

Developing an Educational Intervention to Strengthen Humanistic Practices of Hemodialysis Nurses in Switzerland

Louise O'Reilly, RN, PhD, *Université de Sherbrooke*; Chantal Cara, RN, PhD, *Université de Montréal*; Philippe Delmas, RN, PhD, *University of Applied Sciences and Arts Western Switzerland*

Abstract

An educational intervention was developed based on Watson's theory of human caring and dispensed to hemodialysis (HD) nurses in Nyon, Switzerland. HD patients point out that human contact with nurses can become therapeutic when characterized by caring. Research has documented the importance of the contribution of such caring practice to the rehabilitation of patients living with a chronic illness. This initiative supports the relevance of exploring humanistic caring practice in order to contribute to the rehabilitation of HD patients. The article presents the principal stages of the theoretical development of the educational intervention.

Keywords: educational intervention, Watson's theory of human caring, humanistic practice, reflective practice, hemodialysis, reflective clinical story

Background

In the course of a recent pilot study aimed at strengthening the caring attitudes and behaviours of hemodialysis (HD) nurses, researchers were led to construct an educational intervention based on the theory of human caring (Watson, 1988, 2008, 2012). As proposed by Sidani and Braden (2011) and given the subject of the study, Watson's theory of human caring was selected as the content theory to provide a framework for the choice of theoretical concepts to include in the intervention. The choice of this theory was based on various elements, particularly the fact that Watson (2000) identifies caring as the essence of nursing, defining it as a relational ontology corresponding to a way of being and becoming more humane toward oneself and others by being authentically present to others and their needs. This humanistic caring practice refers to the nurse's moral commitment to relieve patients' suffering and promote their human dignity (Cara & O'Reilly, 2008) by establishing a relationship with them based on humanistic values, including respect, uniqueness, and freedom of choice (Cara, 2010). In addition to these elements, Watson (2008) also proposed ten carative factors (CF) to guide nursing practice. The concrete nature of these CFs facilitates the nurses' appropriation and application of the humanistic caring practice in one's daily clinical work. We therefore utilized Watson's concept of "carative factors" rather than her latest concept of "clinical caritas processes."

Developing the Educational Intervention

The development of the educational intervention in Switzerland was strongly based on a pilot study realized in Québec, Canada (O'Reilly & Cara, 2011). This original educational intervention was aimed at promoting humanistic practices of nurses working with spinal cord injury

patients hospitalized in a Montreal rehabilitation center.

This phase, which lasted approximately five months and received expert validation (content and process), consisted of selecting and defining the theoretical concepts and developing learning activities (Table 1) to optimize appropriation and application of these concepts within the clinical context of HD. The educational intervention was offered over a three-week period and comprised four sessions, each 3.5 hr long, held at a site nearby the hospital. Each session was divided into two distinct parts, the first lasting 1.5 hr and focusing on theoretical concepts, and the second dealing more with interactive learning activities.

Choice of theoretical concepts. The theme of the educational intervention was humanistic nursing practice. With a view to ensure optimal understanding and development of humanistic nursing practice, the content selected to be taught corresponded to the concepts of the theory of human caring developed by Watson (1988, 1999, 2006, 2008, 2012).

Definition of theoretical concepts. Each of the theoretical concepts chosen was defined based on Watson's writings. These definitions corresponded to the theoretical content taught in the educational intervention.

In the very first training session, a parallel was drawn between *caring practice* and *humanistic practice*. In this regard, Watson (2012) described nursing care in terms of a caring relationship, whose aim it is to help cared-for persons, living a health experience, give meaning to their suffering and disharmony. This caring practice is said to be humanistic in that it is centered on the person, that is, the person's experience, the meaning given by the person living the experience, and the person's relationships with nurses, family members, and significant others (Cara, 2010). Moreover, numerous values within Watson's theory correspond to humanistic values. Consequently, various humanistic values fundamental to

humanistic practice were also covered over the course of the educational intervention. These values included respect of human dignity, belief in the potential (strengths) of the person, recognition of the individual's freedom of choice, patients and nurses considered copartners in care, importance given to the individual's subjectivity, and belief that the relational dimension is fundamental to humanistic care (Cara & O'Reilly, 2008; Watson, 1988).

The concept of *person/environment* was defined in terms of an indivisible mindbodyspirit (Watson, 2008). The "body" designated the physical dimensions, the "spirit" referred to the soul and the person's beliefs, values, and search for meaning, and the "mind" concerned perceptions, emotions, past experiences, and knowledge (Cara & O'Reilly, 2008). According to Watson (1988), individuals possess a "phenomenal field," which corresponds to their life history or frame of reference at a given point in their existence. Hence, the meeting between a nurse and a cared-for person corresponds to the meeting of two phenomenal fields (Watson, 1988). Finally, Watson (2008) stipulated that persons were "beings-in-the-world," that is, they remained in close interaction with their environment (e.g., cared-for person's room, family, significant others). The concept of *health*, for its part, corresponded to a unique subjective experience influenced by the person's values and past experiences (Watson, 2008). Thus, health designated a state of harmony across the person's three indivisible spheres of mind, body, and spirit. Conversely, explained Watson, disease corresponded to a state of disharmony among these spheres. Watson also invites us to think about health in terms of the meaning that a health experience has for the person living it.

For its part, the central concept of *nursing* for Watson (2001, 2006) referred to the "transpersonal caring relationship" that designates the fact of "being with" another human in a soul-to-soul connection that transcends the self-ego and the physical body, in which each person perceives the other as a unique being-in-the-world (Watson, 2001, 2006). Accordingly, this caring relationship "allows nurses to assist cared-for persons in giving meaning to their health situation and their suffering while aiming for health promotion, harmony, and empowerment, of both the person and the nurse (Cara, 2010; Cara & O'Reilly, 2008; Watson, 1988, 2008). Underlying the transpersonal caring relationship is the notion of relationships put forth by Buber (1970a, 1970b).

Table 1

Synthesis of the pedagogical dimension of the educational intervention

Session and topic	Objectives	Learning activities
Session 1: Appropriation of fundamental concepts of caring practice	To describe the fundamental concepts of Watson's theory of human caring: <ul style="list-style-type: none"> ■ Caring values, attitudes, and behaviours ■ Central concepts of person/environment, health, and nursing ■ Concepts of caring, caring occasion, and caring moment ■ Phenomenal field ■ Transpersonal caring relationship - To recognize these concepts in the reflective nursing situation #1 - To gain awareness of the relevance of the humanistic approach to caring for HD patients	-Paper documentation <ol style="list-style-type: none"> (1) Handout of PowerPoint (2) Cara (2010) (3) Cara & O'Reilly (2008) - Focusing exercise - Theoretical presentation - Reflective nursing situation #1: <i>Caring moment: a moment of well-being for both patient and nurse</i> - Individual exercise (Quiz) - Debriefing of participants
Session 2: Appropriation of fundamental concepts of caring practice (cont'd)	- To describe each of the ten carative factors (CF) of Watson's theory of human caring (2008): <ul style="list-style-type: none"> ■ CF1 – humanistic-altruistic system of value ■ CF2 – faith-hope ■ CF3 – sensitivity to self and others ■ CF4 – helping-trusting human, care relationship ■ CF5 – expressing positive and negative feelings ■ CF6 – creative problem-solving caring process ■ CF7 – transpersonal teaching-learning ■ CF8 – supportive, protective and/or corrective mental, physical, societal, and spiritual environment ■ F9 – human needs assistance ■ CF10 – existential-phenomenological-spiritual forces - To recognize the CF in the reflective nursing situation #2	- Review of questions and content of session #1 - Paper documentation <ol style="list-style-type: none"> (1) Handout of PowerPoint (2) Cara (2010) (3) Cara & O'Reilly (2008) - Focusing exercise - Theoretical presentation - Reflective nursing situation #2: <i>Easing pain and suffering: contribution of transpersonal caring relationship</i> - Debriefing of participants
Session 3: Dehumanizing and humanistic nursing practices and their impact	- To describe the components of dehumanizing practice - To recognize the impact of dehumanizing practice on the well-being of the patient and nurses in nursing situation #3 - To grasp the importance of humanistic practice in nursing care - To integrate nurses' humanistic practice in role play (ties with concepts of Watson's theory)	- Review of questions and content of session # 2 - Paper documentation <ol style="list-style-type: none"> (1) Handout of PowerPoint (2) Cara (2010) (3) Cara & O'Reilly (2008) - Focusing exercise - Theoretical presentation - Clinical vignette #3 on dehumanizing practice: <i>Nathalie</i> - Role play - Debriefing of participants
Session 4: Search for meaning: instilling hope through humanistic practice	- To describe the different features related to the concept of hope - To gain awareness of the added value of hope in the quality of life of HD patients - To recognize the different humanistic interventions that instill hope within reflective nursing situation #4 - To discuss the search for meaning among HD patients - To discuss the nurses' meaning in their work	- Review of questions and content of session # 3 - Paper documentation <ol style="list-style-type: none"> (1) Handout of PowerPoint (2) Cara (2010) (3) Cara & O'Reilly (2008) - Focusing exercise - Theoretical presentation - Reflective nursing situation #4: <i>Instilling hope like a breath of life</i> - Evaluation of overall educational intervention

In his writings, this Jewish philosopher examined the *I-Thou/I-It* relationship. From his point of view, the *I-Thou* relationship exemplifies a reciprocal relationship that confers importance to the person's subjective world, engages the person as a whole, and necessitates a certain quality of

presence, which makes it possible to know and understand oneself and others better. At the other end, the *I-It* relationship is more a subject-object relationship that places importance on the objective world and does not engage the person as a whole. It focuses on the tasks at hand as

well as the distance between the cared-for person and the carer, which results in an incomplete image of the person (Buber, 1970a, 1970b). Caring is honoured when the *I-Thou* relationship is present; it cannot exist within the context of the *I-It* relationship.

The concept of *caring occasion* designates for Watson (1988), the gathering in time and space where both the patient and the nurse “come together with their unique life histories and phenomenal fields, creating a distinct caring moment in space and time” (Sitzman & Watson, 2014, p. 18). In other words, each *caring moment* allows the cared-for person and the nurse to make choices together and decide on actions to take in the situation (Watson, 1988). The *caring moment* is therefore an opportunity where both can meet with their respective life stories within a human-to-human relationship, sharing their experiences, perceptions, feelings, hopes, thoughts, and or beliefs. According to Watson (1988), an *actual caring occasion* holds a greater phenomenal field of its own in a given moment, as it turns out that their relationship becomes part of each person’s story.

During the second session of the educational intervention, the 10 CFs defined by Watson (2008) were covered. The first three CF designate humanistic fundamentals, whereas the seven others constitute scientific fundamentals. The first CF, *a humanistic-altruistic value system*, refers to solicitude, uniqueness, diversity, holism, and avoidance of the use of hermetic medical jargon that reduces human beings and their experience. For Watson, the second CF, *faith-hope*, indicates the belief that we have in the individual’s potential. Given that hope is essential to achieving mindbodyspirit harmony, the nurse’s role, according to Watson, consists of guiding the person in developing a realistic hope. The third CF, *sensitivity to self and others*, corresponds in particular to gaining awareness of one’s strengths and limitations (Watson, 2008). The first thing to do in order to develop this sensitivity is to pay attention to one’s thoughts and emotions. Many people do not see their full potential. They look outwardly when the answer to be found is on the inside. If nurses are not sensitive to their own way of being (emotions, feelings, thoughts), it will be difficult for them to be sensitive toward others. The third CF has to do also with helping patients see how their illness impacts their family.

Among the seven remaining, *a helping-trusting human care relationship*, the fourth CF, corresponds to the development and maintenance of a helping and trusting relationship by way of an intentional commitment, active listening, genuine interest in the other person in the sense of the person’s subjectivity, and a non-judgmental approach (Watson, 2008). The fifth CF, *expressing positive and negative feelings*, refers to allowing the expression of and embracing both positive and negative perceptions, thoughts, and emotions. This is not only liberating but serves also to clarify matters. The sixth CF, *a creative problem-solving caring process*, honours the artistic and scientific dimension of care. For Watson (2008), it involves

problem solving and the renewal of professional practices. In a way, it amounts to celebrating the care process as creative, non-linear, intuitive, and unique to each situation. The seventh CF, *transpersonal teaching-learning*, corresponds, according to Watson (2008), to a form of teaching that respects the cared-for person’s rhythm (realistic objectives) and frame of reference (needs). Also, this teaching-learning, which remains within the cared-for person’s academic and cultural reach, is offered at the person’s convenience and pace. According to Watson (2008), the eighth CF, *a supportive, protective and/or corrective mental, physical, societal, and spiritual environment*, comprises numerous dimensions. First and foremost, this CF demands that the person’s physical and psychological comfort is attended to. In this regard, changing the person’s position when in bed, making sure that the bed is comfortable, alleviating muscular tension by offering therapeutic touching and massages, controlling pain through proper medication management, and listening to the person are all excellent ways of achieving this end. Within this same CF, the nurse must see to it that the environment is comfortable. According to Watson, the room corresponds to a place of healing. In this regard, turning down the light, the noise, and the temperature are ways of achieving this. This same CF reminds us to be alert about protecting the person’s intimacy, particularly as regards certain body parts. It also refers to the prevention of falls, infection, and errors of all sorts. It is important to remember that feeling safe and protected is a basic need. Moreover, the protection of human dignity, that is, against humiliation, stigmatization, the invasion of one’s intimacy, and the disclosure of confidential information, remains a dimension related to this eighth CF. According to Watson (2008), the ninth CF, *human needs assistance*, corresponds to assistance care aimed at meeting the person’s needs. These needs can be of different types: biophysical (nutrition and hydration, elimination, respiration), psycho-physical (activity and inactivity, sexuality, creativity, intimacy), psycho-social (accomplishment, belongingness) and intra-personal (self-actualization, spiritual growth) (Watson, 2008). Given that Watson defined the cared-for person as a mindbodyspirit, these three components are integrated in each need. For example, when giving a bath, the nurse touches the patient’s physical body, spirit (person’s beliefs and value of preserving one’s human dignity), and mind (emotions of well-being and security). Finally, with the tenth CF, *existential-phenomenological-spiritual forces*, Watson (2008) encourages nurses to look at the priorities of cared-for persons and the meaning that they give to the situation and to their life. It is important to remember that traumatic events (unique) force the patients to re-assess their life (what is

important? what are my priorities? what is the meaning of my life?). Thus, explained Watson, a tragedy can turn into a miracle of courage and strength, and open onto another reality.

The third session focused on dehumanizing practice and its impact as well as on the obstacles to a humanistic practice and the contributions of a caring practice. The results of a qualitative phenomenological study especially informed this section of the educational intervention (Avoine, 2012; Avoine, O’Reilly, & Michaud, 2012a,b). *Dehumanizing practice* was qualified as nonethical (botched, abusive, degrading, and unacceptable), noncommitted (centered on the minimal technical task at hand, egocentric, indifferent, and inattentive), insidious (sporadic and silent), and infectious (contagious) in that it tends to spread to others (Avoine; Avoine et al.). This same qualitative study shed light on the impact of such practice on cared-for persons, the rehabilitation process as well as the work and care environment. The impacts on the cared-for persons include that they stop expressing their needs, perceive themselves as human beings of lesser importance, and prefer to die rather than relive dehumanizing events. Regarding the rehabilitation process, the results of this study showed that dehumanizing practice caused rehabilitation to slow down or regress and that it instilled a sense of abandonment. According to the researchers, many patients pointed out that if nurses had “been with” them, their rehabilitation would have been completed more rapidly. As for the work and care environment, nurses’ dehumanizing practice generated a pernicious climate and an atmosphere of distrust (Avoine; Avoine et al.). The cared-for person could no longer trust the nurse and, eventually, the entire staff. For their part, the *obstacles* limiting nurses’ caring practice were drawn from a phenomenological study (O’Reilly, Cara, Avoine, & Brousseau, 2010a, b, 2011; O’Reilly, Cara, & Avoine, 2011) performed in a rehabilitation setting. Such obstacles included workload, lack of care continuity, complexity of clinical situations, difference in values, short supply of human resources, and lack of knowledge regarding rehabilitation care (O’Reilly, Cara, Avoine, & Brousseau 2011; O’Reilly, Cara, & Avoine). As for the *contributions* of caring practice, they have been documented in another phenomenological study (O’Reilly, 2007; O’Reilly & Cara, 2010) in terms of how such practice promotes alignment of the patient’s and the nurse’s mindbodyspirit. Alignment occurs when expressed needs are met, the person’s rehabilitation progresses, and both the cared-for person and the nurse experience a sense of well-being and interior growth.

In order to make the differences between humanistic practice and dehumanizing practice more concrete, a parallel was drawn with the works of Halldorsdottir (1991, 2012). This

researcher outlined five modes of being with cared-for persons, describing their contributions and repercussions. The “biogenic or life-giving mode” illustrates a person-to-person relationship that promotes growth and healing. The “bioactive or life-sustaining mode” translates into a supportive, encouraging, and reassuring relationship, which promotes a sense of security in the individual. The “biopassive or life-neutral mode” is characterized by a lack of interaction with the cared-for person and the absence of any positive contribution. The “biostatic or life-restricting mode” is marked by insensitivity and indifference on the part of the nurse, resulting in the patient sensing discouragement. Lastly, in the “biocidal or life-destroying mode,” the nurse considers the cared-for person as an object, thereby exacerbating the person’s suffering (Halldorsdottir, 1991, 2012). The first two modes are clearly akin to humanistic practice, whereas the last two are associated with dehumanizing practice. For its part, the third mode seems closer to dehumanizing practice on account of the lack of commitment by the nurse, who is contented of doing the bare minimal. Finally, the works of Halldorsdottir (1991, 2012) remind participants in the educational intervention that their relationship with the cared-for person can be helpful or on the contrary, detrimental to the patient.

The fourth and final session concerned the search for meaning, the notion of hope at the end of life, and nursing interventions that elicit it. To discuss these topics, the following reflective questions were given to the participants following a reflective clinical vignette: *How did the nurse help Simone find a meaning in her life? How did the nurse contribute to foster hope in Simone? How did helping Simone find a meaning to her life experience allow the nurse to find a meaning to her daily clinical practice?* Moreover, an emphasis was placed both on the importance of taking advantage of all the caring moments that arise in order to make a difference in the life of the cared-for person and on the quality of one’s presence and listening. Cara (2010) pointed out that, in order to listen, nurses must silence their interior and exterior voices in order to be opened to the other person’s story. This author mentioned also that “listening to a patient can be difficult at times on account of the many tasks nurses must perform. However, it is worthwhile for nurses to take the time to listen effectively for the information they will garner, the relationship they will consolidate with patients, and the partnership they will establish with them” (free translation, Cara, 2010, p. 96).

Developing learning activities. For the purpose of helping construct a picture of humanistic care in each participant, foster the integration of theory in practice, and facilitate an exploration and introspection of professional practice, reflective

practice (Boykin, 1998; Cara & O’Reilly, 2008; Johns, 2009; Schön, 1994) was selected to provide a framework for developing learning activities.

For Schön (1994), reflective practice corresponds to taking a critical look at one’s nursing practice and at the factors that influenced a given clinical situation in order to learn from the reflections and improve one’s professional practice going forward. Accordingly, and in line with Boykin (1998), we believe that reflective practice contributes to caring practice by helping nurses meet the needs of patients more effectively, which explains why the choice of this framework is appropriate for guiding the development of the pedagogical dimension of the educational intervention.

In order to foster appropriation of such practice, it was necessary to develop learning activities to this end. The following section will exemplify each of these activities, which together aimed at the development of a competent know-how, that is, humanistic practice that contributes to the rehabilitation of HD patients.

Sequential content. The content of the educational intervention (theoretical concepts and reflective nursing situations) (Le Boterf, 2007, 2008) was presented in order of complexity, from simplest to most complex, to facilitate learning. As mentioned earlier, the first session essentially covered the notions of person/environment, health, nursing, caring, caring occasion, caring moment, and the transpersonal caring relationship. The second session dealt with the ten CFs. In the third session, the discussion focused primarily on dehumanizing nursing practice and its impact. Finally, the last session served to reflect on the most complex of the concepts, including search for meaning, hope, and nursing interventions that instill hope.

Focusing exercises. These exercises were based on the focusing process (Lamboy, 2006) at the core of the person-centered approach developed by Rogers (1951). This six-step technique (Gendlin, 1978) consists of cultivating a certain interior attitude for grasping problems differently and allowing new possibilities to emerge on how to approach a situation, position oneself, and take action. For Lamboy (2006), the first step of “clearing a space” serves to create the conditions conducive to listening to what resonates inside oneself from a proper distance. The nurses participating in our study engaged in this first step for 10 minutes by way of simple introspection exercises at the beginning of each session. This allowed them to be more attuned to themselves and others, to create a space of openness to contact with others, particularly the patients in their care, based on a humanistic approach. This first step of “clearing a space”

was an opportunity for them to set aside their professional constraints and concerns momentarily as well as to allow themselves a cleared personal space. In our opinion, this is an essential step in order to be able to embrace the theory of human caring. Moreover, Watson (2005) herself has encouraged nurses to use this type of activity.

Paper documentation. At the start of each session, participants were handed a folder with paper documentation, including the pedagogical objectives of the session, articles in French on Watson’s theory of human caring (for example, Cara, 2010; Cara & O’Reilly, 2008), handouts of PowerPoint presentations, and a notepad.

Reflective nursing situations. The use of reflective nursing situations (Hills & Watson, 2011; Johns, 2009) through clinical vignettes served to help each participant construct and expand her vision of humanistic nursing practice, to deepen her reflection on her daily practice, and to foster appropriation of the theoretical content taught.

More specifically, three reflective nursing situations were developed by drawing on the true nursing story of Simone (not her real name), who suffered from chronic active terminal kidney failure and received HD treatment. Each nursing situation concerned a critical time in her life experience (first contact with a dialysis center; episode of complications in her kidney disease; end-of-life care). Drawing on Watson’s theory of human caring, each reflective nursing situation covered in detail humanistic nursing practice in HD treatment. Watson’s theoretical concepts were identified and placed between parentheses in the text to elucidate their relationship with humanistic practice. This detail made it possible for the participants to operationalize the concepts.

The first reflective nursing situation was titled “*Caring moment: a moment of well-being for both patient and nurse*” (Appendix A, Reflective Nursing Situation #1). Used in the course of the first session, this story covered in particular the concepts of *caring occasion* and *caring moment* by discussing the importance of seizing each occasion to transform it into a *caring moment* for both the cared-for person and the nurse. For its part, the reflective nursing situation titled “*Easing pain and suffering: contribution of the transpersonal caring relationship*” was used in the course of the second session. It documented primarily the contribution of the transpersonal caring relationship and of the CFs to comfort Simone. For the fourth and last session, the last nursing situation titled “*Instilling hope like a breath of life*” concerned primarily the concepts of hope and search for meaning. Each reflective nursing situation ended with a series of reflective questions, such as: *How can humanistic practice*

be integrated in daily practice? What are the benefits of a humanistic professional practice?

Reflective nursing situation on dehumanizing practice. The fictional nursing situation titled *Nathalie* concerned dehumanizing practice. Used in the course of the third session, this vignette served to sensitize the participants to Nathalie's experience of dehumanisation and to the impact of such practice on both the patient and the nurse.

Role play. In the course of the third session of the educational intervention, the use of role play allowed acting out (gestures) and explaining verbally the transformation of dehumanizing practice into humanistic nursing practice. To this end, a role-play scenario was developed involving three characters, namely, the cared-for person (played by a participant), the nurse (played by a researcher), and the nurse's inner thoughts (played by the other researcher) explaining the ties between the humanistic care provided and the theoretical concepts of Watson's theory of human caring.

Before engaging in role-play, however, dehumanizing practice and its negative impact were discussed. Then, prior to covering the reflective nursing situations entitled *Nathalie*, which illustrated such practice, it was indispensable to create a safe learning environment. As recommended by Hills and Watson (2011) and at our request, the participants created a sacred space in which to hold an open, honest discussion free of value judgements. Thereafter, the participants were split into two groups, one assuming the role of the nurse and the other, that of the cared-for person. Before reading the vignette aloud, we asked the participants to concentrate and to attempt to put themselves in the place of their character. This learning activity really helped each one of them to discover personally the meaning and impact of nursing (Hills & Watson, 2011). After reading the nursing situation aloud, reflective questions were presented to the participants, such as: *How did you feel as the patient or as the nurse? What makes a practice dehumanizing in your opinion? What could the nurse have done to "be with" Nathalie?*

Following reflective questioning on dehumanizing practice, role playing took place. Contrary to the nursing situation titled *Nathalie*, which illustrated an impersonal reception on the clinical unit, lack of respect for the person's physical intimacy, and brusqueness when taking vital signs, the role-play script emphasized instead a humanistic reception on the unit (theoretical ties to the notions of caring occasion and caring moment), respect of the cared-for person's intimacy, human dignity, and individual pace (tied to humanistic values), how the person's

unique needs were met (tied to CF9), and allowing the person to express concerns freely (tied to CF5). Thus, through the words of the role play, the nurse offered the cared-for person humanistic care and, at the same time, expressed aloud the nurse's thoughts and links related to Watson's theory in order to grasp the connexion between the theoretical elements and the nursing care offered.

Debriefing of participants at the end of each session. At the end of each session, time was set aside for nurses and educators (researchers) to share their comments regarding the learning activities, the theoretical content learned, and their lived experience of the overall educational intervention. Such debriefing allowed participants to construct an opinion of the education received, an opinion that was explored at the end of the intervention through individual semi-structured qualitative interviews.

Conclusion

This prototype of an educational intervention was validated by experts with respect to its theoretical and pedagogical dimensions, and in terms of the needs of the population under study. In order to examine the feasibility, acceptability, and preliminary effects of the intervention, a mixed-design pilot study was undertaken. The results obtained will allow us to refine and adjust the theoretical content, the learning activities, and how the pedagogical intervention is delivered.

References

- 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 dehumanizing practices as experienced by current and previous rehabilitation inpatients]. Master's thesis, Université de Sherbrooke, Quebec, Canada.
- Avoine, M. P., O'Reilly, L., & Michaud, C. (2012a). *The signification of dehumanizing practices of nurses in a physical rehabilitation setting from the patient perspective: A phenomenological study*. Paper session presented at the 33rd Annual Conference of the International Association for Human Caring, Philadelphia, PA.
- Avoine, M. P., O'Reilly, L., & Michaud, C. (2012b). *La signification des pratiques déshumanisantes d'infirmières en réadaptation selon la perception de patients: résultats et ouvertures sur l'avenir* [The meaning of the dehumanizing practices of rehabilitation nurses from the patient's perspective: Results and future opportunities]. Paper session presented at the 5th world conference of the Secrétariat International Des Infirmières et Infirmiers de l'Espace Francophone (SIDIEF), Geneva, Switzerland.
- 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.
- Buber, M. (1970a). *I and thou* (W. Kauffman, Trans.). New York, NY: Scribners.
- Buber, M. (1970b). *Je et Tu* [I and Thou] (translated from German to French by G. Bianquis). Paris, France: Aubier Montaigne.
- Cara, C. (2010). Chapitre 5 – Les fondements théoriques du Caring dans la pratique infirmière [Chapter 5: The theoretical fundamentals of caring in nursing practice]. In P. Potter, & A. Perry (Eds.), *Soins infirmiers: Théorie et pratique* (pp. 84-99). Montreal, Canada: Chenelière Éducation.
- 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 [Grasping Jean Watson's theory of human caring through reflective practice in a clinical situation]. *Recherche en soins infirmiers*, 95, (Décembre), 37-45.
- Gendlin, E. T. (1978). *Focusing* (2nd ed.). New York, NY: Bantam Books.
- Halldorsdottir, S. (1991). Five basic modes of being with another. In D. A. Gaut, & M. M. Leininger (Eds.), *Caring: The compassionate healer* (pp. 37-49). New York, NY: National League for Nursing.
- Halldorsdottir, S. (2012). *Caring or uncaring: What nursing is and what it is not – revisited*. Paper session presented at the 33rd Annual Conference of the International Association of Human Caring, Philadelphia, PA.
- Hills, M., & Watson, J. (2011). *Creating a caring science curriculum. An emancipatory pedagogy for nursing*. New York, NY: Springer Publishing Company.
- Johns, C. (2009). *Becoming a reflective practitioner* (3rd ed.). Oxford, UK: Wiley-Blackwell.
- Lambooy, B. (2006). *Devenir qui je suis : une autre approche de la personne* [Becoming who I am: Another person-centred approach]. Paris, France: Desclée De Brouwer.
- Le Boterf, G. (2007). *Professionaliser : le modèle de la navigation professionnelle* [Professionalizing: The professional navigation model]. Paris, France: Éditions d'Organisation.
- Le Boterf, G. (2008). *Repenser la compétence* (2e édition) [Rethinking competence (2nd ed.)]. Paris, France: Éditions d'Organisation.
- O'Reilly, L. (2007). *La signification de l'expérience d' "être avec" la personne soignée et sa contribution à la réadaptation: la perception d'infirmières* [The meaning of the experience of "being with" the cared-for person and its contribution to rehabilitation: The nurse's

- perspective]. Doctoral research, 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 receiving rehabilitation care: A profound, therapeutic and transformative human encounter]. *Recherche en soins infirmiers*, 103, Décembre, 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. (2011, April). Interventions humanistes de l'infirmière et sa contribution à la réadaptation : ce qu'en disent les patients [Humanistic interventions by nurses and their contribution to rehabilitation: What patients think]. Paper session presented at the 1st International Symposium on Nursing Intervention Research, Montreal, Canada.
- O'Reilly, L., Cara, C., Avoine, M. P., & Brousseau, S. (2010a). "Being with" the nurse from the patients' perspective: A phenomenological study in a rehabilitation center applying Watson's caring model. Paper session presented at the 31st Annual Conference of the International Association for Human Caring, Minnesota, MN.
- O'Reilly, L., Cara, C., Avoine, M. P., & Brousseau, S. (2010b, November). *Défis et enjeux de pratiques humanistes en réadaptation : La perspective de personnes hospitalisées* [Challenges and issues of humanistic practice in rehabilitation: The perspective of persons hospitalized]. Paper session presented at the 2010 Annual Conference of the OIIQ, Montreal, Canada.
- O'Reilly, L., Cara, C., Avoine, M. P., & Brousseau, S. (2011, April). *Être avec l'infirmière selon la perspective de patients en réadaptation : un soin qui contribue à leur autonomie et leur résilience* ["Being with" nurses from the perspective of rehabilitation patients: Care that contributes to their autonomy and resilience]. Paper session presented at the International conference "Resilience: new intervention perspectives on rehabilitation", Montreal, Canada.
- Rogers, C. (1951). *Client-centered therapy, its current practice, implications and theory*. Boston, MA: Houghton Mifflin.
- Schön, D. A. (1994). *Le praticien réflexif* [The reflective practitioner]. Montreal, Canada: Éditions Logiques.
- Sidani, S., & Braden, C. J. (2011). *Design, evaluation, and translation of nursing interventions*. Oxford, United Kingdom: Jones Wiley & Sons.
- Watson, J. (1988). *Nursing: Human science and human care. A theory of nursing* (2nd printing). New York, NY: National League for Nursing.
- Watson, J. (1999). *Postmodern nursing and beyond*. Toronto, Canada: Churchill Livingstone.
- Watson, J. (2000). Via negativa: Considering caring by way of non-caring. *Australian Journal of Holistic Nursing*, 7(1), 4-8.
- Watson, J. (2001). Theory of human caring. In M. E. Parker (Ed.), *Nursing theories and nursing practices* (pp. 344-354). Philadelphia, PA: F. A. Davis.
- Watson, J. (2005). *Caring science as sacred science*. Philadelphia, PA: F. A. Davis.
- Watson, J. (2006). Theory of human caring. In M. E. Parker, *Nursing theories and nursing practice* (pp. 295-308). Philadelphia: F. A. Davis.
- Watson, J. (2008). *Nursing: The philosophy and science of caring* (Rev. ed.). Boulder, CO: University Press of Colorado.
- Watson, J. (2012). *Human caring science. A theory of nursing* (2nd ed.). Boulder, CO: Jones & Bartlett.
- establish a relationship with her (CF4). I head over to give her a warm welcome (CF1) because I know the first contacts are critical to building a relationship of trust (CF4). I notice that she is staring blankly at the machine as though mesmerized. She seems to listen to the doctor religiously without asking any questions. I take advantage of a call received by Dr. Dupont to introduce myself and welcome her to the unit (CF1). In order to establish a secure basis (CF8), I specify to her that I am the nurse in charge of treatment for Mr. Durand (not his real name), the person hooked up to the HD equipment she is scrutinizing. Mr. Durand is a good-humoured fellow and he seizes the instant to say: "We make a good team here: everyone gets along just fine and, in the end, we're happy to see each other three times a week." I perceive that Simone is shaken by his words as her face tightens and she sheds a few tears (CF3, CF5). Moved by the scene, I say to her, as I touch her back gently: "It must be hard for you." (CF3, CF5, CF8). I see that her eyes well up once again but I cannot pursue the exchange as Dr. Dupont returns and resumes his explanations regarding how the HD unit functions. I feel the need to stay close to her like a presence (CF2) accompanying her through this painful situation. I take a quick glance toward Dr. Dupont, with whom we have worked for years, and signify non-verbally that I think my presence by her side is necessary (CF9). I perceive that Simone is tired (CF9) and has lost interest in what Dr. Dupont has to say. I offer her a chair and suggest she take advantage of a snack (CF9) that we are preparing for our present patients. She does not respond immediately, so I respect her privacy (CF1), but then I perceive a quiver of her lips and she whispers, "I'd appreciate a snack once Dr. Dupont is done with his explanation, thank you." I advise my colleagues that I'll be busy for a few minutes in the rest area with a patient who will be undergoing dialysis very soon so that they can take over the care of the patients in my charge this day (CF6). There is a certain respect (CF1) among our team to allow each of us to be in harmony with our way of conceiving care.

Appendix A

REFLECTIVE NURSING SITUATION #1 Caring moment: A moment of well-being for both patient and nurse

Simone (not her real name) is 60 years old and after years of hard work as a cleaning lady, she decides to retire. With her husband, she plans to travel the world after dedicating herself to children and grandchildren for 35 years. For the past 10 years, Simone has lived with a chronic kidney disease (CKD), which she manages most conscientiously together with her nephrologist, Dr. Dupont (not his real name). Her latest test results indicate a worrisome deterioration of her kidney function and the necessity, sooner than later, to resort to HD. Although Dr. Dupont has been preparing her for some time for this eventuality, she always hoped that she might be spared, especially during her retirement when she planned to enjoy her free time otherwise than in a HD unit. The announcement of the HD treatment comes as a shock that brings the world she had built crashing to the ground. Dr. Dupont decides nonetheless to have her visit the center and meet the care team.

My meeting with Simone

I notice Simone, petite and reserved, accompanied by Dr. Dupont in the HD unit. Dr. Dupont shows her how the HD unit functions by following a patient in my care. This affords an opportunity (caring occasion/moment) for me to

My meeting with Simone continues

I prepare our meeting place so that it is calm and soothing (I forward the phone line to the nurses' station, for example) (CF8) and I get a snack for Simone (CF9). Dr. Dupont accompanies her to our meeting and takes his leave, reminding her of their appointment the following week. This makes me understand that the date of her first dialysis has been set and that Simone now faces a quick shift in treatment (CF3). I again welcome Simone warmly (CF1), who seems to have gotten over her instant of despair. I ask her whether the tour with her doctor went well (CF5). She replies: "Dr. Dupont is a good person; he's been with me

for the past 10 years. He warned me a year ago that I might need dialysis, but I didn't want to think about it, I figured he must say that to all his patients, but here I am. . . (silence) (CF5), what had to happen happened" (CF3). I invite her to talk to me about the situation she is going through (CF5) as it is important for me and the team to get to know her better (CF6) in order to provide her with better accompaniment (CF8, CF9). I sense that her emotions are starting to build up again (CF3, CF5) and she goes silent for a long while, which I respect (CF1). I place my hand on hers in order to accompany this difficult situation (CF4). She goes on: "It's not fair. I just retired and I wanted to travel, not be stuck behind a machine. There were other things I wanted to experience, that's all" (CF5). I ask her what it means for her to undergo dialysis (CF10): "It's a prison sentence for me," she says and then goes silent for a long while. Still holding her hand, I point out to her that she has managed to avoid dialysis treatment up until the age of 60 after many, many years of living with kidney failure thanks, no doubt, to her strength fighting day after day against this insidious disease (CF3, CF7). She was thus able to avoid dialysis during her most active years, which is no small feat (CF3). In addition, I point out to her that the HD center, where she has been admitted, has agreements with other centers at the national and international levels, which will make it possible for her to travel.

I feel Simone is more reassured (CF8) but still apprehensive about procedures (CF9): "So, in the end, what happens, I mean, I saw the machine but I didn't catch everything Dr. Dupont said." Slowly, I cover at her pace (CF1) the explanations (CF7) regarding the procedures for a HD treatment and I allow her to interrupt me for further details. I explain to her (CF7) all the precautions we take during hook-up so that she is not overly frightened. I also hand her a brochure (CF7) that our team developed for new HD patients. I take a break to allow her to enjoy her snack, but I feel it might be interesting to explore her social network (CF6). I ask her whether she can talk to me about her family (CF5). "Yes, of course. I've been married for 40 years, and I have three beautiful children and ten grandchildren; that's a lot of people to take care of. I call them often, and they have been very supportive through it all." I point out to her that she has a large family and that the bond she has with them is very important in order to get through this period of transition (CF2). I propose that she return at her convenience with her husband so that he might see the center for himself and ask any questions of his own (CF7). Finally, I specify that her first day of HD treatment falls on a day I am working and that I can be her designated nurse for her first dialysis session, if it pleases her (CF4). Simone remains silent for a minute before saying to me: "Thank you for taking this time with

me (caring occasion/moment). Without you, I would have gone home sad, helpless, and angry. I feel reassured now. See you next week, then" (CF5). I understand that my caring relationship (CF4) allowed Simone to regain a certain mindbodyspirit harmony but I know, from the literature on the subject and from experience, that Simone will go through other transitions.

In sum, these different opportunities led to a caring moment that allowed establishing a deep and authentic relationship between Simone and sharing emotions, thoughts, and experiences (CF5). This relationship will be all the more useful in helping her maintain her harmony through all the transitions that she will experience following changes in her state of health (CF4). I return to my post after 15 minutes with a sense of well-being at once professional and personal.

Reflective questions

1. At what time did Simone's nursing care begin and how?
2. Can you point out the nurse's humanistic attitudes?
3. Can you identify the different caring occasions/moments and explain what characterizes them?
4. What were the nurse's humanistic interventions that fostered Simone's harmony?
5. What allows you to say that the caring relationship was transpersonal?

Author Note

Louise O'Reilly, RN, PhD is Associate Professor, School of Nursing, Faculty of Medicine and Health Sciences, Université de Sherbrooke, Québec, Canada; she is also researcher at the Centre for Interdisciplinary Research in Rehabilitation (CRIR) of Greater Montreal. Chantal Cara, RN, PhD is Full Professor, Faculty of Nursing, Université de Montréal, Québec, Canada; Dr. Cara is also researcher at the CRIR of Greater Montreal. Philippe Delmas, RN, PhD is Full Professor, University of Applied Sciences and Arts Western Switzerland, School of Nursing, La Source, Lausanne, Switzerland.

Correspondence regarding this article may be sent to Dr. Louise O'Reilly, Associate Professor, School of Nursing, Faculty of Medicine and Health Sciences, Université de Sherbrooke, Québec, Canada. Electronic mail may be sent via the Internet to louise.oreilly@usherbrooke.ca
