



## Caring Made Visible

*Kristen M. Swanson, RN, PhD, FAAN, is associate professor at the Department of Family and Child Nursing, University of Washington. She has developed a theory on the “Five Caring Processes of Nursing,” which she discusses below with Pat Jakobsen, RN, BSN, a member of the CNJ Editorial Advisory Board. Later, Mary Koloroutis, RN, MS, director of Clinical and Professional Development at 910-bed Abbott Northwestern Hospital, shares how her organization has applied the Five Caring Processes.*

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Jakobsen: Kristen, you have designed a theory that translates caring into five visible actions, or processes. Tell us about your theory and how you came up with it.

Swanson: I started with a deep interest in understanding what it was like for women to miscarry. I was a doctoral student and, when I approached my chairperson, Dr. Jean Watson, who founded the Center for Human Caring in Colorado, she told me that she would work with me if I would explore what caring meant from the perception of women who miscarried.

At the end of that study, I suggested there were five basic processes – knowing, being with, doing for, enabling and maintaining belief. At the time I defined them differently, tied to the context of miscarriage. So for example, I defined “knowing” as “describing the woman’s desire to have others understand the meaning of miscarriage in her life.” That went on to become, “striving to understand an event as it has meaning in the life of the other.” So you see the progress of the definitions – from the angle of the one who is cared for to the angle of those caring and of their intent.

The second study was a post-doctoral study done at the University of Washington, with Dr. Kathryn Barnard. The intention at that point, I had gone on to have my second child, who was not well at birth and ended up at a newborn intensive care unit. That had actually happened at Denver. I had some not-too-good experiences while he was in the hospital. Some of the difficult experiences I had were clearly related to his well-being, but the other piece of it was the nursing care I received was not everything I believed nursing could be. Since I have such a love for nursing, that was a painful thing for me to heal from, that maybe nursing wasn’t all of what I thought it could be. Once I healed a little



from that experience and had a little distance from it, a couple of things hit me. First was how much I wished that I had received the kind of caring that the women who had miscarried had described in my earlier study. Second, I began to reflect on some of the conditions that the nurses had been working under during the time my son was born. Some of those conditions included having just switched over to 12-hour shifts, such that they were coming or going to work at 3 a.m. or 3 p.m. Since many of them lived in the mountains, that meant 3 a.m. trips to work. At the same time, they had switched from a Level II to a Level III nursery, which meant that they were now getting very sick babies. My little boy, when all was said and done, would probably have been the intensity of a Level II nursery. So in the eyes of the nurses, he was not the sickest child, but in my eyes, the sickest child in the room. So I also thought that discrepancy could have played itself out in me acting as though it was the end of the world and for the nurses, this may have been a fairly routine problem. So I left that experience and decided that if I really wanted to understand what caring for vulnerable infants might be like, that maybe I needed to get several sides of the story.

So I set out to do a study of what it's like to provide caring to vulnerable infants. The people I interviewed were the care providers and I translated that to mean professional and parent providers. I interviewed mothers, fathers, physicians and nurses about what it is like to provide care for a vulnerable baby. The second study helped me further understand what caring was all about.

The third and final study involved in the development of the theory was the study of high-risk mothers. That study was about a study conducted by Dr. Barnard and her colleagues at the University of Washington. The interventions I was interested in had taken place about five years earlier and involved master's prepared public health nurses who worked with newly pregnant women who were at high social risk, determined by financial status, being single, low education and other factors they were living with and referred to Dr. Barnard's project. The purpose of the project was to help the woman to take care of herself in order that she might best take care of her infant. When I was first invited to the University of Washington, I was given an opportunity to speak to the advanced practice nurses who had care for those high-risk mothers. But when I met them, it was about five years after they had finished the study. The nurses heard me present my caring theory and they became so excited and said, "That exactly captures what we did with those high-risk mothers." There were 68 high-risk mothers and five nurses. The actual physical and verbal interventions were as varied as the life circumstances the high-risk mothers found themselves under. So when the nurses tried to classify their interventions,



they found that the caring theory made the most sense of tying together all of what they had done five years earlier. As the researcher I became interested: If this is what the providers say it involved, what would the recipients say they got?

I tracked down eight of those original mothers and to go out and interview them. To begin with, I asked if they even remembered the nurse. The answer was overwhelmingly so. The moms proceeded to tell me wonderful stories of how the nurse was there for them, strengthened them and helped them find ways to counter negative messages from their environment about how she should parent or what she should be doing about her life. The mothers would describe that, no matter how hard it got, there was my nurse and I could check it out with her and then I would know where to go next. So there was tremendous evidence that the mothers had experienced caring at the hands of the nurses that many years earlier and in fact their babies were now 5 years old and these women were in relatively good places in their lives and I could trace that back to the intensive nursing interventions.

So those three studies combined – miscarriage, NICU and high-risk moms – helped me to keep clarifying a bit further what each of the categories meant. At the end of that time, I ended up saying I had a theory of caring and I was able to publish it in *Nursing Research*, talking about how this had been developed across three different pregnancy situations. I've gone on to do some experimental testing of the theory, practice applications and other things since, but that's the story of how it got started.

Jakobsen: Could you tell us about the Five Caring Processes you developed?

Swanson: The first category, knowing, actually took me a while to see it. At the time it was identified, was “describes a woman's desire to have others understand the meaning of her miscarriage experience.” In its refined form, I describe it as “knowing is striving to understand an event as it has meaning in the life of the other.” It involves several ways of putting that desire into action.

The subcategories – or the ways that we go about knowing – is that we try to avoid assumptions about the other person. That doesn't mean we let go of everything we know about the disease condition they may be experiencing or even the typical responses people might have to a diagnosis. But what it does mean is we check out what we know and find out if it happens to be true for this individual. So for example, many women feel angry when they're first diagnosed with breast cancer. So we might ask this woman to tell us



how she's feeling or say, "This is hard, isn't it? What is this like for you?" You leave a space for her to fill in.

The next thing is we try to center on the one we're caring for. That they become the center of the conversation and they know it. That right now the whole focus is on them and their experience. We may get entréed by talking about the weather or traffic, but you shift your gaze in such a way that the client gets the understanding that right now my time and focus is for you. That lets them know you're ready to try to understand what they're going through.

Another part of knowing is assessing thoroughly, seeking what is said and not said on the client's part. Sometimes it's also probing sufficiently that you can help them come up with the words to describe what they're feeling. Sometimes so much of what we do is in our responses to the stories they tell.

"Seeking cues" is the next category and was a very interesting finding for me. That came from a year studying in the newborn intensive care unit. I would watch expert nurses with tiny babies – weighing a pound or a pound and a half. A nurse would say to me, "Oh, look at him, he's looking really stressed right now." I would see this little red baby, squeezed up, eyes closed, attached to a number of tubes and I would think, "Well, he's not crying, but..." then five or 10 minutes later, she would say, "Oh, look at him now; he looks so peaceful." Yet I would still see the same thing – an incredibly tiny baby, attached to all those tubes. I would have to say, "What do you mean the baby looks peaceful?" So she would point out physiologic cues – if the baby was laying splayed out, arms and legs out, that is a way to know that they're beyond the ability to soothe themselves. When babies can curl themselves back into the fetal position, that means they are more at peace. They are enough in control of their bodies. Or she would say, "Look, he's able to suck on the pacifier. He's calming himself down." These nurses knew how to look at physiologic cues as indicators of the babies' emotions. I did not have the trained eye to see those cues. It struck me how these nurses, by examining the physiologic cues of the infants were in essence restoring the personhood of those tiny babies and in so doing, were restoring the baby's ability to communicate, even if only through altered breathing patterns or body positioning. That's a magnificent example of striving to understand this baby's life by seeking subtle cues.

The last piece in "knowing" is that when you really begin to understand what's going on for another person, you cannot help but get yourself – your own personhood – engaged.



You cannot stand behind your professional armor; you end up being one human being relating to another. As a result, the one caring and the one being cared for are engaged.

At that point – engagement of two selves – you can't help but move on to the next level, which is “being with.” I define this as being emotionally present with another. When we're able to “be with” someone, several things happen.

First, we're able to “be there:” By being emotionally present for our patients, they get the sense that they really matter. That no matter how bad the circumstances might be, we don't abandon them. Sometimes giving somebody an extra minute and a half in the emergency says “I'm here to listen.” Sometimes it's when you're working in the middle of the night and you choose to have your cup of coffee alongside of somebody's bed instead of at the station. It's that sense that you're willing to give them time and give of yourself.

The next one is you convey that availability. Even if you can't sit for a while, you say “You know, I'm really rushed tonight, but you matter to me. Here's the call bell; if you ring this, I'll do the best I can to get to you in five minutes. If I don't here is an alternative way to reach me.” It's giving that message that you're there for them. Or, when a woman must leave for the night while her husband is in the intensive care unit, you say to the wife, “Listen, you need to take care of yourself because you're going to be much better for your husband if you have some sleep. But I know what's going to happen: You're going to panic. Call us. We're here. We answer the phone any time.” You give the sense that you understand what they're going through and that they are not alone in this. “I'm here and I'm really hanging in with you.” That's conveying availability.

Then sharing feelings – it's that willingness to smile at a birth, get frustrated with someone when they just can't take that step, it's being willing to stand alongside of somebody in rehab and see them move and shout “Yes!” with them. It's that sense that you're right there with what is happening to them. You are in it, with feeling.

But being with, when you're sharing feelings with them, it's always doing it in such a way that you are not burdening clients with your experience of their experience. The bottom line is: It is still her having the baby or him in the midst of dying, not you. It is being clear that, although you are happy or sad that this is happening with clients, you are aware that you are happy or sad *for them*. It may not always feel that way; sometimes you may feel distraught because the patient's situation brings up old issues for you. That is when we have to acknowledge our responsibility and pull out, refer the client [to another professional] until we can get ourselves together.



The “not burdening” part of “being with” calls upon providers to be self-reflective and know their limits. We need to teach students that and we need to support each other in our limitations. Also, in making our team stronger, we have to recognize that what we do is hard and we may become too engaged. We need to set up deals together: When you see me beginning to lose myself or my effectiveness, please care for me enough to make the tough call and pull me out.

You might say the occupational hazard of being with is that we might become too close. That’s part of being human. We need to know enough to pull ourselves out or have our peers ready to pull us out.

Jakobsen: That’s a good point.

Swanson: Next: “Doing for.” I need to point out that if you have successfully conveyed to the patient the message that I understand what is going on for you and it matters to me – you both know them and are able to be with them – then the actions that you do feel and are so much more relevant to the patient. “Doing for” is doing for the patient what they would do for themselves if it were possible. But doing no more than that.

The reason I say doing no more than that is recognizing that you don’t want to make somebody else dependent on you. The goal is to let them be in charge and take care of their own life, whatever their life might happen to be at the moment.

Having said that, there are times when you realize patients are capable of, say, brushing their hair. But you say, “Do you mind if I brush your hair?” and have a conversation with them as you brush. They’re perfectly capable of brushing their hair, but for you it is an act of affection or to comfort and massage; it is more from a “being with” stance. You’re not doing it because it would be so much more efficient if you grabbed the brush and did their hair.

So that’s one of the first things I say doing for involves: It involves comforting patients and maybe you can even consider whether they are capable of comforting themselves at that moment. Maybe that’s what it takes, that one of us has to step in and comfort.

Jakobsen: This sounds a lot like what is coming out of intention THEORY?



Swanson: Yes, in fact Delores Gaut, a nurse philosopher, says that if you want to understand caring, you not only have to observe the act, but you have to learn the intent of the doer. When a newborn intensive care unit nurse puts a pacifier in a premature baby's mouth, what a simple act. Clearly, it's "doing for" the baby, who can't reach over and get it, but what's so impressive is understanding the *intent* of the doer. Because prematurely born babies aren't as neurologically well developed as they could be, one of the things we recognize is that when they suck, they self-soothe. At the same time there is evidence that they are building dendrites, that by sucking, their central nervous systems become more mature. So the newborn intensive care unit nurse who puts the pacifier in the baby's mouth and returns three minutes later to change the baby's diaper actually has taken three more minutes to finish a job she could have done immediately. But she has taken the time to allow the baby to restore some energy and do the soothing for him or herself.

Another part of doing for – "comforting" – is anticipating others' needs. Setting them up to be successful. So much of what we do for people in recovery or rehab is we think about what kinds of implements or situations or environments would make them most able to succeed. We anticipate their needs and set up the environment in such a way that they can remain independent and succeed.

For example, we want to establish a routine pain-medication schedule sufficiently so the person can continue independently. That's a wonderful thing to know you are anticipating their pain. Another example is setting up the bedside table with the water and call bell close enough they can reach it themselves. We anticipate those things to set the person up to succeed.

On to "Performing competently and skillfully." I recently reviewed quantitative caring research. In 15 or so studies, nurses were asked, "Of all these caring behaviors, what is the most important to you?" Then they ask patients the same question. What's fascinating is about 95 percent of the time, patients will identify "knows how to give shots and monitor IVs" as the most important caring nursing behaviors. Nurses will say, "Listens to the patient" as the most important caring behavior. If you take the opposite end, nurses will say "Knows how to give shots and manage equipment" as one of the top five behaviors only 7 percent of the time. Patients choose "listening to patients" only 10 percent of the time as their top five behaviors for nurses. So the opposite is happening.



The problem with quantitative research on caring is that those two statements are not linked. When asked, nurses and patients will follow Maslow's Hierarchy of Needs and choose the same goal – safe, individualized care. But nurses are challenged by the acts of getting to know each pt's personal needs for safe care, whereas patients are challenged by how the foreign, highly technical equipment surrounding them will be safely used to meet their personal needs. I believe it comes down to the point of least knowledge: for the nurse, the least knowledge is, when you walk into the room fresh, it is, 'Who is this patient?' For the patient, the least knowledge is, "What is all this around my bed?" That research examined behaviors and not, as you said, intents or meanings.

After performing competently and skillfully is protecting. When "doing for" is done well, we protect our clients. It is much like anticipating their needs, but it's setting up a place where their dignity and physical well-being are preserved.

In the last part of "doing for" I use the phrase "preserving dignity." That is acting in such a way that their personhood is saved, as well as their body.

Jakobsen: Great.

Swanson: Enabling is next. I refer to enabling as facilitating the other's passage through difficult events and life transitions. How we go about doing that is through informing, explaining what is going on, supporting and allowing people to be just where they are, focusing on the issue in front of them, working with them to generate alternatives and think through how we're going to handle this now and in the future. And we validate and give feedback on how people are progressing as they learn. It's the teaching and learning component, done in such a way that we're ultimately about putting the patient or consumer back on center stage and getting ourselves out of our coaching act. It's about empowering people, families and communities to know how to care for themselves.

Last category: maintaining belief. This is called sustaining faith in the capacity of the other to get through an event or transition and face the future with meaning. Those events and transitions include episodes of wellness and illness, births, deaths and many of the other reasons we as nurses have to encounter people. When we believe in people, we hold them in esteem. We are willing to maintain a hope-filled, as opposed to a hopeless, attitude when we work with people. As best we can, we also offer optimism. And if nothing else, we go the whole distance; we don't abandon people no matter how bad the situation may get.



Recently I added “helping find meaning.” This includes affirming their experience and whatever meaning they derive. A really neat one I found in the literature was “creating memories” with people – helping them to make sacred or special what they’re going through. We focus on living while we acknowledge dying if that’s the case. We do many things in our psycho-social care – help people find peace, alleviate guilt. People even apologize for being dependent on you. Part of this “finding meaning” is working with people around their religious and spiritual needs.

Jakobsen: As nurses, we probably do this more than we think.

Swanson: I once thought that practicing in that fashion was just something about me, my upbringing and my spiritual beliefs. and not a nurse role per se. But I’ve come to realize that central to good nursing is this ability to recognize the sacredness of someone’s experience, the meaningfulness and specialness of it. I work with women who miscarry and so often I find they will describe the unfolding events as they realize a pregnancy is ending and how they go to the emergency room and have all this blood and pain and middle-of-the-night decisions – “how much blood is too much blood?” and they’re saying it in a flat voice. At some point I stop them and say, “Wait a minute. Listen to what you’re describing to me that you’ve gone through. You have been through a lot.” They just look at me. I say, “You know, when life hands us an emergency, it generally doesn’t include a blaze of light and a neon sign saying “Tragedy under way.” Sometimes it takes us so much time to name what we have been through. This is part of affirming their experience; when they can name it, feel it, identify it for what it is, they’re capable of releasing it.

When I say we offer optimism, an optimistic way of approaching somebody is with a sense that they can find meaning in what they’re going through.

After having gone through the categories – knowing, being with, doing for, enabling and maintaining belief – the impression would be that I see maintaining belief as the end of it. In fact, I believe it’s the beginning of caring. Maybe what brings us to nursing is our belief in people, our ability to hold them in esteem and see them as persons of dignity and worth. When we say things like, “I’m a people person and I want to make a difference,” I think what we mean is that we believe in people. We see life, death and illness as meaningful, transitional events. Why else would you choose to make your living being next to people in pain and difficult times?

Why do we stand by a parent whose child has been diagnosed with an end-stage disease? Why do we stay and start talking about the child’s play needs or teaching needs, or the



family's needs? We do this because we see a tomorrow, even if it feels like the end of the world for the family whose child is about to die. Without explicitly saying to the family, "Here is what your tomorrow looks like," we move right away into teaching modalities. We talk about comforting, maintaining the child and the human growth and development needs. The family gets the unspoken message that there is a tomorrow and that tomorrow will still have meaning. I believe that's what motivates nurses to act in a caring fashion: We believe in people and their right to get through events and transitions and find meaning. That's what gets us started and if we truly feel that way, then we're going to try to understand what it's like for this person and treat them as though they matter.

When patients and families know that they are understood and that they matter, then those visible actions – the “doing fors” and “enablings” – can occur. Many people think those “therapeutics,” if you will, are solely what nursing is; they miss those behind-the-scenes parts of caring – maintaining belief, knowing and being with. Those are the things that I think set up enabling as relevant and contributing to the client's well-being.

Jakobsen: Kristen, that's wonderful. You've kind of answered this question as an undercurrent, but I'm going to ask it. You told us how you picked these three groups of people, but I also want to know, what was the impact on you as a researcher working with them?

Swanson: I have been working with women who miscarry for 15 years. I want to back up a bit and tell you about the intervention study I did.

My goal was to understand the impact of a caring-based counseling program on women's healing the first year after miscarrying. That put me in the position of consciously conducting a caring-based intervention. About 240 women were enrolled, so about 120 of them got the intervention. I met with each of them for an hour three times to talk about what miscarrying was like for them. What's fascinating is when I did this, I myself was going through a significant loss in my life, a divorce. In that counseling, I learned how healing it was for me to see the strength of people to confront the situation, courageously talk about it, cry about it, let all these feelings flow and then be able to name what they went through.

I talked with them within a week of the loss. They came back for a session in five weeks, and a third session five weeks later. So each session would be like little boiling chips to get their feelings to come to the surface. After that, they would work on the healing. I got to watch every five weeks where they were with their healing process. It was humbling



and invigorating and empowering for me to see the strength of, in this case, women's spirit. It made me realize no matter how tough something looks, I should not be afraid of somebody's deep and full feelings because getting them out is a courageous act on their part and it is what allows their healing to begin. I got to witness that every five weeks and then I got the birth announcements nine months or two years later, depending on what happened with that family.

So for me, I was empowered and strengthened. I became deeply spiritually aware of my gifts and the fact that I believe we all come to this earth with a certain amount of grace and gifts and a certain contract with the universe of what we're supposed to fulfill. When I was doing my counseling work and now, with my research, and I see the audience's reception, I get the sense that I'm exercising my gifts and maybe I've been a pretty decent steward of the gifts that I was given. I've been lucky enough to get to exercise it.

Jakobsen: You've touched our hearts.

Swanson: That's what I hope for everybody to know about doing their work. When you do it and you get that high, that grand feeling about yourself, then you know you are a steward of your gift.

Jakobsen: I have one logistic question for you. When you were interviewing the women who miscarried, about two-thirds of the way through you said you found your initial questions on caring behaviors naive. How did that become apparent?

Swanson: For my dissertation, I planned to interview 20 women for my dissertation. When I was about 15 interviews into my study, I went to see my chairperson, Jean Watson at the University of Colorado, to talk to her about my findings. When I went to visit with Jean and I described what it was like to miscarry, she had tears in her eyes and kept saying, "This is so rich!" So I knew I had gotten it. Then she asked about the material on caring. I began to list for her: It means listening, giving time and I had all these behaviors. And I'll never forget the look on Jean's face; she was clearly unimpressed. She said, "You don't have it." I walked out of her office feeling empty and wondering what I would do. I only had five more women to interview and if I haven't found it in the first 15 am I ever going to see this?

The next day I interviewed my 16th informant. She had a toddler, but had had a still birth and a miscarriage, which brought her into my study. This woman could talk and talk about her miscarriage; we had a magnificent interview. We went out to the sandbox with



the 2-year-old and I carried the tape recorder. We were so at home and this woman told me one story after another. Just before leaving, I asked if she'd mind if I looked at my questionnaire. I pulled out my caring questions and I said to her, "Would you do me a favor? Would you tell me some of the things that people said or did that made you feel cared for or cared about?"

She looked me in the eye and said, "I've got to tell you the truth. When you invited me into the study and said one of the things we'd like at was caring, I almost turned you down because if you're asking me to tell you what people said or did, I don't know that I can remember them. I suppose if you really need me to so you can fill out your questionnaire I can come up with something."

I was frozen in place. Suddenly I looked at her and said, "If you can't tell me the words and behaviors, can you tell me the message you got and how they reacted to you?"

She said, "You want messages instead of words and behaviors?" She looked at me and her eyes welled up with tears and she said, "You know, you need people to understand that it really, really hurts." I burst out crying. I hadn't cried in any of my interviews – all those stories of pain. But I finally got from her that the point was she needed to be understood. After that, the rest would come.

So at the time, I called it knowing: She wanted others to know what she'd gone through. All I can tell you is once I saw that she wanted somebody to know what it was like for her, the rest of the categories fell like dominoes.

The "maintaining belief" category was the hardest for me to name, though. I think it was the 20th woman, an African-American woman. I was awkward as I interviewed her – a Caucasian woman interviewing an African-American woman. she told me the most awful thing you can get is when somebody says, "Oh, forget it. You just can't try again. Give it up." What you need is somebody encouraging you to try again. Even as she said it I was confused because so many women had told me about a neighbor or someone telling them, "Oh, that's OK. You can try again." I heard that from so many women, yet this woman told me the worst thing is someone not telling you to try again. I was confused, but I didn't ask her on the spot. Later, I asked, "What you said was you want people to tell you to try again." And she said, "What I want is for them to offer me a little hope. I don't want somebody to say, 'Just hang it up. You're done.' I just want people to offer a little bit of hope." So I realized, again, the intent of the doer was that when somebody says they listen to you, they understand you, they're emotionally present to you and then they reach over



and hold your hand and say, “This hurts now, but you do have a future. You *can* try again.” That’s the difference saying, “You’re young; you can try again.” It’s the intent of the doer, the one caring, that matters.

So out of her conversation I got that she wanted people to believe in her, not just to try again, but that ultimately she will do whatever is the right thing for her to do. An important part of caring is that we believe people will get through this. If they don’t it is between them and their maker because there are limits to what we can do. We have to accept that. And it’s not a despairing thing if there are limits to what we can do. For me, if I have in mind that there is a grander scheme than anything that might happen in our earthly existence, it is another way for me to continue to believe that things ultimately will be OK.

Jakobsen: My last question: How did you envision the model being used by the practicing nurse – and how do you see it being used?

Swanson: I have to tell you I’m still amazed when I hear anybody uses it. Just amazed.

How do I see it being used? I think it could be two conscious templates in the back of someone’s head as they’re practicing. Maybe not consciously as they’re practicing, but as they’re reflecting on their practice later. I could see it being a way of making sense of what they did. I can see it in care planning, for example, if you are writing a protocol on, say, counseling breast cancer survivors: You would scan the research on what people typically go through when they survive breast cancer. What are the walls they come up against? What are the growth experiences inherent in healing from breast cancer? After a good literature review to know what’s ahead, then in terms of your “knowing” – trying to understand what it’s like for Mrs. Smith who is sitting in front of you – you would call up the two templates. First, the caring template, which says it’s important for me to begin with the desire to understand what she’s going through and avoid assumptions, but at the same time not denying all the work you just did to figure out the pitfalls or wonderful moments that lie ahead in this healing. So you use your book learning, your lit reviews, if nothing else your experience working with these clients for years to direct the informed questions you ask and get to the heart of the matter.

The other knowledge is the conscious attempt to be caring. Even as you’re designing your teaching strategies – the learning needs of a postpartum mother or of someone with newly diagnosed diabetes – will all be based on the template of the knowledge of the disease process and then lining up how I’m going to set up my conscious caring. So it is



how the two of them come together. It's a way of practicing and blending that with an expertise of a disease and its healing trajectory.

For research, wouldn't it be wonderful if all of our nursing research studies were lined up in such a way that we were to talk about the doing-fors and the enablings as a way that we're approaching our nursing interventions? I think by consciously using that language in our research, teaching and practice, we could illuminate what nurses' work, how essential it is and what it costs. But until we bring to the foreground the language and the actions of caring. ... We have the meanings, now let's fill in the actions – and then fill in the costs and identify what it takes to get those caring actions done. I wish the profession would make a conscious attempt to blend our practice, language and teaching with that vocabulary.

I guess I would say the knowing, being with, doing for, enabling and maintaining belief is a catchy enough five-part process that we could hang our everyday language on those five categories. If we just made a point of coming back and saying, "When I'm assessing thoroughly, I'm trying to know what it's like for this person. ..."

Jakobsen: Yes. If you hadn't said it, I would have. That leads us into our question for Mary Koloroutis: How are you using this model and what is the nurses' reaction to it?

Koloroutis: I would like to start with our organizational nursing philosophy, which we wrote in 1989. Called "Advocacy through Caring," it is a philosophy that grounds nursing practice in our organization in caring and helping people maintain health, affecting healing and adapting to stressful experiences and supporting a dignified death. It is founded in a nurse-patient relationship based on personal presence and rapport. We define it as acts and attitudes of critical thinking, clinical competency, compassion and respect, and listening and acceptance.

We maintain this philosophy even within the shifting healthcare environment. This includes the institutional business pressures and changes we were experiencing when we drafted the philosophy and that we continue to experience. It evolved out of a post-downsizing event where a group of nurse leaders gathered and said, "This was incredibly painful. We want to be team players, but we believe we have a serious obligation to make sure we are safeguarding care to patients. How do we know decisions that we are making for increasing efficiency, effectiveness and productivity in the organization are not going to run counter to good and safe patient care?" These events stimulated our drafting of this philosophy.



Our next step after we outlined what we believe about caring was how to support its intentional implementation and integration into our daily practice. We drafted a vision saying that each nurse will live our philosophy in practice every day. Another quote, by Bonnie Wesorick [developer of the Clinical Practice Model and founder of CPM Resource Center, Grand Rapids, Mich.] has driven us in recent years: She said that caring will never be the essence of nursing practice unless it is a norm in daily practice within organizations. When you ask nurses what the essence of their practice is, caring comes up as number one. Yet organizations are not set up around a caring framework, but rather around a systemic fragmentation or division of work. Nurses have had to survive and ensure caring within that context. When you look at what is spoken about day to day, what is visible, the essence of practice – caring – is not there. It is about tasks, productivity and efficiency.

We wanted to make visible what we know we all hold dear to our hearts and believe in, and we wanted it to be strategic, intentional and evolving over time.

One of our first strategies was to design a development program or retreat for nursing staff that would reconnect us with the reason we entered nursing – pride in practice. We wanted a program to help us stay in touch with who we are as human beings so that we can be fully human to another. A program to give us a chance to interact as colleagues and reinforce the power in collegial support and processes and to create a shared vision that would carry forward caring and healing as the essence of our practice. It was within the context of designing such a program, which we called Personal Mastery, which six of us consulted the literature and found Kristen’s work.

What jumped out to us immediately was the fundamental truth of the work. Second, it met “pragmatic” criteria. We know that for practicing nurses, theoretical constructs are something they may consult at various points in their career, but not day-to-day when they are with patients. As you said, Kristen, we wanted them to have that template in their heads. How could we provide the resources for them to carry with them and have access to it during day-to-day decision-making? Kristen’s processes met those criteria.

We integrated her framework into our curriculum. Our retreat is three days and her framework drives the second day, the time we spend looking at our practice. Since our first retreat in 1992, we’ve integrated the caring-practices framework by bringing patients and families in to tell their stories about their care experiences – what constituted a caring experience and what did not. Patients and families tell their stories to the entire



group and then interact with small groups of nurses and other professionals. They engage in a dialog about what really mattered for them when they were experiencing their illness. Over and over, we found the Five Caring Processes being reinforced.

Kristen, your mention of the quantitative research on competent technical behavior interested me. At our retreats, patients and families never bring up a really great shot or IV start as a caring behavior. Instead, we have found they expect that as a foundation. When it comes up in their stories, it has been more around times that they experienced incompetence or clumsiness around the technical act. But then it always moves to the poor interpersonal relationship that accompanied the act that made the patient feel isolated, misunderstood and not seen. They tell us over and over that their top needs are to be seen as a human being, heard and understood, which is consistent with the work you have done.

The other way we have integrated the Five Caring Processes framework is our clinical orientation program, with caring as the core component. One of the most pragmatic and effective ways is through our Nursing Practice Board. In the last two years, the board has been set up to monitor and regulate nursing practice and assure the best practice possible. Clinicians bring in practice stories to case reviews – either best practice or areas of concern. We use the five processes as the reflective framework to evaluate the case. That has been effective; it is familiar and people can really work with it.

Another application I feel particularly proud of is that our system, Allina Health Care, has drafted guiding principles for corporation-wide ethics. One of the principles is caring – which in and of itself feels pretty terrific. Within that description, we talk about the principle of caring that requires a responsiveness and a sensitivity to the whole person, to individual circumstances and to relationships, as well as to the caregiving required to meet a person's physical needs. "Caring is valued not merely as a means to an end, but as a process with inherent moral significance which transcends the goal of caring. Nurse scholar Kristen Swanson has identified five processes of caring. ..." The five processes follow. I want you to know, Kristen, that you are the only named scholar in this entire document.

We started using this at our facility as a reflective framework in case reviews. We look not only at clinical cases, but we have just restructured our ethics committee to include an organizational ethics arm. Our case reviews include a reflection on caring, presence and the implications of caring behaviors and interactions.



As a core of our work, caring is intentional. As we introduce it, we talk about caring as not just about being nice; it is knowledge-based, grounded in research and it is an intentional and deliberate act, with the well-being of the other the focus of that act. It has taken away the trivial description of caring and recognized it as foundational and knowledge-based.

Just a P.S.: Because we are a corporation, your framework is also inside the nursing philosophy at United Hospital in St. Paul and at our 14 regional hospitals. That has come through a partnership to determine consistent practice. I see that strengthening. Our system-wide Patient Care Council is looking at a systematic approach to nursing. We found that your framework is one of the core commonalities we have. I anticipate we will build on that in the next few years.

Jakobsen: What is the nurses' reaction to this?

Koloroutis: The nurses and other clinicians who attend our Personal Mastery Program are very positive. It makes sense. It is pragmatic. They can engage quickly in conversation about it. They seem to reflect on its ultimate truth. I think the methodology we use helps, which is first having patients share their experiences and then linking the framework with what the patients already told us. When we do post-reflection on their stories and put the framework up there, they start to put in specific examples the patients have given us that fit into the five processes. It's an effective way to leverage it.

Koloroutis: Kristen, one of the things that struck me: We describe "maintaining belief" and "knowing" as the foundation or philosophical basis. "Being with," "enabling" and "doing for" are more interventional. It is interesting as I listen to you, you cluster them. ...

Swanson: I see the "being with" as the bridge between what is going on in the nurse's head and the visible acts of caring. It's the place that legitimizes, in the patients' eyes, any actions we do afterwards. It is because they sense – on that "being with" scale – that they matter. Only after that do our actions count, even when we do them a little clumsily.

One thing I wanted to share with you all, remember I said I did this large literature review on caring research. One thing I came up with was a compilation, according to about 60 different qualitative studies, on the consequences of caring – what happens when caring is enacted. It was 1,185 participants across 30 different research studies.



For the clients, this is what the outcomes of caring are: emotionally and spiritually they have enhanced self-worth, self-knowledge and coping; increased well-being and quality of life. They feel reassured, confident, and good, have gained control, independence and power and feel sustained. They also cite positive mental attitude, uplifting consequences,

satisfaction and so forth. Physically, they feel enhanced healing, they feel safe, as though their life has been saved. There were decreased costs and lengths of stay. They feel the care supports their current energy level and increased their physical comfort. They noted better coordination of care. Socially, they have the sense of having participated in a meaningful, reciprocal relationship. Families are empowered and less dependent. They feel they can trust somebody, that there is somebody they can count on. And caring made them feel decreased alienation from the healthcare system.

Alternatively, client outcomes from feeling as though someone did not care include: feeling humiliated, frightened, out of control. Clients feel despair, helplessness, alienation, vulnerability, with lingering bad memories and decreased physical healing.

The nurses' experience of participating in non-caring relationships included feeling hardened, oblivious, robot-like, depressed, frightened and worn down.

Conversely, for nurses the outcomes of caring – that is, how it feels for a nurse to practice in a caring fashion – includes: A sense of accomplishment, self-satisfaction and having a purpose to his or her own life. They experience a sense of gratitude, well-being, wholeness, self-transformation, respect for life and an awareness of their own mortality and an ability to look inward. Professionally, they feel enhanced intuition and professional judgment. It increases their skills and knowledge and mobilizes more caring, while they feel increased empathy and make fewer assumptions about the way the world is. They cite satisfaction, love of nursing, and finally, a sense of collegiality, connectedness and of having a relationship with the patient when they can practice in a caring fashion.