practices as perceived by the patients. Finally, the secondary analysis covered only two pilot studies, which might limit the generalizabil-

ity of results. To our knowledge, no other study of the sort has been conducted in any other care setting, which denotes a paucity of investigation in the field of interventions of this type.

Conclusion

Despite differences between the care settings of each pilot study (Quebec and Switzerland), our secondary analysis revealed a high level of convergence regarding the feasibility and acceptability of the French-language humanistic educational intervention. Moreover, there was convergence in terms of the benefits perceived by both groups of nurses. In fact, they expressed an enhancement of their humanistic practices (care approach centered on the person cared for, intensification of reflexive practice) and revealed a certain number of personal benefits (confidence, lowered stress, motivation, meaningfulness of work) and group benefits (work organization, teamwork). In other words, results converged across the board for the secondary analysis (feasibility, acceptability, benefits). This state of affairs suggests a convergence of results associated with feasibility, acceptability and post-intervention benefits for the humanistic practice of the two groups of French-speaking nurse participants working in distinct cultural and organizational contexts.

On a different note, the convergence in the results suggests that this educational intervention, the purpose of which was to promote caring attitudes and behaviors in nurses, not only met the expectations and aspirations of the participating nurses but also reinforced their conception of clinical nursing practice, and that, especially in settings characterized by a high degree of technicity, as it is the case in hemodialysis departments. This observation reinforces the idea that the conception of caring transcends cultural boundaries and constitutes a common focal point for nurses. This point has been raised by theorists such as Leininger (2013), who underlined the universality of caring across cultures: "Human care appears to have existed through time and is universal to human existence and helping processes and, therefore, it must be preserved" (p. 134). At a time when we are experiencing an epidemiological surge of chronic diseases entailing drastic changes in the daily life of those afflicted, the delivery of humanistic care has never been a more central element to support patients' lived experience, behavior changes and, more broadly, their quality of life.

Finally, this secondary analysis contributed to reinforce the idea that the practice of caring constitutes the main focal point of nurses and that it can be updated or refreshed through the delivery of a humanistic educational intervention. For this reason, it seems necessary, in light of the results obtained, to propose this type of intervention as a CPD activity in the aim of promoting humanistic care not only within care establishment but in other sectors as well. Consequently, it would be worthwhile to undertake a larger-scale mixed-methods study with an experimental design involving a cluster randomized controlled trial where the learning activities could be improved, and the number of training sessions could be increased. Finally, it would be interesting to examine the utility of proposing this type of training for managers as well, as they are indispensable links in any effort to support and valorize these practices within healthcare establishments.

References

- Andersson, E. K., Willman, A., Sjöström-Strand, A., & Borglin, G. (2015). Registered nurses' descriptions of caring: A phenomenographic interview study. *BMC Nursing, 14*, 16. <http://dx.doi.org/10.1186/s12912-015-0067-9>
- Avoine, M. P. (2012). *La signification de pratiques déshumanisantes telles que vécues par des patients hospitalisés ou ayant été hospitalisés en centre de réadaptation* [The meaning of dehumanising practices as experienced by current and previous rehabilitation inpatients]. Quebec, Canada: Master's thesis, Université de Sherbrooke.
- Avoine, M. P. (2016). *La pratique déshumanisante: Ce que c'est et comment la transformer en pratique humaniste* [A dehumanising practice: What it is and how to transform it in a humanistic practice]. Interactive workshop within the 3rd conference Journée de la Recherche Chantal Caron. Québec, Canada: School of Nursing, Université de Sherbrooke.
- Avoine, M. P., O'Reilly, L., & Michaud, C. (2012). *The signification of dehumanizing practices of nurses in a physical rehabilitation setting from the patient perspective: A phenomenological study*. Oral presentation. 33rd Annual Conference, International Association for Human Caring, Philadelphia, PA.
- Avoine, M. P., O'Reilly, L., Michaud, C., & St-Cyr Tribble, D. (2011). Dehumanization in health care: A concept analysis. *International Journal for Human Caring, 15*(3), 60.
- Beagan, B., & Ells, C. (2007). Values that matter, barriers that interfere: The struggle of Canadian nurses to enact their values. *The Canadian Journal of Nursing Research, 39*(4), 37–57.
- Beck, C. T. (1992). Caring among nursing students. *Nurse Educator, 17*(6), 22–27.
- Benefit [Def. 3]. (n.d.). In *Cambridge dictionary online*. Retrieved from <https://dictionary.cambridge.org/fr/>

- Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco, CA: Jossey-Bass.
- Boykin, A. (1998). Nursing as caring through the reflective lens. In C. Johns & D. Freshwater (Eds.), *Transforming nursing through reflective practice* (pp. 45–50). Malden, MA: Blackwell Science.
- Boykin, A., & Schoenhofer, S. O. (2001). *Nursing as caring: A model for transforming practice* (2nd ed.). Boston, MA: Jones and Bartlett Publishers & National League for Nursing.
- Boykin, A., Schoenhofer, S., & Valentine, K. (2014). *Health care system transformation for nursing and health care leaders: Implementing a culture of caring*. New York, NY: Springer Publishing.
- Brilowski, G. A., & Wendler, M. C. (2005). An evolutionary concept analysis of caring. *Journal of Advanced Nursing*, 50(6), 641–650. <http://dx.doi.org/10.1111/j.1365-2648.2005.03449.x>
- Brousseau, S., Alderson, M., & Cara, C. (2008). A caring environment to foster male nurses' quality of working life in community setting. *International Journal for Human Caring*, 12(1), 33–43.
- Brousseau, S., Blais, R., & Cara, C. (2017). Exploration mixte séquentielle de la qualité de vie au travail des cadres gestionnaires infirmiers de premier niveau œuvrant en établissement québécois [Sequential mixed exploration of the quality of worklife of nurse managers]. *Revue Franco-phone Internationale de recherche infirmière*, 3(3), 159–179.
- Brousseau, S., Cara, C., & Blais, R. (2016). Experiential meaning of a decent quality of work life for nurse managers in a university hospital. *Journal Hospital Administration*, 5(5), 41–52.
- Brousseau, S., Cara, C., & Blais, R. (2017a). A humanistic caring quality of work life model in nursing administration based on watson's philosophy. *International Journal for Human Caring*, 21(1), 2–8.
- Brousseau, S., Cara, C., & Blais, R. (2017b). Une dialectique de la qualité de vie au travail de cadres infirmiers de premier niveau: Une étude phénoménologique avec une perspective humaniste [A dialectic of quality of worklife of nurse managers: A Phenomenological Study]. *Revue Francophone Internationale de recherche infirmière*, 3(2), 129–144.
- Brown, D., McWilliam, C., & Ward-Griffin, C. (2006). Client-centred empowering partnering in nursing. *Journal of Advanced Nursing*, 53(2), 160–168. <http://dx.doi.org/10.1111/j.1365-2648.2006.03711.x>
- Cara, C. (1997). Managers' subjugation and empowerment of caring practices: A relational caring inquiry with staff nurses. *Dissertation Abstracts International*, 58(04), University Microfilms International No. AAT97-28055, 1797.
- Cara, C. (1999). Relational caring inquiry: Nurses' perspective on how management can promote a caring practice. *International Journal for Human Caring*, 3(1), 22–30.
- Cara, C. (2002). *Creating a caring environment in nursing research*. Paper presented at the Annual Conference of the International Association for Human Caring, Boston, USA.
- Cara, C. (2003). A pragmatic view of Jean Watson's Caring theory. *International Journal of Human Caring*, 7(3), 51–61.
- Cara, C. (2004). *Le «caring» en 2004: Le vivre dans sa pratique au quotidien* [Caring in 2004: Living it in our daily practice]. Opening keynote for the 26th conference of the International Association for Human Caring, Montréal, Québec, Canada.
- Cara, C. (2008). *Une approche de caring pour préserver la dimension humaine en gestion* [A Caring approach to preserve the human dimension in management]. Keynote at the annual conference of the Association des gestionnaires infirmiers d'urgence du Québec, Saint-Sauveur, Québec.
- Cara, C. (2010). Explorer les fondements théoriques du caring dans la pratique infirmière [The theoretical foundations of caring in nursing practice]. In P. A. Potter, A. G. Perry, C. Dallaire, S. Le May, & Y. Brassard (Eds.), *Soins infirmiers - Fondements généraux* (C. Dallaire, S. Le May & Y. Brassard, Trans., 3rd ed., Vol. 1, pp. 84–99). Montréal, Québec: Chenelière Éducation.
- Cara, C., & O'Reilly, L. (2011). Relever le défi d'une pratique humaniste en réadaptation: Un luxe ou une nécessité? [Meeting the challenge of a humanistic practice in rehabilitation: A luxury or a necessity?]. Web diffusion of the *National conference in rehabilitation*. Laval, Quebec: Jewish Rehabilitation Hospital.
- Cara, C., Gauvin-Lepage, J., Lefebvre, H., Létourneau, D., Alderson, M., Robinette, L., . . . Mathieu, C. (2016). Le Modèle humaniste des soins infirmiers – UdeM: Perspective novatrice et pragmatique [The Humanistic Model of Nursing Care – UdeM: Innovative pragmatic perspective]. *Recherche en soins infirmiers*, 2(125), 20–31.
- Cara, C. (2017). *Rediscovering love, compassion, and caring to alleviate dehumanization*. Keynote presented at the Annual Conference of the International Association for Human Caring, Edmonton, Alberta, Canada.
- Cara, C., Nyberg, J., & Brousseau, S. (2011). Fostering the co-existence of caring philosophy and economics in today's health care system. *Nursing Administration Quarterly*, 35(1), 1–9.
- Cara, C., & O'Reilly, L. (2008). S'approprier la théorie du human caring de Jean Watson par la pratique réflexive lors d'une situation clinique [Appropriation of Jean Watson's theory of human caring through reflective practice with a clinical situation]. *Recherche en soins infirmiers*, 95, 37–45.
- Cara, C., O'Reilly, L., & Brousseau, S. (2017). Relational caring inquiry: The added value of caring ontology in nursing research. In S. Lee, P. Palmieri, & J. Watson (Eds.), *Global advances in human caring literacy* (pp. 101–114). New York, NY: Springer Publishing.
- Carron, A. V. (1982). Cohesiveness in sport groups: Interpretations and considerations. *Journal of Sport Psychology*, 4, 123–138.
- Cazale, L., Tremblay, D., Roberge, D., Touati, N., Denis, J. -L., & Pineault, R. (2006). Développement et application d'une vignette Clinique pour apprécier la qualité des soins en oncologie [Development and application of a clinical vignette to assess the quality of oncology care]. *Revue d'épidémiologie et de santé publique*, 54, 407–420.
- Convergence [Def. 1]. (n.d.). In *Cambridge dictionary online*. Retrieved from <https://dictionary.cambridge.org/fr/>

- Delmas, P., O'Reilly, L., Iglesias, K., Cara, C., & Burnier, M. (2016). Feasibility, acceptability and preliminary effects of an educational intervention to strengthen humanistic practice among haemodialysis nurses in the Canton of Vaud, Switzerland: A pilot study. *International Journal for Human Caring*, 20(1), 31–43.
- Delmas, P., O'Reilly, L., & Cara, C. (2014). Mise en place et évaluation d'une intervention éducative sur le renforcement des pratiques humanistes des infirmières: Étude pilote [Establishment and evaluation of an educational intervention on strengthening the humanistic practices of nurses: Pilot study]. Presentation at the *Colloque international francophone*. Lausanne (Suisse).
- Delmas, P., O'Reilly, L., & Cara, C. (2015). Faisabilité et acceptabilité d'une intervention éducative humaniste pour les infirmières [Feasibility and acceptability of a humanistic educational intervention for nurses]. Oral communication in the 6th Congrès mondial du SIDIIEF. Montréal.
- DiNapoli, P. P., Nelson, J., Turkel, M., & Watson, J. (2010). Measuring the caritas processes: Caring factor survey. *International Journal for Human Caring*, 14, 16–21.
- Dinç, L., & Gastmans, C. (2013). Trust in nurse-patient relationships: A literature review. *Nursing Ethics*, 20(5), 501–516. <http://dx.doi.org/10.1177/0969733012468463>
- Divergence [Def. 2]. (n.d.). In *Cambridge dictionary online*. Retrieved from <https://dictionary.cambridge.org/fr/>
- Duffy, A. (2007). A concept analysis of reflective practice: Determining its value to nurses. *British Journal of Nursing*, 16(22), 1400–1407. <http://dx.doi.org/10.12968/bjon.2007.16.22.27771>
- Duffy, K. (2013). Providing constructive feedback to students during mentoring. *Nursing Standard*, 27(31), 50–56. <http://dx.doi.org/10.7748/ns2013.04.27.31.50.e7334>
- Duffy, J. R. (2009). *Quality caring in nursing: Applying theory to clinical practice, education, and leadership*. New York, NY: Springer Publishing.
- Duffy, J. R., & Hoskins, L. M. (2003). The quality-caring model. *Blending dual paradigms. Advances in Nursing Science*, 26(1), 77–88.
- Duquette, A., & Cara, C. (2000). Le caring et la santé de l'infirmière [Caring and the nurse's health]. *L'infirmière Canadienne*, 1(2), 10–11.
- Durgun Ozan, Y., & Okumuş, H. (2017). Effects of nursing care based on watson's theory of human caring on anxiety, distress, and coping, when infertility treatment fails: A randomized controlled trial. *Journal of Caring Sciences*, 6(2), 95–109. <http://dx.doi.org/10.15171/jcs.2017.010>
- Enns, C. L., & Sawatzky, J. A. (2016). Emergency nurses' perspectives: Factors affecting caring. *Journal of Emergency Nursing*, 42(3), 240–245. <http://dx.doi.org/10.1016/j.jen.2015.12.003>
- Erci, B., Sayan, A., Tortumluoglu, G., Kiliç, D., Şahin, O., & Güngörmüş, Z. (2003). The effectiveness of Watson's caring model on the quality of life and blood pressure of patients with hypertension. *Journal of Advanced Nursing*, 41(2), 130–139.
- Euswas, P. (1993). The actualized caring moment: A grounded theory of caring in nursing practice. In D. A. Gaut (Ed.), *A global agenda for caring. Fourteenth Annual Caring Research Conference* (pp. 309–323). New York, NY: National League for Nursing.
- Feeley, N., Cossette, S., Côté, J., Héon, M., Stremler, R., Martorella, G., & Purden, M. (2009). The importance of piloting an RCT intervention. *The Canadian Journal of Nursing Research*, 41(2), 84–99.
- Fingeld-Connett, D. (2008). Meta-synthesis of caring in nursing. *Journal of Clinical Nursing*, 17, 194–204.
- Fingeld-Connett, D. (2013). Meta-synthesis of caring in nursing. In M. C. Smith, M. C. Turkel, & Z. R. Wolf (Eds.), *Caring in nursing classics. An essential resource* (pp. 103–114). New York, NY: Springer Publishing.
- Giorgi, A. (1997). The Theory, Practice, and Evaluation of the Phenomenological Method as a Qualitative Research Procedure. *Journal of Phenomenological Psychology*, 28(2), 235–260.
- Graber, D. R. (2009). Organizational and individual perspectives on caring in hospitals. *Journal of Health and Human Services Administration*, 31(4), 517–537.
- Graber, D. R., Mitcham, M. D., Coker-Bolt, P., Wise, H. H., Jacques, P., Edlunc, B., & Annan-Coults, D. (2012). The Caring Professionals Program: Educational approaches that integrate caring attitudes and empathic behaviors into health professions education. *Journal of Allied Health*, 41(2), 90–96. <http://www.ingentaconnect.com/content/asahp/jah>.
- Halldorsdottir, S. (1990). Five basic mode of being with another. In D. A. Gaut & M. Leininger (Eds.), *Caring: The compassionate healer* (pp. 37–49). New York, NY: National League for Nursing Press.
- Heaton, J. (2004). *Reworking qualitative data*. London: Sage.
- Heaton, J. (2008). Secondary analysis of qualitative data: An overview. *Historical Social Research*, 33, 33–45.
- Hills, M., & Watson, J. (2011). *Creating a caring science curriculum. An emancipatory pedagogy for nursing*. New York, NY: Springer Publishing.
- Horton-Deutsch, S., & Cara, C. (2017). Learning through reflection and reflection on learning: Pedagogies in action. In S. Horton-Deutsch & G. D. Sherwood (Eds.), *Reflective practice: Transforming education and improving outcomes* (Ch.7, pp. 137–166). New York, NY: Springer Publishing.
- Johns, C. (2009). *Becoming a reflective practitioner* (3rd ed.). Sussex, UK: Wiley-Blackwell.
- Kosowski, M. M. (1995). Clinical learning experiences and professional nurse caring: A critical phenomenological study of female baccalaureate nursing students. *The Journal of Nursing Educator*, 34(5), 235–242.
- Lee, D. S., Tu, J. V., Chong, A., & Alter, D. A. (2008). Patient satisfaction and its relationship with quality and outcomes of care after acute myocardial infarction. *Circulation*, 118(19), 1938–1945. <http://dx.doi.org/10.1161/CIRCULATIONAHA.108.792713>
- Liu, K., You, L. M., Chen, S. X., Hao, Y. T., Zhu, X. W., Zhang, L. F., & Aiken, L. H. (2012). The relationship between hospital work environment and nurse outcomes in Guangdong, China: A nurse questionnaire survey. *Journal of Clinical Nursing*, 21(9–10), 1476–1485. <http://dx.doi.org/10.1111/j.1365-2702.2011.03991.x>

- Lucke, K. T. (1999). Outcomes of nurse caring as perceived by individuals with spinal cord injury during rehabilitation. *Rehabilitation Nursing*, 24(6), 247–253.
- Leininger, M. M. (2013). Caring – An essential human need. Proceedings of three national caring conferences. In M. C. Smith, M. C. Turkel, & Z. R. Wolf (Eds.), *Caring in nursing classics. An essential resource* (pp. 127–141). New York, NY: Springer publishing.
- Létourneau, D., Cara, C., & Goudreau, J. (2016). Agir avec humanisme: L'approche humaine et relationnelle du soin, un pouvoir de l'infirmière [Act with humanism: Human and relational approach]. *Perspective infirmière*, 13(5), 32–34. <https://www.oiiq.org/sites/default/files/uploads/periodiques/Perspective/vol13no5/10-formation.pdf>.
- Létourneau, D., Cara, C., & Goudreau, J. (2017). Humanizing nursing care: An analysis of caring theories through the lens of humanism. *International Journal for Human Caring*, 21(1), 32–40.
- McNamara, S. A. (1995). Perioperative nurses' perceptions of caring practices. *AORN Journal*, 61(2), 377–388.
- Newman, M. A., Sime, A. M., & Cororan-Perry, S. A. (1991). The focus of the discipline of nursing. *Advances in Nursing Sciences*, 14(1), 1–6.
- O'Reilly, L., Delmas, P., & Cara, C. (2012). Optimisation des pratiques humanistes: Une intervention éducative novatrice Québécoise et Helvétique auprès d'infirmières travaillant avec des clientèles atteintes de maladies chroniques [Optimization of humanistic practices: An educative intervention (Quebec & Switzerland) for nurses working with chronically ill patients]. Abstract on SIDIEF Conference Website, 5th World congress of francophone nurses SIDIEF. Geneva, Switzerland.
- O'Reilly, L., Cara, C., Avoine, M. P., & Brousseau, S. (2011). Résilience: Pour voir autrement l'intervention en réadaptation [Resilience: To see the rehabilitation intervention differently]. *Revue: Développement humain, handicap et social*, 19(1), 111–116.
- O'Reilly, L., Cara, C., & Delmas, P. (2016). Developing an educational intervention to strengthen the humanistic practices of hemodialysis nurses in Switzerland. *International Journal for Human Caring*, 20(1), 24–30.
- O'Reilly, L. (2007). *La signification de l'expérience d'«être avec» la personne soignée et sa contribution la réadaptation: La perception d'infirmières* [The meaning of the experience of "being with" the person being cared for and their contribution to rehabilitation: The perception of nurses]. Doctoral Dissertation, Faculty of Nursing, Université de Montréal. AAT NR 35727.
- O'Reilly, L., & Cara, C. (2010). «Être avec» la personne soignée en réadaptation: Une rencontre humaine profonde thérapeutique et transformatrice [« Being with » the person cared for in rehabilitation: A deep therapeutic and transformative human encounter]. *Recherche en soins infirmiers*, 103, 46–66.
- O'Reilly, L., & Cara, C. (2011). A caring educational intervention with nurses to enhance health care humanization and quality. *International Journal for Human Caring*, 15(3), 75.
- O'Reilly, L., Cara, C., Avoine, M. P., & Brousseau, S. (2010). Défis et enjeux de pratiques humanistes en réadaptation: La perspective de personnes hospitalisées [Challenges of humanistic practices in rehabilitation: The perspective of hospitalized people]. Oral communication presented at the annual congress of the *Ordre des Infirmières et Infirmiers du Québec*. Montréal, Québec.
- O'Reilly, L., & Cara, C. (2014). La phénoménologie de Husserl [The phenomenology of Husserl]. In M. Corbière & N. Larivière (Eds.), *Méthodes qualitatives, quantitatives et mixtes: Dans la recherche en sciences sociales, humaines et de la santé* (pp. 29–48). Montréal: Presses de l'Université du Québec.
- O'Reilly, L., Cara, C., & Delmas, P. (2015). Intervention éducative renforçant les pratiques humanistes d'infirmières [Educative intervention to reinforce nurses' humanistic practices]. Proceedings of the World congress of francophone nurses SIDIEF. Montréal, Canada.
- Perry, A. G., & Cara, C. (2017). Explorer les fondements théoriques du caring dans la pratique infirmière [The theoretical foundations of caring in nursing practice]. In P. A. Potter, A. G. Perry, P. Stockert, & A. Hall (Eds.), *Soins infirmiers - Fondements généraux* (C. Dallaire, S. Le May, Y. Brassard, Trans., 4th ed., Vol. 1, pp. 72–87). Montréal, Québec: Chenelière Éducation.
- Rafii, F., Hajinezhad, M. E., & Haghani, H. (2008). Nurse caring in Iran and its relationship with patient satisfaction. *Australian Journal of Advanced Nursing*, 26(29), 75–84.
- Roach, M. S. (1987). *The human act of caring: A blueprint for health professions*. Toronto, Ontario: Canadian Hospital Association.
- Roach, M. S. (2002). *Caring, the human mode of being: A blueprint for the health professions* (2nd ed.). Ottawa: Presses de l'ACS.
- Sargent, A. (2012). Reframing caring as discursive practice: A critical review of conceptual analyses of caring in nursing. *Nursing Inquiry*, 19(2), 134–143. <http://dx.doi.org/10.1111/j.1440-1800.2011.00559.x>
- Schoenhofer, S. O., & Boykin, A. (1998). The value of caring experienced in nursing. *International Journal for Human Caring*, 2(4), 9–15. <http://www.humancaring.org/journal/index.htm>.
- Sidani, S., & Braden, C. J. (2011). *Design, evaluation and translation of nursing interventions*. Wiley-Blackwell: Oxford.
- St-Germain, D., Blais, R., & Cara, C. (2008). La contribution de l'approche de caring des infirmières la sécurité des patients en réadaptation: Une étude novatrice [The Contribution of nurses' caring approach to patient safety in rehabilitation: An Innovative Study]. *Recherche en Soins Infirmiers*, 95, 57–69.
- St-Germain, D., Blais, R., & Cara, C. (2009). Patient safety: The contribution of "rehabilitation caring" to its definition. *International Journal for Human Caring*, 13(1), 60–65.
- Swanson, K. M. (1999). What is known about caring in nursing science. A literacy meta-analysis. In A. S. Hinshaw, S. L. Feetham, & J. L. F. Shaver (Eds.), *Handbook of clinical nursing research* (pp. 31–60). Thousand Oaks: Sage.

- Swanson, K. M. (2013). What is known about caring in nursing science: A literacy meta-analysis. In M. C. Smith, M. C. Turkel, & Z. R. Wolf (Eds.), *Caring in nursing classics. An essential resource* (pp. 59–102). New York, NY: Springer publishing.
- Thorne, S. (1998). Ethical and representational issues in qualitative secondary analysis. *Qualitative Health Research*, 8(4), 547–555. <http://dx.doi.org/10.1177/104973239800800408>
- Turkel, M. C. (2014). Response to Chapter 9. In A. Boykin, S. Schoenhofer, & K. Valentine (Eds.), *Health care system transformation for nursing and health care leaders: Implementing a culture of caring* (pp. 207–210). New York, NY: Springer Publishing.
- Varcoe, C., Doane, G., Pauly, B., Rodney, P., Storch, J. L., Mahoney, K., . . . Starzomski, R. (2004). Ethical practice in nursing: Working the in-betweens. *Journal of Advanced Nursing*, 45(3), 316–325. <http://dx.doi.org/10.1046/j.1365-2648.2003.02892.x>
- Watson, J. (1979). *Nursing: The philosophy and science of caring*. Boston, MA: Little Brown.
- Watson, J. (1988). *Human science and human care: A theory of nursing* (2nd printing). New York, NY: National League for Nursing.
- Watson, J. (1997). The theory of human caring: Retrospective and prospective. *Nursing Science Quarterly*, 10(1), 49–52. <http://dx.doi.org/10.1177/089431849701000114>
- Watson, J. (1999). *Postmodern nursing and beyond*. Toronto, ON: Churchill Livingstone.
- Watson, J. (2005). *Caring science as sacred science*. Philadelphia, PA: F.A. Davis Company.
- Watson, J. (2006). Caring theory as an ethical guide to administrative and clinical practices. *Nursing Administration Quarterly*, 30(1), 48–55. <http://journals.lww.com/naqjournal/pages/default.aspx>.
- Watson, J. (2008). *Nursing: The philosophy and science of caring* (rev. ed.). Boulder, CO: University Press of Colorado.
- Watson, J. (2009). Caring science and human caring theory: Transforming personal and professional practices of nursing and health care. *Journal of Health and Human Services Administration*, 31(4), 466–482.
- Watson, J. (2013). The theory of human caring: Retrospective and prospective. In M. Smith, M. Turkel, & Z. Wolf (Eds.), *Caring in nursing classics. An essential resource* (pp. 237–242). New York, NY: Springer Publishing.
- Watson, J. (2012). *Human caring science: A theory of caring science* (2nd ed.). Sudbury, ON: Jones & Bartlett Learning.
- Watson, R., Hoogbruin, A. L., Rumeu, C., Beunza, M., Barbarin, B., Macdonald, J., & McCready, T. (2003). Differences and similarities in the perception of caring between Spanish and UK nurses. *Journal of Clinical Nursing*, 12(1), 85–92. <http://dx.doi.org/10.1046/j.1365-2702.2003.00671.x>
- Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research*, 11(4), 522–537. <http://dx.doi.org/10.1177/104973201129119299>
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