Caring is a critical concept in nursing and healthcare. The authors in this column examine the significance of caring science as developed by Watson to nursing practice. In this piece, Jean Watson discusses the significance of caring for healing and Barbara Brewer describes the application of the model in a magnet hospital practice setting. Jean Watson is a Distinguished Professor of Nursing holding the Murchinson-Scoville Endowed Chair in Caring Science, University of Colorado. Barbara Brewer is the Director of Professional Practice at the John C. Lincoln North Mountain Hospital, Magnet designated since 2004. Dr. Brewer has been a proponent of Watson’s theory and used the approach to give voice to nurses’ caring practices. She is a Magnet Hospital appraiser and has been a nurse leader for more than 30 years. She served as vice president for quality at Clarian Health. Dr. Brewer has been a member of International Caritas Consortium since 2007 and is an advisory board member for research for the Watson Caring Science Institute.

Pamela Clarke (PC): Dr. Watson, would you discuss the most significant impact of your theory over time on nursing practice?

Jean Watson (JW): As evidenced with the latest developments in professional nursing practice and theory-guided practice models, caring theory/caring science and caritas nursing models are increasingly prominent. The frequency and number of Magnet hospital’s use of caring theory as one core Magnet criterion, is evidence and testimony of caring theory and its impact on nursing over time.

As nursing advances, matures, and evolves in its higher/deeper consciousness, of its timeless mission and covenant with society, for sustaining humanity, it will continue to awaken to the essence or core of human caring. Caritas nursing is making new connections between caring and love becomes the energetic basis for sustaining humanity. It is

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from this deep caritas perspective and moral foundation of caring that nursing honors its commitment to offer compassionate human caring to society and humanity.

The most recent developments in caring-theory-guided practices are manifesting, not only through the Magnet hospital initiatives, but in the developments through the International Caritas Consortium (ICC). This is an invited network of hospitals, educational program representatives, and individuals, authentically committed to expanding and implementing caring theory/caritas nursing. The gatherings are creating safe space with like-minded others and myself, whereby individuals are able to explore and experiment in deepening the practices of the human dimensions of caring-healing, returning to heart-centered-loving practices.

These caritas gatherings are sponsored by hospitals that are dedicated to authentically implementing caring theory and healing models for staff as well as for patients. Some living examples of these committed systems are the ICC sponsors over these past few years. They include:

- University of Colorado College of Nursing and selected hospitals
- Miami Baptist HealthCare System Miami, Florida
- Resurrection Healthcare, Chicago, Illinois
- Inova Health, Fairfax, Virginia
- Central Baptist Health, Lexington, Kentucky
- Scripps Health, La Jolla, California
- Bon Secours, St. Mary’s Hospital, Richmond, Virginia
- Scottsdale Health, Scottsdale, Arizona
- Jacksonville Baptist Health, Jacksonville, Florida
- Bon Secours St. Francis System, Charleston, South Carolina
- Wyoming Medical Center, Casper, Wyoming

Upcoming sites (2010-2011) are:

- Kaiser Antioch, Antioch, California
- Chesapeake Regional Medical Center, Chesapeake, Virginia
- Winter Haven Hospital, Winter Haven, Florida

Many of these systems are recognized as Magnet hospitals, or are on the journey toward Magnet. Each of them is authentically committed to implementing and living out caring theory as the professional model for nursing and their entire system. These Web sites, www.watsoncaringscience.org and www.caritasconsortium.org were created to provide information for professionals.

PC: To what extent has your approach in caring science helped to develop the concept of caring for nursing as a scientific discipline?

JW: I think this is something that only time will tell, in retrospect, rather than knowing the influence at this point in our history. On the other hand, there is increasing attention and commitment to developing and practicing human caring as an ethical, philosophical, as well as theoretical model for nursing and beyond. The developments, highlighted in Question 1 above, provide beginning evidence of how caring science and caring theory is influencing nursing as a whole.

The American Association of Colleges of Nursing (AACN) document: “Essentials of Baccalaureate Education for Professional Nursing Practice” (AACN, 2008) states that “the generalist nurse practices from a holistic caring framework. Holistic nursing care is comprehensive and focuses on the mind, body, and spirit as well as emotions” (p. 9). This inclusion of caring framework indicates how caring is acknowledged as a framework for nursing, attesting to how this concept is affecting nursing as a whole. “The literature on caring from the field of nursing is the most prominent source of work on the epistemic and philosophical-theoretical nature of caring” (Watson, 2005, p. 17); even though increasingly other disciplines are interested in the phenomenon of human caring in relation to healing, healthy communities, and even peace (Watson, 2005).

Other developments, during the past decade or so, have included some of the following:

- Endowed Chair in “Caring Science” (University of Colorado College of Nursing);
- Non-profit foundation: Watson Caring Science Institute;
- Academic structures and departments which contain nursing, named caring science (Sweden and Finland);
- International journals with focus on caring: Scandinavian Journal of Caring Science and International Journal of Human Caring;
- International professional organization: International Association of Human Caring;
Key recommendations for caring as the core concept for nursing in national reports for example, American Academy of Nursing (AAN) Wingspread conference;

Curricular criteria (new AACN essentials document, noted above) and National League for Nursing standards;

Developments in academic discourses such as the definition of nursing: “caring in the human health-illness experience,” acknowledging an evolving unitary paradigm that unites and integrates some of the ontological-epistemic dialectic including caring in nursing (Newman, Sime, & Corcoran-Perry, 1991).

PC: There is some discourse about whether caring science is uniquely nursing. Was it your intent with your model to focus broadly on caring/healing in healthcare rather than nursing per se?

JW: My focus has been on nursing in relation to its covenant to offer compassionate human service to sustain and preserve human dignity and humanity; to sustain caring in instances where it is threatened, biologically or otherwise; a concern with deep caring-healing relationships with humans who are experiencing suffering, loss, grief, death, change/transition with life threats and challenges, and seeking meaning to be in right-relation, harmony with self and other, and that which is greater than human. Thus, my focus on caring, and caring-healing relationships, emerges from within the discipline of nursing and the practice of professional nursing; but paradoxically transcends nursing. Thus human caring-healing and caring science is increasingly grounded in the discipline of nursing, but becoming transdisciplinary, whereby nursing’s ontological-epistemic and praxis focus on caring is relevant to all health, healing, and human service practitioners and scholars.

To summarize this I quote from my earlier work:

This theory/philosophy involves making explicit human caring and relationship-centered caring is a foundational ethic for healing practices; it honors the unity of the whole human being, while also attending to creating a healing environment. Caring-healing modalities and nursing arts are reintegrated as essentials to ensure attention to quality of life, inner healing experiences, subjective meaning, and caring practices, which affect patient outcomes and system successes alike.

This work places human-to-human-caring as central to professional nursing responsibilities, the role and moral foundation for the profession. Preserving human dignity, relationships and integrity through human caring are ultimately the measures by which patient’s evaluate their often-cure dominated experiences. (Watson, 2005, p. 51)

Thus, this perspective on caring is embedded in nursing and its maturing/evolving as a distinct unitary caring science discipline and profession. As nursing embodies caring science as an ethic and practice focus, it is increasingly relevant to all health professions. Indeed, the early interdisciplinary recommendations from the Pew-Fetzer project (Tressolini & Pew-Fetzer Task Group, 1994) in which I was involved acknowledged this relevance to all health professions. I quote:

The central task of all health professions education—in nursing, medicine, dentistry, public health, psychology, social work, and the allied health professions—must be to help students, faculty, and practitioners learn how to form caring, healing relationships with patients, their communities and with each others, and with themselves . . . the knowledge, skills, and values necessary for effective relationships . . . . Developing practitioners to mature as reflective learners and professionals who understand the patient as a person, recognize and deal with multiple contributions to health and illness and understand the essential nature of healing relationships. (p. 34)

PC: Could you describe the impact of caring science on global health: What has been the international impact of caring science on nursing?

JW: In addition to the above discussions offering evidence of caring science developments, and manifestations of caring theory in practice, there is a ground swell of global initiatives in caring science in education and clinical setting worldwide. For example, my invited connections with colleagues in diverse cultures and locations in the world, just over the past decade or so, have included core caring science workshops, keynotes, and programs in some of the following countries: Australia, New Zealand, Japan, China, Hong Kong, Taiwan, Canada, Lebanon, Denmark, Indonesia, Norway, The Netherlands, Finland, Sweden, Scotland, Germany, Wales, Venezuela, Brazil, Peru, Jamaica, Colombia, Portugal, Spain, Madeira Island,
Portugal, Azores, Portugal, Italy, Ireland, Greece, England, and Mexico among others. Colleagues from around the world attend my intensive caring theory seminars, as part of the International Certificate Program in Caring-Healing, offered in May of each year at University of Colorado (www.nursing.ucdenver.edu/caring).

Nurse educators and nurse professionals worldwide are seeking more authentic practices, giving meaning and purpose to their professional lives and work. Much of this changing consciousness has been triggered by the nursing shortage, nursing despair over system demands, as well as an awareness of a lack of human caring in our personal/professional lives, and in both systems and society.

Nurses universally appear to be torn between the human caring values and the calling that attracted them to the profession, and the technologically, high paced, task-oriented biomedical practices and institutional demands, heavy patient load, along with outdated industrial practice patterns (Watson & Foster, 2003). It has been reported in some comprehensive summary research that nurses who are not able to practice caring become hardened, brittle, worn down, and robot-like (Swanson, 1999).

As nursing evolves in its consciousness of its very foundation of human caring, which has to be further developed, educators, practitioners and health systems worldwide realize radical change from within is an essential and necessary requirement to reverse the non-caring trend many experience in hospitals and healthcare in society today. In other words, all the change approaches to date, attempt to solve the healthcare crisis in the United States of America and other Westernized countries by focusing on external issues and forces. These include such system solutions as economics, technology, management-organization, access control, and environmental hospitality models. Other proposed solutions focus on nursing recruitment and retention, better compensation packages, signing bonuses, relocation fees, and hiring increased numbers of minimally-educated laypersons or assistants. These tactics comprise superficial and short-term approaches. What caring science and nursing offer universally is a deeper, moral, philosophical, knowledgeable, value-based approach relevant to sustaining the integrity and dignity of humanity worldwide as well as the profession of nursing.

The most fundamental resource and the most precious and powerful source for authentic reform/ transformation of hospitals and clinical agencies is competent, compassionate, knowledgeable, and caring nurses and health practitioners. Nurses and practitioners who are literate with caring relationships are capable of having loving, heart-centered compassionate, kind, and sensitively meaningful, personal caring connections with an increasingly enlightened humanity.

PC: Dr. Brewer, would you discuss nursing practice in your hospital using caring science and talk about the process by which your hospital decided to use and implement Watson’s theory and philosophy as a practice model?

Barbara Brewer (BB): I began working at John C. Lincoln North Mountain Hospital 4 years ago. When I arrived I observed a solid caring culture from all levels of the organization. As a Magnet hospital, we are always looking at opportunities to grow. One of the areas where I thought we could become stronger was in our professional practice model. During one of our shared leadership meetings our chief nurse distributed an article on caring. The staff nurses were very excited about using a caring framework to guide their practice. As a result, I pulled together a group of bedside nurses, clinical educators, and managers to review different caring theories to evaluate whether we might recommend one for adoption by the nursing leadership team. We began by looking at all the caring models and thought that Watson’s model might be a good fit. Many of our nurses are in school and had studied Watson’s work in their theory course. We reviewed many pieces of literature before deciding on two articles for all nurse leaders to read before the presentation. At an all-day nurse leadership meeting we presented an overview of Watson’s model. There were about 80 nurses in attendance representing senior leadership, managers, charge nurses, shared leadership chairs, educators, and team leaders. The group agreed by consensus that Watson’s model would be a good fit for our hospital and agreed with our recommendation to adopt the model as our professional practice model. They pushed us one step further. They recommended that we consider inviting our interdisciplinary colleagues to consider adopting the model across all disciplines.

The next step was to pull together an implementation team. We invited our chaplain, a respiratory therapist, the director of housekeeping, and nursing
staff to help us design implementation. Together we developed educational strategies for staff illustrating the integration of caring theory with our values. We demonstrated how caring was already present in the environment. We then looked at carative factors and used pictures and stories to help explain the concepts. The team decided to begin the educational rollout with nurses during nurses week. In addition to the educational sessions planned by the implementation team, nurse managers were asked to do something special during the week. The implementation team provided them with options, such as dimming lights during peak activity, asking staff to share something special about one of the other staff during team gatherings, or anything else of their choosing that exemplified staff caring for each other.

It was at about this time we were very fortunate to have the opportunity to hear Dr. Watson at a nearby health system in Scottsdale. A number of those responsible for implementation heard her speak and were excited about the path we were taking. It was a great opportunity for leaders to hear her. A year later she came to Lincoln. Dr. Watson has presented at the hospital twice.

**PC:** How was your leadership important to developing the model in practice?

**BB:** Since implementation of Watson’s theory, we have planned many activities to continue to raise understanding through education and dialogue. Conversations about caring happen at council and staff meetings and are included in our annual competency process. We have also added an award for a nurse and an interdisciplinary staff member who best exemplified caring as expressed by the caritas processes during the previous year.

As a leader, my goal is to bring meaning in many ways. It is always a challenge to translate abstract language used in theory to language used in everyday practice. Several activities have centered on translation, which included building a word table using caring as the framework, power point presentations using art, personal stories illustrating practice examples of caritas processes, and our circle of light retreats.

We believe that before we can care for others, we must care for ourselves. The circle of light is an example of how the theory can be used in practice to demonstrate caring for the caregiver. The circle, held quarterly, consists of a 2-hour retreat focused on reigniting each participant’s passion for caregiving.

The idea came from my work at Clarian Health Partners and the Caritas Consortium. Clarian leadership held regular multi-day retreats focusing on care for caregivers. Persons who attended were very positive about the experience and returned with renewed passion for their work. Then at a Caritas Consortium meeting a leadership team from Jacksonville Baptist Health described a similar program. They gave me the idea to try something within our hospital. We could not afford multiple day retreats, but I felt we could do something. At first we called it a caring tea, but some of the men did not feel like a tea was something they would attend. So we changed the name of the event to the circle of light. The event is hosted by members of our implementation team who bring in various teas and treats. We schedule about 2 hours and nurses from all units participate with about 20 individuals attending a session. We encourage all staff to attend, but began with our registered nurses. We ask them two questions, “Why did you become a nurse,” and “Describe a particular patient who has been important in your career.”

We gather in a meeting room located on campus but outside of the hospital. We transform the room with low lighting and some personal items such as scatter rugs and candles. Tables are covered with cloths and one of our team members folds cloth napkins to resemble candles. Individuals arrive to soft background music and are asked to join us for some tea and a pastry. Once participants have had a chance to engage with each other, we move to the other end of the room where we have chairs placed in a circle. We organized the event in this way because we did not want late arrivals to disrupt the experience for the other participants.

We begin the circle with a centering exercise. I lead the centering meditation with a singing bowl made specially for the Watson Caring Science Institute. The bowl is tuned to the vibration of the heart. The chaplain speaks briefly about laying of hands and Nightingale’s work. At the end of his presentations he asks each participant to draw a silver circle containing a single word from the bowl he brings for the occasion. Each person can either share their word or not, depending on their preference. Everyone gets to keep their circle as a souvenir of their participation. Everyone is always amazed at how their energy attracts a word that is most meaningful to them. Then one of our clinical educators who organized the circle invites participants to
answer the first question. Each time we have done this we have learned that many participants did not come to nursing as their first career choice. For some it was a career guided by parents, for others it was a second career, and for still others it was a calling from childhood.

The sharing is very significant to the participants and creates a certain bonding. We all leave knowing something about others’ most memorable nursing moments and we feel closer. This program is one of the concrete ways the agency demonstrates the concept of caring for the caregiver. We were very fortunate to have Dr. Watson join our circle during a recent visit in March. She honored us by leading the centering exercise and blessing our singing bowl.

At our spring 2008 Caritas Consortium, Dr. Watson launched the Watson Caring Science Institute, an international non-profit foundation created to advance the philosophies, theories and practices of Watson’s human caring. In October at our fall meeting, the Watson Institute began a caritas coach program. I was fortunate to be selected to be a member of the first cohort. The training includes 4 days of intensive didactic content with faculty selected by Dr. Watson. Coach training occurs over a 6-month period. During the 6 months, participants are expected to complete provided readings, participate on conference calls, journal about their coaching experience, complete at least three reflective narratives, and a project, which is culminated with a poster presentation at a Caritas Consortium meeting. My project was a book, A Caritas Journey (Brewer, 2009) that I created to illustrate caring through art as an esthetic way of knowing. Caritas process concepts are illustrated through my photographs and words selected to clarify and translate theoretical language. We use the book with our staff to stimulate dialogue on the essences of Watson’s work.

PC: I am aware of the database evolving from the practice setting. Can you tell me about your research on the caring database?

BB: Dr. Joanne Duffy invited members of the Caritas Consortium to be part of a pilot study to evaluate the feasibility of building an International Caring Comparative Database (ICCD) using her 36-item caring assessment tool (Duffy, Hoskins, & Seifert, 2007). The tool measures eight dimensions of caring, mutual problem-solving, attentive reassurance, human respect, encouraging manner, appreciation of unique meanings, healing environment, affiliation needs, and basic human needs. Members who wished to participate were asked to pay a small fee to cover the cost of building the database and writing quarterly reports for each participating hospital. Each participating hospital was asked to select a coordinator who would be trained in the study procedures by Dr. Duffy and would then be responsible for organizing quarterly data collection and entry for their site. Members from 12 different hospitals participated. I was the coordinator for our hospital where we collected data from patients admitted to 10 of our inpatient units. To be included in the sample, patients had to have been on the study unit for a minimum of 24 hours and cognitively able to complete the survey. Coordinators were allowed to organize data collection in a manner that worked best for their organization. I invited members of the clinical research team and our caring implementation team to be our data collectors. I thought data collection would provide them with the chance to learn about the research process while helping us to understand the level of caring perceived by patients. Data collectors, all nurses except for one respiratory therapist, were assigned to a single unit, but were never assigned to a unit where they provided care. I am a co-investigator on the project with Dr. Duffy. All data were submitted to me electronically from each participating hospital. My role has been building the database and doing the statistical analysis for the project. We have completed the pilot, which consisted of four quarters of data collection, and are in the process of doing our final analysis. Our goal is to submit a manuscript for publication within the next few weeks. We will evaluate the reliability and validity of the instrument using the complete data set as well as evaluate changes in facility scores over the four quarters.

PC: Would you address the international impact of Watson’s model from a practice perspective?

BB: Dr. Watson’s work resonates with nurses throughout the world. Nurse researchers and educators from Denmark, Hong Kong, Mexico, and Japan have attended Consortium meetings during the last couple of years. Caring science is the basis for the curriculum at the Red Cross School of Nursing in Hiroshima, Japan. If you look at the Watson Caring Science Institute Web site you will find photographs of Watson lecturing all over the world. She has a candle that she takes wherever she speaks.
She uses it to share the light of nursing around the world. When she was with us in March, the candle had been around the world 10 times!

Some very exciting events will be occurring in 2010. Watson is currently planning the Million Nurse Global Caring Field Project designed as an international effort to promote health for all. Watson’s vision was inspired by Oprah Winfrey and her work with Eckhart Tolle to reach a million people around the globe all together by offering a course on Tolle’s book, A New Earth. The concept of a million people online for a single purpose gave her the idea of having a million nurses creating an energy field. The intent is to connect simultaneously with a million nurses (or more) around the globe: to create and radiate an energetic Caring Consciousness Field of Heart-Centered Love for Self, Others, and the Planet Earth. This intentional focused experience honors and extends the human caring vibration of nurses into the universal energy field of humanity facilitating healing and health for all. (Watson, 2009, para 1)

This vision was expanded through the latest evidence-based research and science of the heart, developed by Institute of HeartMath. HeartMath is a company that uses the concept of coherence of the heart, brain, and respiratory system to reduce stress. Through their research they have demonstrated human connectedness through an electromagnetic field that we each radiate around us (Institute of HeartMath, 2009). The Institute has global coherence energy monitors designed to detect electromagnetic waves, which will be used to detect shifts in energy as nurses join Watson’s meditation. The idea is that nurses throughout the world will join the meditation by logging onto a Web site at noon in their time zone.

Implementing a theory-based professional practice model in the practice setting has its rewards and challenges. Nurses are not always comfortable articulating the caring work they do. The abstract language of theory can be off-putting and difficult to put into practice, but at the same time to translate it into something more accessible to bedside nurses can open many new possibilities and give voice to the important work we do. As we continue to provide care in ever more complex environments, understanding the importance of our human connectedness to healing, will push us to be more mindful of our intentions for heart-centered caring relationships.

References


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