Chapter 1. Aim and purpose

1.1 Introduction and aim

In most hospitals in Australia, Do Not Resuscitate (DNR) orders are widely used (Johnstone, 1989). The aim of this investigative report is to explore the nurses' needs to be aware of dilemmas related to this DNR status and how Watson's science of human to human caring can help nurses overcome these dilemmas.

Traditionally nursing training has focussed on the cure domain of health work. Thus nurses do not easily deal with the termination of a human's life. Some nurses wish to avoid facing the dilemma of a DNR decision. Some wish to be involved but genuinely do not know how to go about expressing their concerns. Nowadays, the nursing profession needs to specifically address the issue of DNR because it intigates the cessation of resuscitation activities. At this point, nurses need to be supported by a strong philosophy to help them deal with these patients and with their own feelings about the situation. Watson's theory of human caring provides guidelines in the event of difficulties for nurses.

Thus this paper aims to investigate a possible solution for the nurse in the current context of DNR orders, a solution which both supports and guides the nurse whilst protecting the patient's autonomy within the nurse and patient relationship. The proposed solution is the adoption of Watson's theory of human caring.
Watson's (1979) view of nursing can offer direction in these DNR situations. She suggests that when the patient is terminally ill nurses should provide both support and comfort care even if medical officers or other medical staff withdraw their treatment. Nursing involves day to day care, which not only looks at patients' quantity of life, but which looks more closely at the patients' need for caring and comfort on a daily basis which creates' quality of life. To implement this approach, nurses need to be in harmony with themselves and with others. The basis of this approach is the development and maintenance of a balance between the mind, body, spirit and emotion in order to broaden nursing care from a physical concept and shift the focus to a more holistic approach.

For nurses working within medical - surgical areas DNR orders are an every day reality. It is therefore essential that, as the primary care givers within the hospital environment, the nurses' perspective should be both considered and respected.

As a nurse, I cannot be passive and devoid of opinion in such ethical matters. All aspects of each DNR order should be thoroughly examined in light of the patient's quality of life, sociological circumstance, philosophy and more. Nurses implementing such treatment orders by definition need to consider ethical, moral, philosophical perspectives and the significance of such policies on the nurse as a professional and as a human and upon the profession as a whole.
1.2 *Context of this investigative report*

The rationale behind a Do Not Resuscitate (DNR) order written by a medical officer is usually an attempt to "avoid over treatment and CPR abuses, particularly in cases involving hopelessly ill patients who would be otherwise hopelessly revived" (Humphry and Wickett, 1987, p.209). This is particularly the case in acute medical - surgical hospital wards, where it is anticipated that patients will be cured, and so the death of patients is more stressful because of its challenge to medicine's ability to cure.

Yarling and McElmurry (1986) persuasively argue that the DNR decision is not a medical decision and neither is it a legal or nursing decision, since it is based primarily on moral values, such as those concerning "the meaning, sanctity, and quality of life" (cited in Johnstone, 1989, p.283). They are suggesting that although the decision is made by medical officers, it should be based more on the values of maintaining human dignity and reducing unnecessary suffering than on the medical condition or legal consideration alone. In my experience, some medical officers currently make DNR decisions on medical and / or legal bases but not based on ethical considerations. I have seen some medical officers make DNR decisions over the phone on the basis of related biological data, with no consideration of the patient's or their families' wishes nor, apparently, the ethics of the situation.
Despite its serious moral and indeed legal implications, the issue of DNR orders has, on the whole, been poorly addressed by the nursing profession. Not only has the issue been poorly addressed by nurses in academic terms as evidenced by the lack of literature on the subject, but also in practical terms as evidenced by the lack of explicit guidelines and policies for nurses governing DNR procedures and practices in most Australian hospitals (Johnstone, 1989).

It may be that nurses have come to view the DNR order as absolutely constituting a lawful and reasonable medical order and therefore not something warranting any special or particular concern, or it may be that nurses are troubled by practices but say or do nothing out of fear that their employment or career prospects may, in some way, be threatened if they speak out. Some nurses are troubled by current practices, and do wish to speak out, but genuinely do not know how to go about expressing their concerns (Johnstone, 1989; Fowler, 1989; Forrester. 1990; Fry, 1992).

Whatever the reasons for the nursing profession's oversight in addressing the DNR issue, Johnstone (1989) believes nurses can no longer ignore the serious moral, legal and professional questions which current DNR practices raise, much less their implications for clinical nursing practice, nursing education and administration. Neither can the nursing profession ignore the point that while the practice of prescribing DNR for seriously ill patients is a commonly accepted one in most Australian hospitals and residential care agencies, it is nevertheless
open to serious question as to whether the practice is wholly acceptable. It can be questioned on the basis of the rights of the patient to determine their own course in life, that is, patient autonomy and related issues of maintaining human dignity. It can also be questioned from the individual nurse's point of view on the basis of the legal and emotional issues which arise when nurses must both care for the patient, focusing traditionally on their physical health, and yet implement DNR orders made by the medical officers.

1.3 Literature Review

1.3.1 Cardiopulmonary resuscitation, its effectiveness and implementation.

Do not resuscitate (DNR) is the denial of Cardiopulmonary resuscitation (CPR). Because CPR is a standing order for all hospital patients, justification of DNR orders must be related to the effectiveness or otherwise of CPR.

Modern Cardiopulmonary Resuscitation (CPR) was introduced in 1960 and received the approval of the American Heart Association in 1974. The term originally described the treatment of Cardiopulmonary arrest with external chest compression and a form of artificial respiration. Cardiopulmonary resuscitation was designed to prevent sudden unexpected death caused by respiratory or cardiac arrest (Sharp & Frederick, 1989).
Cardiopulmonary resuscitation has the distinction of being the only medical intervention the health care team feels obligated to do without an order (Bedell and Delbance, 1984). Almost all patients are eligible for CPR because cardiopulmonary arrest is usually the last pathophysiologic event in the process of dying (Blackhall, 1987).

Severe damage may be sustained by the heart, the lungs or the brain during resuscitation, resulting in death or irreversible coma (Bedell, Pelle, Masher, and Cleary, 1986). Health professionals must realise that there is a point when nothing more can be done to restore a patient's health. At such times, care delivery may be more honourable than dramatic attempts at health restoration and enabling a cure. Increased technology has given the ability to not only delay death but prolong life in a manner that raises questions concerning the quality of that life. Such prolongation of life can often lead to a painful or unconscious existence (Younger, 1987), which is often of short duration (Marchette, Box, and Arnall, 1993). A poor quality life as manifested by pain and incapacitation, may be unwanted by the patient. In addition, the staff caring for the critically and terminally ill may find such nursing depressing or upsetting (Goffnett et al, 1985; Martin & Redland, 1988) for reasons detailed later in this chapter. Thus, the provision of care for terminally ill patients can be a negative experience for all concerned.
1.3.2 The Do Not Resuscitate order.

Do Not Resuscitate (DNR) is an order made by medical officers to allow the non-implementation of cardiopulmonary resuscitation (Bedell and Delbance, 1984). The history of the presentation of DNR orders has varied according to the legal implications for those who make the order. Punch (1984) said that in the past, DNR orders were not written down under the false assumption that legal liability was reduced by the non-documentation of DNR orders. This resulted in the development of other methods to communicate a DNR order, such as verbal orders, secret language codes, and even instructions given to staff on how fast to walk when responding to a cardiopulmonary arrest.

Originally DNR orders were written only for the terminally ill, those with less than a 10% prospect of surviving their situation and recovering to the point of being discharged from the hospital (Campbell and Field, 1991). Many hospitals have, or are considering, expanding patient eligibility for DNR orders to include competent patients with progressively debilitating disease (Blackhall, 1987). As Sharp and Frederick (1989) suggest, this is a different approach to the DNR order, in that the patient may want maximal therapeutic treatment for their disease but does not want to be resuscitated in the event of a cardiac or respiratory emergency.

In a review of some studies, conducted by Curtin (1989), it was reported that some physicians are hesitant to write DNR orders because they are
concerned that their patients will not receive sufficient or adequate nursing care for their comfort. However Savulescu (1994) found aggressive therapies are generally not discontinued at the time a DNR order is written. Also Savulescu's study found that patients with DNR orders were given equal or greater amounts of medical and nursing care than patients who were candidates for resuscitation. This is further supported by Stewart's article (1989), which indicates that a DNR order specifically states that it does not apply to any other care which the patient might receive. In palliative and hospice care, treatment of patients allows death with dignity with the emphasis on pain relief and active promotion of physical and mental comfort rather than prolongation of life. Such aggressive care is not downgraded by such an order as DNR (Stewart, 1989).

However, some studies have found that at the time DNR decisions have been made, the majority of relevant patients were mentally incompetent to participate in the DNR decision (Bedell et al., 1986; Zimmerman and Knaus, 1986). Such a label is placed on depressed patients in a general medical unit (Stephens, 1986). This raises the issue of the role of the patient in DNR decisions.

1.3.3 The patient's role in current DNR decisions.

DNR orders are sometimes made without discussion of the issue with the patient or their family and sometimes without informing the patient or the family that such a decision has been made (Goffnett, Eyer, and
Stack, 1985). Given that the decision to withhold CPR can also be viewed as an ethical issue, it would ideally be made involving the patient's own wishes, based on their moral beliefs (not those of the medical officers or nurses) in order to promote patient autonomy and their human rights. The NSW Health Department (1993) states that special emphasis should be placed on patient autonomy by all health care practitioners and recommends that "patients have a right to discuss and make decisions about all aspects of their treatment, including the foregoing of treatment" (p. 2).

This recommendation follows trends elsewhere in the world. For example, Cody (1985) from America states that the patient should be the primary active agent and decision-maker, and when not able to be so, their previous wishes should be elicited from the family.

Interim guidelines on management, with dignity, of the dying in Australia (NSW Health Department, 1993) apply to all DNR situations, including those in acute medical - surgical areas, which are the concern of this paper. These guidelines state that the patient has the right to refuse any treatment. If the patient's condition precludes involvement in decision-making, an advocate should be involved. The contents of any advance directives should also be taken into account. Also where there is a request for continuation of medically futile treatment, the attending medical officer should consider the request in the context of the overall management plan and the best interests of the patient at that time (NSW Health Department, 1993).
The guidelines further state that where the patient is not capable of involvement, and no advocate or advance directive has been arranged, any views that the patient was known to hold should be taken into consideration. These views may be known by their family or by health care professionals. Also, if the patient's views are not known to anyone, then decisions should be made at the discretion of the attending medical officer, after consultation with the family, in the best interests of the patient. The ultimate responsibility for medical decisions made still rests with the responsible attending medical officer, regardless of the patient's wishes.

From my own personal experience, as a nurse in a medical-surgical ward of a large metropolitan hospital, staff-patient relations and the working environment improve considerably when the doctor weighs up the opinions of others, - both other health professional and patients, and considers whether the quality of life is as important as its length. This creates an atmosphere for open and patient centred nursing care and one which fosters patient/relative rapport with staff. There are fewer hidden feelings; dignity and caring prevail, full discussion ensues and everyone works toward the same goal.

1.3.3.1 Patient's needs

Problems surrounding issues of dying and death are many. Health professionals, families and individuals all must cope with different
aspects of these problems. With regards to this problem, I will initially investigate issues related to patients needs.

Patients' attitudes are often shaped by the information their attending medical officers provide. Thus decision making concerning DNR, even when left to the patient, is still largely influenced by the medical officer. Also, some medical officers and nurses in acute medical-surgical wards genuinely believe that patients or their relatives should not be included in the process of making DNR decisions (Perry et al., 1986).

Many authors (Louis, 1992; Curtin, 1989; Pottle, 1992; Mead and Turnbull, 1995) have written that the final decision to undergo or forgo treatment must be based upon the principle of autonomy and on the competent patients' wishes, desires and values after they have been given accurate information on their prognosis, information on the available options and the potential risks and benefits of each option. The term autonomy here means self and rule, or governance or law. Thus when speaking of the concept of autonomy, what is commonly being referred to is a person's ability to make or to exercise self-determining choice-literally, self-governing. Intended here is the additional notion of respect for persons that is, of treating or respecting persons as ends in themselves, as dignified and rational, autonomous choosers, and not as the mere means to the ends of others (Kant, 1972; Benn, 1971, cited in Johnstone, 1989).
Beauchamp and Walter (1982) emphasise the basic meaning of autonomy as meaning that people should be free to choose and entitled to act on their preferences provided their decisions and actions do not stand to violate, or impinge on, the moral interests of others. According to Chipman (1991) unless patients exercise their freedom of self-determination then their integrity, their wholeness as a person, will be seriously and unjustly compromised.

Patients' families also need to be involved. Families are important resources. They can offer singular contributions to the situation-as sources of information, support, and direct assistance. They also may help make judgments about the capacity of an individual to make decisions. In general, the validity of a family member's opinion about a patient's "usual behaviour" is enhanced if it is supported by more than one family member. However, as Siegler (1987), argues, family members' interpretations of the patient's values and behaviours should not necessarily replace the patient's stated values in the context of the nurse-patient relationship itself. Although often helpful and insightful, family members' observations alone should not determine the course of action.

The concept of dignity is closely associated with autonomy. There are many definitions of dignity, (Hobbes, 1968; Kant, 1972; Swenson, 1981; Skinner, 1973) and what one person might consider dignity, another person might equally reject - and this has important implications for nursing care delivery in particular, and health care management
generally. Despite the variety of definitions and interpretations of the	onnections dignity and dying with dignity, a number of common elements
are shared. These are:
1. that persons have intrinsic moral worth, and thus ought to be treated
   as ends in themselves, and not as mere means to the ends of others;
2. that persons should be respected as autonomous choosers, and thus
   as beings capable of exercising self-determining choice;
3. that persons should be facilitated and supported in the course of
   exercising their autonomous choices;
4. that persons should be facilitated and supported in their attempts to
   maintain their self-respect and self-esteem.

Dignity can be seen to be a human rights issue, and as such is valued by
society as indicated in Consumer Health Rights by the Health Forum of
Australia (1989), which supports the rights of individuals who may be
unable to exercise their rights. In some cases a person independent of
the care giver and institution may be required to act on an individual's
behalf. Such cases have the right to receive health care in privacy and to
be treated with respect and dignity.

However, as Johnstone (1989) indicates, communication in hospitals is
often unfortunately so poor that patients who may desire to die with
peace and dignity, are sometimes subjected to full scale CPR, merely
prolonging a life of poor quality and outlook based on the medical
officer's decision alone.
1.3.4 Dilemmas facing nurses caring for patients with DNR status.

There are many dilemmas facing nurses who care for patients with DNR status. These dilemmas are moral and ethical, and also arise from nursing's traditional focus on cure, from nurses personal values, and from the socialisation of nurses into the culture of nursing obedience to medical teams.

Several Australian states (Victoria, Northern Territory) have legislation is plan to allow patients to die without anything being done to artificially keep them alive (Aids Council of NSW, 1994). This is often called "natural death" legislation. NSW has guidelines for the medical system entitled "Dying with Dignity" (1993) which guide professionals in making decisions to withhold treatment. These guidelines recognise the right of the person who is ill to make decisions about all aspects of their treatment, including stopping or withholding "futile treatment" (NSW Heath Department, 1993, p.4). The 1995 euthanasia legislation passed in the Northern Territory in 1995 takes this even further within strict guidelines.

"Futile treatment" involves investigations and treatment which, according to professional judgement, will lead to inappropriate outcomes such as continued pain, unacceptable quality of life or maintenance of a vegetative state with no possibility of a reversal of that conditions. The Northern Territory guidelines leave the decision making with the medical officers. For nurses who are obliged to protect
and support patient's wishes, this situation can be difficult for them when patient's and medical officer's opinions are in conflict. If nurses act on the patient's wishes against the medical officer's orders in these matters, the nurse is legally responsible for his/her actions and can be sued or disciplined.

Historically, nurses have been taught to obey doctors' instructions in order to uphold the medical officers' professional reputation (Rumhold, 1986) and so they are often having to implement decisions with which they know the patient's does not concur (Johnstone, 1989).

Verbal DNR orders to nurses can make it difficult to prove that medical officers orders have been properly understood and obeyed. The Victoria Nursing Council (1988), guideline stated "an employer does not relieve the registered nurses responsibility for their own acts and may not provide immunity in case of negligence" (p.4).

Also, according to Johnstone (1989), it is often the case that DNR orders can be documented as 'cares for comfort only' or 'nursing care only'. This means that nurses have to interpret to what extent to fulfil the order. In fact, there is always room to question whether CPR should, or should not be implemented in cases such as this. This can leave nurses in a difficult legal situation.

Nurses personal value systems and the way they view death or dying, can be different for each individual nurse. Their attitudes toward the
right to die can be coloured by their culture and what they are taught to value.

Although nursing education, according to Ney (1989), socialises the nurse to see patients holistically and act as an advocate in the patient's best interest, being an advocate for a patient who wants to be allowed to die may be a real problem for a nurse whose personal values conflict with the patient's wishes.

Traditionally nursing has involved helping people cope with and recover from illness, and its basic aim has been to assist with a physical cure (Gray and Pratt, 1991). This means that helping people die may be somewhat alien to nurses as a result of their training focus on cure. There is a risk that patients who are dying experience abandonment because nurses may find it difficult to come to grips with the reality of death and may seek to avoid it. Also, denial of death is a reflection of societal values which revere youth, health and vitality, and look to technological advances that will 'win the battle over death' (Stein-Parbury, 1993). This can cause a dilemma for nurses whose sense of duty may be strongly tied to notions of cure or whose own ability to accept death is not yet well-developed.

Also, Yarling and McElmurry (1986) labelled the conflict between nursing and medicine around the DNR decision-making issue as paradigmatic of the general nature of the historical relationship between nursing and medicine. Medical authoritarianism and institutional
constraints often impede the practice of nursing. Thus, nurses may face a dilemma because of the necessity placed on them to carry out a DNR order which they may feel unwarranted on any one of a number of grounds, including personal and moral issues and their role as patients advocate.

In medical - surgical wards, nurses are almost invariably left with the ultimate decision of whether or not to initiate CPR in an arrest situation. I do not believe this is always fully understood by attending nurses themselves. It is nonsense to suggest that nurses have no unique moral, legal or professional responsibilities in situations where a patient's life and well being are hanging in the balance and are in their control. However, in these difficult situations, nurses have to consider how to protect their own interests as well as the interests of their patients.

1.3.5 Watson's theory and its relationship to DNR situations in acute medical - surgical contexts

When DNR orders are made, both nurses and patients involved have particular needs. The patients need to have their basic human rights respected and to be allowed to maintain their self respect through maintaining their autonomy. Nurses need guidelines to assist them with the many dilemmas they face, as outlined above.

Watson's theory is based on a practical acknowledgment of patient's rights by maintaining their dignity and their autonomy in individual
patient-nurse relationships. It is based on a wider view of nursing than
traditional nursing - it views nursing as caring rather than curing, so that
nurses using Watson's theory have a holistic healing goal which includes
aspects of patients other than simply their physical selves.

Watson's (1979) theory also helps nurses overcome their socialisation
into the cure domain of health and medical team obedience by
promoting and validating the nurses' role of patient advocate.

For those nurses whose personal values concerning death and dying
conflict with a DNR decision, it can make the nursing of DNR patients
difficult. Watson's (1979) theory promotes the honest expression of
their feelings and does not view such situations as being harmful to the
quality of the nursing care provided.

However, Watson's theory cannot overcome the legal dilemmas faced
by nurses if they follow patients' wishes in opposition to medical
officers' orders. Also, the time that is required for Watson's theory to be
implemented can make it very difficult to use effectively when nurses
have multiple patients to deal with simultaneously. It takes much time
to establish a honest mutual relationship and a hectic schedule does not
present the most conducive atmosphere for this to happen.
1.4 Summary

The problems surrounding issues of dying and death are many. Health professionals, families and individuals must all cope with different aspects of these problems. As I suggested earlier, dilemmas for nurses often arise in the care of a DNR patient. Nurses have to be aware of these dilemmas and of the dilemmas for their families. Caring for a patient with DNR status requires focussing on the patient's autonomy as well as on the patient's wishes. This view of caring supports a concept of quality of life where a person leads their life independently and maintains their human dignity. The nurse has to consider the patient's rights foremost. Jean Watson's theory of nursing explicates the natural connections between individuals in human to human care. She suggests that nursing can occur within a framework of natural relatedness between the nurse and the patient. Thus the nurse and the patient begin from a point of relationship, and togetherness rather than from a point of separateness.

The following chapter explores Jean Watson's theoretical framework in detail, as a prelude to investigating its usefulness in the context of nursing DNR patients in acute medical - surgical hospital wards.
Chapter 2. Theoretical framework

2.1 Introduction

Curing patients of a disease is one of the principal goals of medicine. However a DNR decision is impossible to make based on the goal of a cure and consequently such a decision can be seen as opposed to the main goal of medicine. It is not always possible to determine one's life value on the hope of cure. The cure approach to medicine explains why so many medical professionals are uncomfortable when dealing with death and with dying patients and their families. However, the nurse is not dealing with only the medical view of care but rather is dealing with patients as a whole. Patients' emotional and spiritual care is heavily influenced by practical nursing. Watson's theoretical framework guides nurses as to how they can approach the patient's death when the patient needs care, support and comfort. Also the theory can help nurses make sure patients have enough information to explore the problems of the body, mind, and spirit. Watson's theory makes a clear distinction between care and cure goals and draws on both empirical and phenomenological approaches to the holistic nursing of patients.
2.2. *Watson and the concept of caring.*

Watson (1979) uses the terms "carative" and "curative" to describe the goals and behaviours she sees as relating to nursing and medicine. Curative factors predominantly relate to medicine and refer to any procedures or actions taken to cure a patient. In contrast, carative factors refer to actions and interactions which aim to provide comfort for patients - emotionally, physically, spiritually, and mentally. Carative factors can be used by the nurse in the delivery of health care. Watson identified ten main carative factors that she believes apply to caring in a nursing context, and which could ultimately distinguish between the care and cure basis of nursing actions.

Watson believes that nurses can render care by providing both support and comfort, even when a medical officer determines that nothing more can be done to improve the patient's physical condition. The carative factors are an intrinsic part of this care. In day to day nursing care, the use of these factors can result in the delivery of the highest level of nursing care.

Nursing without caring can be argued to be less effective than caring nursing because it involves simply following medical officer's orders, not responding to patient needs, and is thus only physically and cure focussed. Because nurses have biological and interpersonal knowledge and skills and regular, frequent contact with patients, they are able to combine caring with their specialised knowledge and so make it more
effective. It is most effective when it is directed towards the physical, emotional, mental and spiritual well-being of the patient. This involves social contributions to care by the nurse. Mature social contributions are well-balanced and holistically driven so that the nurse, to provide the best professional, holistic care, must themselves be well-balanced individuals.

In the past decade, nursing theorists, such as Leininger (1988), Brody (1988), Gadow (1985), Reverby (1987), and Radsma (1994) have identified caring as a paradigm unique to nursing. Caring has been described as the "core" or the "essence" of nursing (Morse, Solberg, Neander, Bottorff, and Johnson, 1990).

The theory of human care, developed by Watson (1979, 1985, 1988, 1994), explains the kind of relationships and transactions that are necessary between the care giver and care receiver to promote and to protect the patient's holistic well being - their physical, spiritual, emotional and mental well being and balance - thereby influencing the patient's healing potential.

In describing the processes involved in caring as well as the outcomes of care, Watson emphasises the psychological, emotional, and spiritual dimensions of care, almost to the exclusion of other characteristics of everyday tasks inherent in nursing care, such as bathing, or procedures involving technical expertise. She presents combinations of interventions related to the process of care, as envisaged by herself, as
carative factors that are enacted in the context of the caring nursing relationship.

Watson initially appears to make the traditional differentiation between care and cure in deriving her carative factors. The term 'carative' is used in contrast to the more common term 'curative' to help the student to differentiate nursing from medicine (Marriner-Tomey, 1989, p.166). On further inspection, however, Watson shifts the traditional meanings of the terms, care and cure: In her formulation, Watson closely associates curing with disease; it is a narrow meaning. Caring, on the other hand, she associates with healing the person. In this manner, Watson, while eschewing the term 'curing' for nurses, brings nurses into the activity of healing (instead of simply 'taking care of') through caring. Caring, as Watson says, is more 'healthogenic' than is curing (Watson, 1979, p.9).

Watson's ideas were initially proposed in the paper titled 'Nursing: the philosophy and science of caring' published in 1979. I think her choice of the term 'science of caring' may, in part, reflect her empirical methods of studying human experiences. However, it also reflects her systematic approach to care. She proposes that nursing care be based on the scientifically-derived bodies of knowledge such as biology and pharmacology which a nurse has access to. Thus, the science of caring is so named because it is based on empirically derived data, yet is extended phenomenologically to include human experiences. This is the
practical component of the theory. She included philosophy in order to bridge the gap between ideas and reality, between theory and practice.

According to Gray and Pratt (1991), an idealistic theory would be one with a high level of clarity and logical or internal consistency but which has little relationship to nursing phenomena in the real world. A realistic theory would be the reverse, having relevance to nursing as it is perceived or experienced, but having minimal significance for the advancement of nursing knowledge due to a low level of conceptual merit.

The least useful theory would be one evaluated as low on both dimensions. Such a theory may be described as cynical and it would be an inappropriate guide for either nursing research or practice. The theory would need considerable conceptual and empirical development in order to raise it to the level of either an idealistic or realistic theory evaluation. Thus, Watson was keen to ensure her theory was both idealistic and realistic.

2.2.1 Watson's Carative Factors.

Watson's theory suggests that nursing care can be delivered using ten carative factors. These factors are combinations of interventions related to the process of human caring. These ten factors are as follows:
1) The formation of a humanistic-altruistic system of values

A humanistic-altruistic system of values is defined by Watson (1979) as "the commitment to and satisfaction of receiving through giving" (p.11). This assumes a focus on the other rather than the self and states that giving can be a source of self satisfaction as well as of value to the receiver. According to Watson (1979), caring must be grounded in a set of universal human values of kindness, concern, and love of self and others (Watson, 1979).

A foundation for empathy is laid as one becomes aware of and appreciative of different ideas, tastes, and divergent views of life, death, and the world in general. This sense of and appreciation of the other is the first stage in the formation of a humanistic-altruistic system of values. Humanistic values and altruistic behaviour can be further developed through consciousness raising and a close examination of one's views, beliefs, and values and through experiences with different cultures; early experiences that have aroused compassion and other emotions; study of the humanities; literary and artistic experiences; value-clarification exercises; and personal growth experiences. Such experiences can lead to a greater understanding of the other and to an appreciation of their views and behaviours. This in turn can encourage a willingness to contribute to their world views by caring for and helping them. Such altruistic behaviour can bring meaning to one's life through
relationships with other people. These values and behaviours Watson (1979) considers essential to caring nursing.

2) **Instillation of faith and hope**

Watson (1979) uses the term 'faith-hope' to refer to beliefs in positive outcomes and hope for the same. These have, over the years, been seen to be important influences in the healing process (Rogers, 1967, Bergin, 1971; Lipkin, 1975).

The instillation of faith-hope complements the formation of a humanistic-altruistic value system and together they enhance the effectiveness of the other carative factors. Instillation of faith-hope in one's self and one's competence or in another person is incorporated into the science of caring by Watson.

The instillation of faith-hope is difficult to define because it is never a finished process. Regardless of the scientific regimen required for the care of a person, the nurse must discover what is meaningful and important for that particular person. The person's beliefs should never be disregarded, they should be encouraged and respected as significant influences in promoting and maintaining health through faith-hope. The nurse must always consider this in order to practice the science of caring. The holistic nature of responding to another person justifies faith-hope as a contributing influence in people's lives.
3) **Cultivation of sensitivity to self and others**

People can feel and think about themselves by themselves but they cannot actually experience each others feelings. The only way to develop sensitivity to one's self and to others is to recognise and experience feelings, that is, painful ones as well as happy ones.

A level of consciousness about one's feelings is required to enable the nurse to understand themselves. A clear understanding of the self can enable more accurate recognition of the emotional states of others. This is a pre-requisite for sensitivity to others. People are often afraid to look within because they fear that if they are honest they will see only imperfections. Sensitivity to one's self and one's feelings can be threatening because it may seem that there is no way to handle feelings or that one is not able to change. Therefore, it seems easier to push back feelings, to deny them, to refuse to deal with them, or to become consumed by them (Watson, 1979).

However, the promotion and acceptance of the expression of positive and negative feelings is necessary. Those who are not sensitive to their own feelings find it difficult to be sensitive to the feelings of others. Sensitivity to one's self and to others may determine the extent to which the nurse is able to develop his/her self and to fully relate that self with others.
If nurses, as helping professionals, fail to be sensitive at painful as well as at happy times, they fail at helping. They succeed only in hiding behind their role and their insecurities and anxieties, and they contribute nothing to their own holistic health nor to the holistic health of others. Nurses must be genuine to themselves and their feelings. Honesty toward self promotes authenticity and sensitivity towards others. A nurse attains and promotes health and higher level functioning only if she or he forms honest person to person relationships as opposed to manipulative relationships.

When the carative factor of sensitivity to themselves and others is operating, nurses function as whole persons and can give holistic care. In this situation both patients and nurses retain their separate identities. Practicing sensitivity to self and others becomes something basic that is common to all types of nursing. Sensitivity to self and others builds on the formation of a humanistic altruistic value system and the instillation of faith hope, and it commits the nurse to helping other people achieve such goals as satisfaction, comfort, freedom from pain and suffering, and higher level wellness.

4) Development of helping-trustful relationships

Development of a helping - trustful relationship is closely related to the promotion and acceptance of the expression of positive and negative feelings, which in turn is built on the formation of a humanistic-altruistic value system and the instillation of faith-hope. All these
factors can then interact to facilitate a holistic approach to understanding and providing nursing care.

The development of a helping trustful relationship according to Watson involves congruence, empathy, non possessive warmth and effective communication. In particular, congruence involves being real, honest, genuine, and authentic; empathy is the ability to experience, and thereby understand the other person's perceptions and feelings and to communicate those understandings; non possessive warmth is demonstrated by a moderate speaking volume, a relaxed, open posture, and facial expressions that are congruent with other communications; whilst effective communication has cognitive, affective, and behavioural response components (Marriner-Tomey, 1989).

Because of the number of patients a nurse must care for and the number of tasks she/he must complete on any one shift, nurses may fail to establish rapport and a helping - trustful relationship with their patients. However, this relationship is very important in the provision of caring nursing. The patient is also far more likely to talk about sensitive matters with the nurse who communicates a genuine caring response. This relationship can thus facilitate a holistic caring approach to nursing that is an approach which considers the emotional, spiritual, physical, and mental aspects of care in an integrated fashion and from the patient's perspective.
5) **Expression of positive and negative feelings**

According to Watson, the expression of both positive and negative feelings is important. Such expression needs to be combined with the other carative factors in the delivery of nursing care. For example, if the nurse is sensitive to the sadness of a patient, she/he may not express his/her own happy feelings as boisterously as if the patient was happy. However an honest expression of feelings, at appropriate times and in appropriate ways, helps develop an authentic relationship through developing sensitivity to self and so to others, as discussed earlier under Watson's third carative factor.

An awareness of one's own feelings may eliminate some of the irrationality of feelings and give one more control over his or her thoughts and behaviours. For example, a person may get irritable or angry inappropriately, without even being fully aware of their feeling and how it influences his or her behaviour. If the person is made aware of the feeling, he or she may understand what triggered it. He or she may accept the feeling as a universal one, that is, common to others in similar situations. This may help in achieving an internal balance between the emotional, physical, mental, and spiritual aspects of a person. This cannot be achieved without the expression of feelings by both participants in the relationship. That realisation may free the person to respond to the feeling with a sense of relief and then to respond to the situation in a more appropriate manner.
6) **Scientific problem - solving approach to decisions.**

Marriner-Tomey (1989) in her discussion of Jean Watson, states that the "use of the nursing process brings a scientific problem - solving approach to nursing care" (p.167). This approach allows for control, prediction and self-correction in the development of the science of caring.

In its absence, nurses must rely on their own tenacity, their beliefs, their intuition or a higher authority in regard to their actions. This is a haphazard approach to the developmental of caring and may rely on accidental discoveries alone (Marriner-Tomey, 1989).

The goal of nursing care is the delivery of quality care. The method for delivering quality care (now for a particular patient or in the future for another patient) is the systematic use of the scientific problem-solving method. This method is known to some as the nursing process, to others as the research process. The use of the scientific problem-solving method is critical to the development and practice of the science of caring.

7) **Promotion of interpersonal teaching - learning**

The promotion of interpersonal teaching-learning is a carative factor that is necessary in almost all of a nurse's encounters with other humans beings.
The effectiveness of teaching is affected by the assessment of the patient's perceptions. Interpersonal teaching should be conducted instead of telling the person what to do or what to expect. It is also affected by the attitudinal qualities that facilitate learning. These same qualities are necessary for an effective helping relationship; namely, congruence, empathy, and non possessive warmth. These qualities enable a free, trusting atmosphere for learning and growth. The teaching - learning relationship is a two-way interpersonal process between the teaching - learning nurse and the teaching - learning patient. A focus on learning rather than on teaching necessitates a concern for the patient and his or her goals, as well as his or her perceptions of events or phenomena. A focus on learning provides the proper orientation, atmosphere, attitudinal qualities, and personalised focus that is necessary for learning.

8) ** Provision for a supportive, protective, and corrective mental, physical, socio-cultural, and spiritual environment. **

The nurse should provide support, protection, or correction for the various components of the patient's internal environment - physical, mental, spiritual, and emotional. Mental and spiritual well-being and socio-cultural beliefs are critically important to the health of persons. The external variables includes the external environment - change, comfort, privacy, safety, and clean-aesthetic surroundings.
Comfort is an external activity or condition that the nurse can often control, because comfort can come from the environment that is controlled in part by the nurse. Comfort activities can be supportive, protective, or even corrective and target a person's internal and external environments. At the same time, the nurse's way of comforting should help the person to function as effectively and efficiently as the limits of his or her health-illness status permit.

The comfort that the nurse provides in the spiritual realm is related to the appreciation of the patient's spirituality and spiritual beliefs. Privacy is a major factor to consider in the patients hospital environment. The depersonalisation that occurs with hospitalisation and the intimate questions, procedures, and treatments connected with hospitalisation contribute to the privacy concerns of the person. The expectation of the hospital staff that the patient will share intimate information and expose his or her body without reserve also contributes to the patient's loss of privacy. Often the basic support, protection, or correction that the nurse provides in the patient's external environment is intended to preserve the patient's privacy.

Providing for a protective, private environment is often a first step toward other therapeutic interactions that promote or maintain health or help with care when someone is ill. Privacy interventions include information, emotional release, providing a setting for self-evaluation, and responding to the basic dignity of a person as a human being.
Safety is also a basic concern of the nurse. It affects activities that the
nurse performs that support, protect, or correct the environment. The
nurse's concern for safety includes knowledge, appreciation, and
tolerance of the behaviour that makes a person feel psychologically safe.
However, much of the nurse's practice activities are concerned with the
physical components of safety. Maintaining safety is especially crucial
in caring for persons who are ill, excited, anxious, or experiencing a loss
of control over their environments. Common changes that accompany
illness, such as weakness, sensory deprivation, sensory overload, or
incapacitation, require a person to modify his or her usual activities and
ways of responding to the environment.

Safety considerations in the environment are critical health features that
are largely confined to the nurse's domain of assessment and health
promotion.

Clean-aesthetic surroundings are the other major aspect of this carative
factor. The purpose of the provision of a supportive, protective, or
corrective environment is quality health care. Cleanliness and aesthetics
are closely linked with quality, in that attention to them promotes a high
level of self-worth and dignity. To appeal to the higher levels in oneself
and others is a worthy goal for health. Indeed to actualise that
component of care may promote self-actualisation or gratification of the
higher order needs of human beings. Aesthetics can contribute to one's
tastes and value system for individualisation, growth, and higher
development. However, aesthetics cannot be gratifying if lower order
needs are not satisfied, for example, cleanliness, safety, comfort, and privacy.

9) **Assistance with the gratification of human needs.**

Gratification of human needs refers to the biophysical, psychophysical, psychosocial, and interpersonal needs of people. People must attain the lower order needs in these areas before attaining needs higher in the hierarchy. For example, food, elimination, and ventilation are lower order biophysical needs. Activity - inactivity and sexuality are lower order psychophysical needs. Achievement and affiliation are higher order psychosocial needs. Self-actualisation is a higher order interpersonal need (Watson, 1979).

Self-actualisation concerns matters of internal importance to a person rather than facts (Erickson, 1963, cited in Watson, 1979). It is a person's desire for and opportunity for self-fulfilment.

The lower order biophysical needs are more fundamental for survival. The higher order needs include the achievement need, the affiliation need, and the need for self-actualisation. They emphasise the development of human potential, maturity, and satisfaction with self and others. Such higher order needs are perhaps the long-range goals towards which nurses can strive. Assistance with the gratification of human needs is important to nursing's role of helping persons in their daily activities as well as facilitating their growth and development.
Watson's approach to needs in the context of the science of caring is a holistic-dynamic approach that synthesises all four areas of need - that is biophysical, psychophysical, psychosocial, and interpersonal - in understanding individual and group motivation and adaptation along the health-illness continuum (Maslow, 1968; Mitchell, 1973, cited in Watson, 1979). One of the basic assumptions for caring under such an approach is that the nurse accepts a person not only as he or she is now, but also as what he or she may become. This involves an appreciation of a person's potentialities as well as actualities. Such an approach retains a holistic-dynamic focus on human needs. Assistance with gratification of human needs leads to a more complete development of each human and in part draws on the other nine carative factors in its enactment.

10) **Allowance for existential-phenomenological forces.**

Phenomenology refers to an emphasis on understanding people from the way things appear to them, that is, from their own phenomenal world. The person and his or her internal and external experience are the focuses of all experience. The totality of experience at any given moment constitutes a phenomenal field. The phenomenal field is the individual's frame of reference, and it can truly be known only by the experiencing person. However, the nurse needs to seek to understand the individual's internal reference point, even though it can never be perfectly known.
A significant aspect of this method is the deriving of evidence that indicates that a person has been really understood by another. The experience of really feeling understood is necessary for the nurse to establish and communicate with other people. This is a phenomenological - existential perspective. The nature of the human being in the world is the whole of one's existence, which is made up of one's biological or physical surrounding, human environment, and includes a person's body.

This approach acknowledges the separateness and identity of each person. This carative factor rests on the personal, subjective experience of the person as the foundation for understanding. It helps the nurse to turn inward, to the self as the source of values and strengths. In day-to-day living that brings problems, struggles, pain and suffering to so many people, the existential-phenomenological factor brings personal meaning to the human predicament.

Dealing with another person as he or she is and in relation to what he or she would like to be or could be is a matter of existential-phenomenological concern for the nurse who practices the science of caring. Nursing as a profession gives serious attention to the health-illness concerns of people.

Nursing practice includes the concept of the wholeness of a person. An existential-phenomenological perspective teaches the nurse that no
aspects of human nature can be repudiated; they can only be integrated, because they simultaneously define characteristics of human nature.

The concepts of existentialism and phenomenology are closely related, and they support a subjective appreciation of the inner world of the experiencing person. The human problems that the nurse encounters may not be directly related to the patient’s external human predicament, but they may be related to the patient’s internal human predicament as he or she experiences the world.

2.2.2 Basic assumptions for Watson’s science of caring in nursing

Watson’s basic assumptions for a science of caring in nursing are broad and complex ones and they provide a foundation for the usefulness of caring as a construct in nursing science. These assumptions are:

1. Caring can be effectively demonstrated and practiced only interpersonally

Interpersonal interaction is a human process which keeps alive a common sense of humanity, that is, what it means to be human. This happens as one identifies with others, and the humanity of the one is reflected in the other.
Watson's science of caring promotes the achievement of potential within and between people and is therefore enacted interpersonally. The first of the three basic interpersonal needs proposed by Watson is inclusion.

This is the need for identity, attention, and association with others and the need to belong, that is, the struggle about whether one is in or out, alone or together, private or public. The second need she proposes is control, which is the need for autonomy, that is, the power to influence authority. The main concern here is dominance and whether one is dependent or independent. The third need she proposes is for affection, which involves the need for intimate, emotional relationships between people. This includes feelings of love, tenderness, acceptance, trust, and warmth toward and from another person. Also other strong feelings include hate, anger, and sadness, in various degrees at different times. Schutz (1967, cited in Watson, 1979) suggests this is strongly related to the affiliation need.

This is one of the assumptions which underlie Watson's ninth carative factor relating to assistance with the gratification of human needs, whereby nursing care aims at optimal health by involving interpersonal dimensions in nursing interactions. The ninth carative factor is related to the other carative factors, as indicated earlier, and so this assumption underpins Watson's entire framework.
2. Caring consists of carative factors that result in the satisfaction of certain human needs.

Optimal health from a holistic-dynamic point of view involves satisfaction of an integrated and broad range of human needs. These needs involve biophysical, psychophysical, psychosocial, and interpersonal needs. The carative factors enable caring aimed at optimal health through the satisfaction of all these needs through interpersonal interactions.

3. Caring responses accept a person not only as he or she is now but as what he or she may become.

The nurse must be able to identify and anticipate human needs that may be important to certain health-illness processes. Because health - illness is a continuum and the goal of nursing is to achieve optimum health, patients will not be static on the continuum. The nurse must focus on what a patient will be - their potentialities, as well as what they are - their actualities. Watson's carative factors are based on a conscious acknowledgment of this process and give guidance on how to care in this context, using a holistic approach.

4. A caring environment is one that offers the development of potential while allowing the person to choose the best action for himself or herself at a given point in time.
Watson's existential phenomenological perspective is based on the notion of patient autonomy and self direction. She suggests that nurses deliver care in recognition of patients' views of themselves and their needs. The basis for this involves an honest, trusting and sensitive nurse - patient relationship, as Watson's carative factors suggest.

5. Effective caring promotes health and individual or family growth.

A frequent emphasis in nursing care is gratification of the lower order needs. This produces more objective, tangible results for both the nurse and the patient, whereas higher need gratification may produce more desirable subjective results, that is more profound happiness, serenity, and richness of inner life. Perhaps it is difficult for persons to work toward self-actualisation as the highest level of gratification of needs, but it is a worthwhile goal for health care in a holistic approach to health. At the same time the pursuit and gratification of needs are active concerns in contemporary society, which places a great emphasis on individualism and family, self-awareness, and self-growth as well as family growth. Thus the practice of caring has a responsibility at the societal and individual level to promote high order growth in oneself and in others. This approach to care based on the curing focus of the medical areas.
6. Caring is more 'healthogenic' than is curing.

Caring involving interpersonal actions aimed at intrapersonal growth in a holistic sense aims at health as an internal harmonious state rather than a cure in a physical/medical sense. If health is accepted as a holistic, harmonious balance of the integrated aspects of a person, then caring aims at this whereas curing focuses on the physical aspects of disease. This focus is the domain of medicine. Thus, nursing aims at health in a holistic sense, and includes patient growth in a human sense whereas curing aims at achieving change in physical status towards a predetermined goal. Cure is complementary to the knowledge and understanding of people, and medicine is only one of a number of ways of treating illnesses.

7. The practice of caring is central to nursing.

Optimal health is based on a holistic approach to health and involves a balanced integration of the various aspects of an individual as mentioned previously. It also facilitates an individual's autonomy. Care supplements, complements, and substitutes for medical cure when cure is not possible. Thus when the cure has failed then the caring process helps the person attain or maintain their health, including a peaceful death. Therefore nursing is concerned with promoting health, preventing illness, caring for the sick, and restoring health. All these processes are based on caring, involving the values and goals as outlined by Watson in her ten carative factors.
The practice of caring as a science of caring requires that the nurse help the patient to gratify his or her needs in their order of importance - from the lower order needs to the higher order needs. The nurse should help to gratify as many needs as she or he can in order to practice effective nursing.

2.3 *The importance of patient autonomy in Watson's framework.*

Watson's ten carative factors and indeed the seven assumptions about care which underpin Watson's framework are all focussed on the nurse's actions and motivations in delivering care. However, the patient must play a role in this interaction. In order to enact their own health, they must be allowed their autonomy. It is in this way that they can express their needs, be free to interact honestly with the nurse and so strive for their own healthy state.

Watson's book of 1988 states:

> Caring begins when the nurse enters the phenomenal field of the patient (person's frame of reference, subjective reality composed of the totality of the human experience) and responds to the patient's condition of being (spirit, soul) in such a manner that the patient releases subjective feelings or thoughts that the patient has longed to release. (p. 35)

Again, this focuses on the patient's ability to express themselves freely in order to strive for their own holistic health by striving for an integrated, harmonious existence.
'Transpersonal caring', an important component of caring, occurs when the nurse detects the subjective world of the patient, experiences union with it and 'expresses the union in such a way that both experience a freeing from isolation' (Watson, 1988, p.76). Transpersonal caring is a spiritual union between two people that transcends self, time, space, and the life history of each other (Watson, 1988). This transcendence allows both the patient and the nurse to enter the phenomenal field of the other.

Under Watson's carative framework and in accordance with her assumptions, the patient is a free and honest participant in the caring interactions with the nurse. As such, they have their own real needs which must be addressed in order to promote their health. According to Maslow (1970, cited in Watson, 1979), the highest order need is self-actualisation. This need is closely related to autonomy as the patient must achieve this state themselves, as the term implies. This cannot be done for them, although nurses can help patients achieve this by employing Watson's ten carative factors.

Autonomy, according to Watson, includes resistance to enculturation. Enculturation involves absorbing a different culture behaving and thinking in those cultural ways in place of their own. Hospitals are still largely controlled by the medical profession (Marchette et al., 1993) with their cure focus. This forms a part of the hospital culture and often dictates the action of nurses. Autonomous patients may not accept this goal, and so may choose to be allowed to die without medical
interaction should they see such a death as a healthy goal for themselves. This request for a 'DNR' order under Watson's theory, would pose no conflict with the delivery of nursing care. However, at present, nursing care is often dictated by medical officers operating from a cure perspective. This perspective often denies patient involvement in DNR decisions and often nurses who nurse from a cure philosophy find it difficult to nurse DNR patients with any health goal in mind.

Summary

In this chapter the various conceptualisations underpinning Watson's theory have been discussed. Watson's basic assumption is that care of patients involves a patient - nurse intra-interrelationship. In other words, Watson's science of caring promotes the potential within and between people and is therefore enacted interpersonally. Watson uses a holistic approach to human care as well as to scientific knowledge. She has conceptualised human care as interpersonal actions which lead to harmony between a person's body, mind, and spirit. She expands on this concept with her ten carative factors, which involve biological, and physiological needs, as well as spiritual, and emotional needs, hierarchically organised from basic needs to higher needs. Watson's ten carative factors are based on a philosophy of existential-phenomenology as evident in her theoretical framework. The philosophical underpinnings of Watson's theory are discussed in detail in the following chapter, as well as its value in the nursing of DNR patients in acute medical - surgical wards.
Chapter 3. A review of the philosophical underpinnings of Watson's theory development.

3.1 Introduction

This chapter discusses how Watson's theory was developed and constructed from philosophies of empiricism, and phenomenology (e.g. existential -phenomenology, and transcendental phenomenology). These philosophies underpin Watson's human science of caring which involves the world of human experience. The essence of her theory of human science of caring looks at the person as a whole. Because every person has a unique value, Watson seeks to recognise that uniqueness by helping a person find meaning in illness, suffering, pain, even patients facing death.

These philosophies are very useful in the nursing of DNR patients and provide guidelines for the nurse to follow in providing support for these patients, in line with their own wishes and dignity.

However, Watson's theory cannot be applied to patients in an unconscious state or patients who for one reason or another are not able to think or reason logically anymore. This is because Watson assumes that the patient is able to function as a whole - physically, spiritually, emotionally, and mentally. Without the mental component in particular, patient autonomy, which is central to Watson's theory, is not possible.
3.2 Empiricism

An empirical approach to knowledge involves the conceptualisation of phenomena on the basis of observations. This view presupposes that knowledge of the world is based upon and derived from sensory experiences. Empiricists claim that 'nothing is in the mind which was not first in the senses' and stand against the claim that some knowledge in the world results from innate ideas. In describing a piece of knowledge as empirical the term 'empirical' refers primarily to how the knowledge is acquired (Gray and Pratt, 1991).

Traditional sciences are empirically derived. Such science deploys too interrelated conceptual systems. The first is an analytical scheme, required to reveal, identify, partition, and classify the items which make up the field of interest. A biological taxonomy has this function. This function is an explanatory scheme, required to formulate theories descriptive of the mechanisms productive of the items revealed in analysis. In a mature and successful science the two systems are coordinated, with the taxonomy finding a justification in the explanatory theories of a field.

As described above, empiricism starts from sensory experiences and relies on observable and verifiable (usually through repetition) data. However, other approaches to knowledge, such as phenomenology, begin from other points.
3.3 Phenomenology

Empirical science had achieved such success by the end of the 19th century that even philosophy was considered to be concerned with empirical statements and logic. However, ethical, religious, and metaphysical concerns were put aside by logical empiricism (Stewart and Mickunas, 1990). The phenomenological movement was a reaction against these extremes and was of profound interest to Edmund Husserl (1859-1938) who contributed probably more than any other philosopher to its development. The work of Husserl led to a further movement of existential phenomenology and three emphases: the importance of the body; freedom of choice and inter subjectivity; and the recognition of others' humanity.

Existential-phenomenology may be regarded as a different way of looking at reality. It focuses on concepts of the self, freewill, one's body, perception, values, language, and metaphysics. The concepts of existential-phenomenology support a subjective appreciation of the inner world of the experience of the person. This world is neither observable nor verifiable in the way in which empiricism approached these concepts. This approach has led to the use of the English terms 'lived experience' and 'lived body' to capture the phenomenological meaning of body. The lived-body therefore becomes the centre for all experience; the source of all motivation for action; the means by which consciousness experiences the world; a backdrop to the current project; and the avenue to awareness of others as embodied consciousness. In
other words, the person cannot even be considered apart from the perspective offered by the body (Stewart and Mickunas, 1990).

Perception for the phenomenologist does not separate the act of perception and the object being perceived, but sees them as continuous. In contrast the empirical concern is with how individuals experience or perceive the real world. For the phenomenologist, the perceived world is the real world (Stewart and Mickunas, 1990). This approach to knowledge and reality, so opposite to an empiricist's approach is used by Watson in conjunction with empirical sciences in order to develop her theory.

Heidegger defines phenomenology as 'an analysis by which the meaning of the various ways in which we exist can be translated from the vague language of everyday existence into the understandable and explicit language of ontology without destroying the way in which these meanings manifest themselves to us in our everyday lives' (Gelven, 1989).

Thus, phenomenology holds that 'every conscious state is conscious of something' and that different levels of conscious experience have different areas of objectivity' (Stewart and Mickunas, 1990). Phenomenological understanding of values goes far beyond the notion of values as simply expressions of like and dislike, to central beliefs in freedom and choice, and respect for others.
Husserl's phenomenology began as a search for the philosophical foundations of logic and evolved into a study of the logical structures of consciousness (Thompson, 1990). In other words, Husserl was concerned with what he saw as two attitudes, the natural attitude (ordinary everyday experience) and the philosophical attitude (theoretical attitude) (Walters, 1994, p.136). This means Husserl was concerned with the phenomena of daily living (the natural attitude) and the reasons for this (the theoretical attitude). These, combined, are called transcendental phenomenology. However, in contrast Heidegger denied that it was possible to bracket one's being-in-the-world in the process of inquiry. He emphasised the situation of human reality in the world such as being-there and stressed the fact that human existence is always existence in the world. Watson's theory of the science of caring is largely but not exclusively based on Heideggerian phenomenology, in that it acknowledges and encourages understanding between people based on their individual view points.

3.3.1 Existential-phenomenology

Existentialism is also generally opposed to empiricism, which assumes that the universe is a determined, ordered system intelligible to the contemplative observer who can discover the natural laws that govern all beings and the role of reason as the power guiding human activity (Reason and Rowan, 1991). The point of view of existentialism, that is the view of the problem of being in the existential, must take precedence over that of knowledge in philosophical investigations. Thus the
problem of existence can have no significance if viewed impartially or in abstraction; it can only be seen in terms of the impact that experiences make on a particular existence. According to existentialism, no individual has a predetermined place or function within a rational system and no one can deduce his supposed duty through reasoning; everyone is compelled to assume the responsibility of making choices. Man is in a condition of anxiety arising from the realisation of his necessary freedom of choice, of his ignorance of the future, of his awareness of manifold possibilities, and of the finiteness of an existence that was preceded by and must terminate in nothingness.

As described earlier, existentialism is regarded as a different way of looking at reality which focuses on the self, freewill, one's body, perception, values, language, and metaphysics. This approach has led to the use of the English terms 'lived experience' and 'lived body' to capture the phenomenological meaning of body (Watson, 1985).

Existential-phenomenology promotes dealing with other persons as he or she is and in relation to what he or she would like to be or could be. This helps to account for the success or failure of a sufferer, whether the origin of the suffering is external or internal, to find meaning and a sense of responsibility in his or her existence. The unseen, and sometimes unknown, psychological events that offer meaning to the human predicament are such things as love for one's children, a belief in another life, a talent to be used, or a memory worth preserving (Maslow, 1968, cited in Watson, 1979).
Existential-phenomenology acknowledges the foundation of the separateness and individual identity of each person.

3.3.2 Transcendental Phenomenology

Watson's use of Husserl's transcendental phenomenology is concerned with the very depth of experience and our openness to our own human nature, our potential for being, that is, our humanness. Transcendental phenomenology requires an experiential depth and is indeed transcendental of pure facts and descriptions insofar as it cherishes the process of a deep and open understanding and a nurturing of ourselves and each other (Watson, 1985).

Husserl (1977) realised that the transcendental method gives access to a hidden or deep realm of experience that functions according to inwrought principles of its own order, without an obligation to rectify the experience as an objective-factual thought, but rather to consider the deeply rich experiential process as a form of transcendence from the experience itself. According to Merleau-Ponty (1962), the transcendental method is not a means of establishing an autonomous transcendental subjectivity, but rather a gesture that initiates "the perpetual beginning of reflection, at the point where the individual life begins to reflect on itself "(Merleau-Ponty, 1962, cited in Watson, 1985, p. 90).
3.3.3 *How empiricism and phenomenology (existential and transcendental) contributes to Watson's theory*

Watson's theory is based on sciences which derive from the empirical approach to knowledge. She composed the sciences of biophysical, psychophysical, psychosocial human needs in her theory of caring.

Furthermore, Watson espoused the use of the scientific problem solving method by nurses. Watson explains this as necessary because; "without the systematic use of the scientific problem-solving method, effective practice is accidental at best and haphazard or harmful at worst" (Watson, 1979, p.56). The scientific problem-solving method is the only method of problem solving that allows for control and prediction, and that permits self-correction. Without the application of the scientific problem-solving method, problem solving can lack a rational, cognitive process that optimises problem identification, data collection, data analysis, evaluation, and self-correction. Thus Watson used the scientific problem-solving method to develop her science of caring through study, guidance, research, knowledge and practice. She emphasises that this method will help the nurse obtain new knowledge, solve stated problems, make judgments and decisions, develop plans, programs, and procedures, and evaluate, correct, and improve nursing.

However, Watson emphasised that the use of the scientific problem-solving method often conflicts with other methods of knowing and this can cause a disjunction between the humanistic values and the scientific
practice demanded in nursing. Nursing deals with human beings, and so it struggles with always requiring observable and verifiable information. A useful attitude to hold in resolving the conflict between the use of scientific methods and the use of other methods for knowing is to realise that philosophically they are basically different assumptions regarding the nature of reality.

Watson's tenth carative factor is based quite explicitly on existential-phenomenological factors. It acknowledges the foundation of the separateness and identity of each person, which draws on the personal meanings involved in human predicaments. According to Watson (1979) dealing with another person in relation to what they would like to be or could be is a matter of existential-phenomenological concern for the nurse who practices the science of caring. In the day-to-day living that brings problems struggles, pain, and suffering to so many people, existential-phenomenological factors bring personal meaning to human dilemmas.

According to Watson (1979), the importance of the existential-phenomenological perspective is that it enables appropriate care suited to the patient's individual needs, as understood by themselves. The experience of really feeling understood by the patient is necessary for the nurse to establish a relationship with and to communicate with other people. However some of her ten carative factors also involve the use of empirically derived information.
Existential-phenomenology is concerned for the individual person's experiences. This helps to instil a high level of feeling for and thinking about as well as behaving in ways considerate of others, which is the basis of Watson's humanistic-altruistic value system. This value system supports a subjective appreciation of the inner world of the experiencing person.

Existential-phenomenology supports the discovery of the person's own unique concrete existence in time and space which facilitates Watson's faith-hope carative factor. The person's beliefs are never to be disregarded, but are treated with encouragement and respect.

Watson draws on Heideggerian phenomenology (Watson, 1979), as can be seen in Watson's theory of human care. Watson (1985) describes caring and events of being, such as illness and health as not objective; they cannot be inspected or studied in the manner of objects as described by Watson. They have to be studied from the "how" rather than the "what". They are not neutral items that call for a neutral and detached independent description. Thus the human phenomena which is the focus of Watson's theory of nursing, is understood through moods, feelings, and emotions.

At the same time, Watson (1985) applied Husserlian transcendental or depth phenomenology. In her book on human caring, she developed an empirical-descriptive phenomenological analysis of human experiences of health and illness in accordance with Husserlian phenomenology.
This can provide a rich description of human meanings of experiences as lived by a person. These experiences can lead to an increased understanding of human behaviour in health and illness and to an exploration of human caring in nursing. According to Watson (1985) "human experiences cannot be measured or experimented with - they are simply there and can only be explicated in their givenness" (Van Kaam, 1966, cited in Watson, 1985, p.88).

3.4 *Human Science*

Human science is based on natural science but also includes the human context. The natural world involves generalisable laws (Leonard, 1989) and the human context involves the lived world of human experience use both these perspectives (Watson, 1985). It incorporates both social and scientific aspects of people. Moreover, a human science perspective opens new vistas and new possibilities for humans and their world of health-illness experiences. These experiences can now be considered from a holistic perspective and can be viewed as a continuum rather than as dichotomies. Such a perspective allows for the ultimate meanings and ethical values of humans, health and nursing. According to Watson (1985, p.16) a human science context is based upon:

- a philosophy of human freedom, involving both choice, and responsibility - this acknowledges that with freedom and choice, a person must also take responsibility for that freedom and choice.
• a biology and psychology of holism - this emphasises the interconnection between a person's physical and psychological (including mental and spiritual) aspects.

• an epistemology that allow not only for empirics, but for advancement of aesthetics, ethical values, intuition, and process discovery - this allows for the advancement of knowledge about people as holistic beings by investigating all aspects a person.

• an ontology of time and space - the ontological view of space and time is that they exist in reality.

• a context of inter human events, processes, and relationships - this focuses on the interpersonal nature of human social existence as the context for human experiences and being.

• a scientific world view that is open - a view of the world which is not limited to the here and how visible components of a context.

Watson's theory includes ideas from transcendental phenomenology which includes aesthetics, wholeness, faith, inspirations and a sense of wonder, mystery, and discovery (Giorgi, 1970, cited in Watson, 1985).

Traditional science views humans as objects and focuses on 'objective' experiences which are considered to be real. However, human science includes a consideration of a person's personal values, and personal experiences. As such it is centred on their daily experiences. Also the traditional science views humans as the sum of biological, spiritual, and cultural aspects. Reality is considered measurable, observable and knowable and human science considers humans as
whole beings for whom the mind, body, and spirit, cannot be separated. Taken together, a scientific approach to the investigation of the whole person is possible.

Nursing has traditionally been based on the empirical evidence of science (Gray and Pratt, 1991). According to much of the literature by such nursing theorists, researchers, and authors such as Davis (1979), Watson (1979, 1985, 1988), Winstead-Fry (1980), Parse (1981), Webster, Jacox, and Baldwin (1981), Downs (1982), Munhall (1982), Chinn (1983), Donaldson (1983), Newman (1979), Leininger (1989), a human science perspective allows nursing to raise serious questions about nursing science and the new directions that nursing must take to be true to its subject matter and its social and scientific responsibility. Such a perspective allows for the questioning of ultimate meanings and ethical values of humans, health and nursing.

Thus human science contributes to the basis of some nursing theories and emphasises a philosophy of human freedom, choice, responsibility, and a bio-psychological holism which proposes a consistent interconnection between people and nature.

3.4.1 Human science and its contribution to Watson's theory of human caring

The foundation of human science is used by Watson in her theory of human caring. Human science is the grounding for her professional
human care process, which includes moral issues, and nurse-patient relationships, and how these affect health and healing. This caring process is linked to interpersonal relationships and it extends to the patient's subjective experience including the patient's relationship with the nurse (Watson, 1985).

Human care is based on people coming together and the establishment of contact between persons; one's mind-body-soul engages with another's mind-body-soul in a lived moment. It also consists of trans personal human-to-human attempts to protect, enhance, and preserve humanity by helping a person find meaning in illness, suffering, pain, and existence in helping another gain self-knowledge, control, and self-healing wherein a sense of inner harmony is restored regardless of the external circumstances.

Supporting this human care process are Watson's ten carative factors (Watson, 1979), as outlined previously in chapter two.

3.6 Holistic view of human nature.

The holistic view of human nature derives from the philosophy outlined above. This view suggests that, consciously or unconsciously, all the elements of a person - mind - body - soul - are linked and that harmony between these leads to a state of health. When these elements are not in balance, the disharmony can result in an illness or disease. Watson uses these beliefs and these values in her theory of human caring. She
suggests that nurses have access to a person's mind, emotions, and inner self indirectly through any sphere - mind, body, and soul-provided the physical body is not perceived or treated as separate from the mind and emotions and the higher sense of self. This view also suggests that love of oneself, respect for oneself, care for oneself, and treatment of oneself is necessary to enable dignity, respect, love and care for others.

Acknowledgment and recognition of the unseen and unknown psychological events that often have great meaning for the human predicament can be seen in Watson's cultivation of sensitivity to self and others which underpins the development of an intrapersonal-interpersonal relationship. This approach is based on a holistic view of a person's body, mind, and soul. They are viewed as an integrated whole and harmony between them enhances a human's life by facilitating health and well being.

The understanding of the separateness and individual identity of each person as well as an acceptance of the expression of positive and negative feelings of different experiences can help to promote effective interpersonal relationships. Again, this is derived from an existential-phenomenology viewpoint. According to Van Kaam (1966, cited in Watson, 1985) an existential-phenomenological understanding of a person can result in a person's feeling really understood.
3.7 Summary

Watson's theory considers the patient's and nurse's interactions from their unique points of view. Watson's human to human contact can be understood as a phenomenological view in contact with another phenomenological view involving a methodological approach to nursing based on empiricism which is viewed by transcendental phenomenology.

It focuses on the body, mind, and soul in unity and so emphasises the humanistic, spiritual, phenomenological and existential significance of human life. Healing a patient, according to Watson, involves achieving a sense of harmony between the mind, body and soul and so this is the essence of nursing goals under her model. This harmony, in turn, generates self-healing processes and gives meaning to one's existence.

This holistic approach to human care suits Watson's theory to the nursing of DNR patients in particular.
Chapter 4. Watson's theory and the nursing of DNR patients.

4.1 Introduction

Watson is aware of the many ethical dilemmas facing nurses as well as the need for 'care' to incorporate autonomy, dignity and quality of life (Watson, 1985). Ethical dilemmas can emerge when DNR decisions are made. Nurses' personal values may be in conflict with their decisions or there may be distress at the lack of 'care' being displayed in the absence of cure. A DNR patient may have no hope of physical cure but their inner being needs should still be addressed.

Watson seeks to present nurses with a guide for dealing with life experiences. Her ten carative factors can benefit nurses both personally and professionally. Watson's significant emphasis on nursing needs focuses on human caring and a patient's quality of life and their prospects for inner harmony and personal development.

Each carative factor is relevant for both the nurse and for patients especially patients who have terminal-illnesses and/or DNR status. DNR patients particularly benefit from the implementation of Watson's theory of human caring because the nurse treats them holistically, and acknowledges their individual needs and wishes. Under Watson's framework, the nurse is able to operate in the domain of care regardless of the patient's state of illness or wellness.
4.2 Summary of DNR patient's and their nurses' needs

As argued in chapter one, the DNR decision should involve the patient's own wishes, in order to promote patient autonomy and human rights and so benefit the patient.

The dignity of a patient is an important issue to be considered in the decision making process of DNR; Dignity is an issues relevant to Watson's first carative factor. It is also seen by some to be a human rights issue, as exemplified in the publication entitled Consumer Health Rights by Health Forum of Australia (1989), which promotes human rights and responsibilities as a way to enhance the health rights of consumers individually and collectively within Australia. Consumer Health Rights (1989) in particular speaks of the need for patients to be given adequate, accurate information and education enabling them to make informed decisions, addressing the assistance which patient education can provide in facilitating a patient's autonomy and dignity even in a DNR situation. These rights mean that patients are entitled to a healthy and safe environment which meets their basic needs and is conducive to their quality of life. Watson agrees with this, but interprets the 'basic needs' at a much deeper level in her carative factors.

However, many articles (Marchette et al.; McLaughlin et al.; Johnstone, 1989) show that in practice the DNR decision making concerns solely the medical staff and neither the patient nor their family are involved in the decision making. However, Cody (1985) states, the patient should
be the primary active agent and decision maker, and when not able to be so, their previous wishes should be elicited from their family.

The American Nurses Association (ANA) in their 1995 Code of Ethics state that patients have moral rights and nurses are obliged to protect and supplement those rights. According to Radsman (1994), it is the nurse's role to give the patient's ability to resolve his/her problems and make decisions themselves rather than to advise or teach. Such an approach is congruent with Watson's (1979) approach, as she states that in the event that a patient cannot function as his or her own autonomous free agent, then an agent designated by the patient must make their decisions. These decisions should be based on the patient's beliefs and values. Watson believes a scientific - problem solving approach to nursing is important but it must be supplemented by a humanistic values system which considers the whole person.

Also the dilemma for nurses in clinical practice involves their required obedience to medical officers' orders, which can be problematic, because nurses are often employed and called upon to be involved in situations in variance with their beliefs and with their patient's wishes. Since nurses are the ones who have to carry out the medical officers' orders, such as, withholding CPR, it is unreasonable to expect nurses to carry out such important orders if they are not aware of why they are doing so, or if they have to carry out such orders unwillingly. This situation has an historical basis in the nurse's role as assistant to the medical officers, who had their own extensive professional domain of
physical cure. Watson's theory offers nurses their own exclusive domain of care, focusing on holistic health, rather than physical cure. Particularly in the case of DNR patients, where medical officers have no hope of enforcing their domain of cure, nurses may suggest alternative treatments and intervention, based on a theory of care such as Watson's theory for their own specialised, professional domain.

Another issue concerning medical obedience and subsequent legal problems is that medical officers often consider the patient's physical and psychological cure without 'treating' spiritual and emotional ailments. Here the emphasis is on physical 'cure' only, which can cause feelings of distress for nurses. The cause of this distress is that when the 'cure' cannot be achieved as in the care of a terminally ill patient and patients with DNR status, the patients can feel loss and a sense of meaninglessness. This can make the nurse feel incompetent in their ability to comfort care for such patients. In my experience administering appropriate medication and treatment is insufficient for these patients whose needs are far greater than those being acknowledged. Thus the relationship between the patient and the nurse is not satisfying for either, as a result of the nurse's traditional cure focus.

Watson's orientation to nursing lies partly in the history and tradition of nursing which has been influenced by medical groups. The professional lives of nurses were directed by medical officers. Nurses were dedicated, self-sacrificing and deferring. This can cause nurses to
have difficulty with authority and self-esteem. They lack autonomy in this system, and may resort to medical authorities for this. In my experience in clinical nursing practice, nurses are very much occupied with the completion of tasks, procedures, charts, physical care, and management of the ward, which does not lend itself to professional or personal autonomy in a holistic caring role.

Nurses are prone to be rigid, conformists, self-controlled, self-regulated, self-composed, and highly professional - to the extent that there may be no expression of personal feelings and no treatment of fellow nurses as individual people (Leonard, 1989).

Thus using Watson's theory, nursing care can be extended to involve not only physical care but concern for the well-being and harmony of all aspects of the patient. It allows for a focus on the patient's health-illness experience and so dignifies the patient by acknowledging and responding to their view of themselves. This approach to nursing draws on a humanistic philosophy. Such a philosophy proposes that all individuals are worthy of respect and dignity (Leonard, 1989).

The Code of Ethics for Nurses in Australia (1993) stipulates that nurses must support the patient's autonomy, dignity, and quality of life despite their level of illness (Australian Nursing Council, 1993). Also Crowden (1994) identifies the fundamental moral commitments of the profession, and this provides nurses with a basis for self and professional reflection, and a guide to ethical practice. It also indicates
to the community the values which nurses hold. Although the Code of Ethics is important in nursing practice internationally as well as in Australia, the way nurses view death and their attitudes toward the right to die are coloured by their culture and what they are taught to value by society.

Socio-cultural differences between patients and nurses concerning death can cause difficulties for nurses. Moral practices based on cultural values and beliefs are not always congruent with ethical definitions of human rights and obligations in each culture. Thus unreflected prescriptions about right and wrong conduct infer action without choice in contrast to the ethical premise that choice involves action. Conflicts can occur, for example, if a family member decides that the patient is not to be given complete information about a diagnosis and prognosis. It is clear that such decisions interfere with the human right to bodily integrity and self-determination (Curtin, 1985), which means the nurse and the patient's family's view of dying with dignity could be different. In such cases, the nurse can experience personal dilemmas involving much stress and anxiety as her own professionally derived beliefs about her role as patient advocate and her own personal beliefs about dying may be in conflict.

Watson's theory (1979) provides support for the nurse in these type of situations. Watson's view of quality of life is based on self-actualisation, and clearly guides the nurse to act as patient advocate in
these situations, supporting the patient's right to information, despite the
family's wishes.

Specifically, in clinical practice acute medical - surgical wards,
Watson's ten carative factors provide guidelines for the support of DNR
patients in the following ways:

4.3. *Watson's carative factors applied to patients' and
nurses' need in DNR patients in acute medical-surgical
context.*

1. *The formation of a humanistic-altruistic system of values.*

*Patient's needs.*

This carative factor aims to facilitate growth and enrichment in the
patient. Altruistic behaviour can bring meaning to one's life through
relationships with other people as explored in chapter two. Thus the
DNR patient is able to find meaning and an inner understanding which
will greatly help his/her through what may be the last phase of their life.

According to Watson (1979) an understanding of one's inner being gives
the patient a keen sense of autonomy as their level of self is raised to a
higher plateau.
Autonomy is represented by one’s choice to be interdependent, a willingness to be cared for and to care for another and an acknowledgment that the experience of interdependence holds the potential for reciprocal growth and enrichment. Thus, Watson's theory facilitates care and growth and development of DNR patients in a holistic sense. Watson's humanistic - altruistic value system is congruent with and actively support patient autonomy.

**Nurses needs**

This first carative factor also helps overcome the dilemmas nurses' face as a result of the traditional focus of nursing on medical cure. This focus leaves nurses without a nursing goal in the care of DNR patients. However, focusing on holistic growth and enrichment can give nurses a realistic and appropriate goal in the nursing of DNR patients.

For truly caring nursing to be practised it is essential that the nurse also develops within a humanistic - altruistic values system. In order to interact positively in relationships with others, a well balanced personality is needed. It is further enhanced by a person who is aware, for example of their own views, values and beliefs and has an appreciation for the views of others.

Thus the nurse can feel a need to contribute to the world, by caring for and helping others. As McLaughlin et al.(1988) said, a nurse with a love of self and others who has a sound set of universal human values
will be better able to cope with DNR situations. Also, Marchette et al. (1993), support this view and indicates that such nurses are less likely to impose their own judgements on patients and their families but will be able to respect their differences and decisions, and so promote the patient's autonomy and protect their dignity. Codes of Ethics developed on and around Watson's human to human caring theory can support both patient's and nurse's growth and development in a personal and professional capacity, thus helping to institutionalise Watson's approach.

There is a certain amount of power that can exist in a patient - nurse relationship. Patient's rights can be forgotten in many difficult circumstances such as lack of time and staff. The humanistic - altruistic values help the nurse to focus back on the patient's needs, and supports them in catering to the whole patient as an emotional, spiritual, mental, physical being. This value system is closely related to the second carative factor - instillation of faith - hope.

2. *Instillation of faith - hope.*

*Patient's needs*

Faith - hope can be an important element in the quality of life of a terminally-ill patient. Where science has no more to offer them they can still establish a sense of faith - hope in the nurse's care for them and so improve their ensuing quality of life. It may help the patient to accept information from the nurse and engage in an attitude change and health -
seeking behaviour (in a holistic sense) so that their remaining life's quality may be improved.

With a faith-hope relationship established, the patient may experience a positive outlook, which can also positively affect their treatment thus lessening their discomfort (Watson, 1979). For DNR patients, faith-hope may be instilled in the nurse, a person, a health regime or their belief system which somehow carries them through their difficult situations and fulfils many psychological needs. Faith-hope can be a crucial ingredient in a DNR patient's sense of self, and builds on their humanistic-altruistic value system to develop their whole self and produce a positive healthy outlook on the remainder of their life. This can positively affect their dignity and autonomy and thus their quality of their life, as argued in the previous section of this chapter.

*Nurse's needs*

The faith-hope factor can have a similar influence on the nurse's outlook on life, nursing, and caring for DNR patients. Faith-hope can provide nurses with a positive outlook, an abandonment of a sense of futility in the absence of cure and a healthy, happy way to view the world. Thus the nurse is able to interact in an affirming way with the patient, feeling confident and assured. If the faith-hope relationship is two way, it is strengthened and a positive patient/nurse relationship can be established, to mutual benefit. This is extremely rewarding for the nurse on a
personal and professional level even when their duties involve the care
of DNR patients with no hope of physical cure.

3. **Cultivation of sensitivity to self and others.**

*Patient's needs*

Watson believes that without this factor nursing care would fail. It is an
extremely important for nurses to feel empathy, for self-actualisation for
self development and growth in others.

The patient is encouraged to face their feelings and problems, come to
terms with them and seek to overcome any shortcomings. The DNR
patient is encouraged to express his/her feelings be they positive or
negative and thus begin to resolve any internal or external conflicts.
This can lead the patient to a sense of inner peace and tranquillity where
psychological, emotional and spiritual growth take precedence. They
have the opportunity to confront their fears, anguish and the various
emotions associated with DNR in an objective, logical way. The patient
is able to work through their feelings towards self development and in
some cases toward self actualisation. Also, this factor connects with
the fourth carative factor, which is development of a helping trustful
relationship.
**Nurse's needs**

As Watson states "it is human to feel" (Watson, 1979, p.17). In other words, nurses who are able to recognise and address their own feelings, be they happy or painful can develop greater sensitivity toward the feelings of others. Such nurses are able to develop their self and fully utilise this self with others.

Nurses may become detached or insensitive to patient's feelings and present them with their professional character as a way to avoid their own feelings. Nurses who have sensitivity to their selves and to others are able to attain and promote higher level functioning and thus form fulfilling personal relationships for honest, mutual benefit rather than manipulative relationships driven by their own inner needs. Thus when the carative factor of sensitivity to themselves and others is operating, nurses function as more complete persons in a holistic sense and so can give more effective holistic care.

If nurses have well defined sense of their own self they are often more open and honest. Such a nurse will not feel threatened by those whose views, feelings, or beliefs conflict with his/her but instead understand and grow from that difference.

Sensitivity to self and others also helps nurses handle their own feelings in difficult circumstances. This has particular relevance to DNR situations.
When the nurse has the tools to come to grips with his/her own feelings, to recognise them and become attended to them, the nurse is much less likely to feel frustrated or true attend by the DNR patients perhaps different views of death. The nurses needs are not pushed back or denied and so they will be able to deal with them without becoming concerned by them and thus distracted from their patient focus or develop manipulative relationships as a result of their own needs.

4. Development of a helping - trust relationship

Patient's needs

Watson believes a helping trusting relationship promotes the patient and nurse relationship and determines the effectiveness of helping. Crowden (1994) found in his study that helping trust relationships involved empathy, congruence, nonpossesive warmth, and effective communication skills all of which are a critical factor in maintaining human dignity. In other words, the nurse with the ability to tune in to the feelings of another person and to affirm these feelings is able to better care for and develop a meaningful relationship with patients.

Empathic understanding tells the person that he or she is important and worthy of the nurse's time. This is particularly necessary in the case of DNR patients who may feel their remaining life is now meaningless. Thus the nurse's empathic communication with these patients can have a
positive affect on their self-esteem and dignity with the resultant positive outcomes discussed earlier.

Fowler (1989) supports this view and emphasises the need for human contact and empathy which enables the patient to live with as much physical, emotional and spiritual comfort as possible, and supports the values of the patient with respect to their own life. Also Watson's fourth carative factor focuses on congruence, empathy and non possessive warmth to help promote effective patient and nurse relationships. It creates an atmosphere which is non threatening, safe, trusting, and secure where acceptance, positive regard, and love are valued. This further enables the nurse to promote the DNR patient's dignity through acceptance and care of the patient.

Nurses needs

Nursing as a health profession, daily confronts people's struggles with their personal interpretations of the human predicament. At the same time death and dying are events that the nurse constantly sees and that often cause the nurse to confront their own interpretation of the human predicament. Watson's theory encourages honest and open communication between the nurse and the patient to facilitate a trusting relationship. This means the nurse is free to express his or her true feelings concerning the patient's wishes, although not imposing his/her views. Thus the nurse is not asked to adopt the patient's views, but morally to enact them on the patient's behalf. This clear difference may
be of some comfort to nurses facing a dilemma as a result of a difference between their own and the patient's views concerning DNR.

When the patient faces a DNR situation, nurses cannot be completely aware of what is going on with each of these patients' feelings. However, congruence between the patient's feelings and the nurse's perceptions needs to be sufficient so that inappropriate feelings and actions by the nurse are not displayed.

The empathy of a nurse is usually restricted by subjective experiences of life, so he/she needs to build up their understanding of the feelings of DNR patients.

Attitudes of judgement and the evaluation of the feelings of the patient with DNR status is not appropriate to the helping - trusting relationship. Acceptance is required.

Non verbal communication is often a much more reliable expression of true feelings for patients with DNR status because when they face the terminal stage of their illness they may can become depressed and do not want to talk, so that the communication skills of the nurse must include non-verbal skills in order to develop the helping - trusting relationship.
5. *Promotion and acceptance of the expression of positive and negative feelings.*

*Patient's needs*

Watson's (1979) fifth carative factor, that is 'expression of positive and negative feelings', focuses on the emotional feelings involved in patients' and nurses' relationships. In my view this factor ties in closely with both carative factors three, and especially four. However, in this case Watson is emphasising cognition and behaviour. Watson (1979) says "affective- cognitive consistency is usually sought by the person. An inconsistence between thoughts and feelings can lead to anxiety, stress, confusion, or even fear, it may alter understanding, influence attitudes, and affect behaviour" (p.40)

The DNR patient may well experience all of these emotions and more. This anxiety is magnified for a patient with cultural differences, when for example, a patient's family may see fit not to inform the patient of the DNR decision or not to translate the reality of the DNR situation. The patient can be left with many unanswered questions and no way of relieving their stress and calming their fears. Being encouraged to promote and accept positive and negative feelings the DNR patient is better equipped to tackle their thoughts constructively and directly. They may develop the ability to discriminate between their emotions and have an understanding of the cognitive processes which are responsible for these feelings. Thus they may experience less fear as
they can rationalise their feelings. However, for the DNR patient with cultural differences, the role of the nurse becomes even more important because culturally different attitudes towards death and dying may not find affirmation in hospital procedures which are contextualised by one dominant culture.

*Nurse’s needs*

As mentioned above, the nurse can play a large role in lessening the stress particularly for a culturally different DNR patient. A nurse who is able to promote and accept the expression of his/her own positive and negative feelings is able to recognise and address this need in others. Through development of a trusting relationship with the patient the nurse can bring up delicate issues with a patient's family which may greatly affect the patient. The nurse can explain the fears the patient may be experiencing and encourage the family to communicate more information to the patient. Being able to focus on these inner feelings improves one's level of awareness and inner control over one's behaviour and actions. This can in turn help the nurse to respond appropriately to DNR patients and monitor the expression of their own feelings when necessary for the patient's benefit, for example, by monitoring feelings of disagreement with a patient's choice.
6. **Systematic use of the scientific problem-solving method for decision making.**

*Patient's needs*

Watson's scientific problem-solving process when applied to the patient as a holistic being allows for more accurate diagnosis of their situation. Without this, patients' may be subjected to nurses' intuitive judgements which can be biased by their own social and cultural perspectives. Scientific problem solving, as suggested by Watson, needs to target the patients problem, as perceived by the patient, and should ultimately aim to help the patient achieve autonomy so they can more fully satisfy their own needs. This contrasts with many current applications of the scientific problem-solving method. For example, I have seen many cancer patients subjected to scientific problem-solving in order to achieve the medical officer's goal of finding an eventual cure for cancer. These procedures have often caused the patient much distress, anxiety discomfort and disappointment.

*Nurse's needs*

This carative factor helps the nurse overcome the dilemma of inappropriate care and consequent feelings of futility. If nurses are prepared to apply this method to the delivery of their care for the patient as a holistic entity, they are able to proceed systematically to provide care which is appropriate and satisfying to the patient's needs. This can
provide both a goal and method of nursing which is appropriate and relevant to DNR patients.

7. **Promotion of interpersonal teaching - learning.**

*Patient's needs*

Patients need to be able to find answer to the questions they have about their illness. The interpersonal aspect of teaching - learning allows individual patients to guide the interaction towards meeting their own learning needs, rather than be restricted to learning what the medical officer or nurse feels should be taught. This benefit comes from the two way interaction possible in interpersonal teaching - learning situations. Control can be left with the patient, thus promoting their autonomy. The outcomes of appropriate teaching - learning for the patient can be;

1. Information promotes accurate expectations and reduces discomforting discrepancies between the degree of stress expected for DNR patient and the degree of stress experienced.

2. Information increases the ability to predict what will happen, leading to the feeling of being in control, and reducing associated fears for of DNR patient.

3. Information fosters the realistic worry and mental rehearsal necessary for emotional acceptance of stress for DNR patients.

4. Information changes beliefs and reduces the dreadful fantasies that may be caused by the impending stress.
5. Information leads to intellectual understanding that may constitute
a method of dealing with the illness and may conceptualise it in a
less stressful way for DNR patients.

6. Information is intimately involved in the evaluation of situations as
threatening and the evaluation of ways of reducing threat for DNR

In this way, information can help create a reciprocal relationship
between the patient and nurse. The nurse, available to the patient
around the clock, can use honed assessment skills to continually monitor
the information needs of the patient and therefore respond to the
individual's ever-changing needs.

Nurse's needs

Patients can feel more satisfied and in control when interpersonal
teaching - learning situations are promoted. By meeting the patient's
expressed needs for information, the nurse can gain much satisfaction as
he/she sees the patient more able to manage and control his/her own
situation as a result of appropriate teaching. The nurse is also able to
learn and really understand the patient's needs and experiences in this
interpersonal interaction if the control of the learning is left to the
patient and not taken own by the nurse. This further helps the nurse to
provide appropriate, systematic care with the and goal of patient
autonomy. This provides an achievable goal for DNR nursing and can
give the nurse personal satisfaction and professional fulfilment.
8 Provision for a supportive, protective or corrective mental, physical, socio-cultural and spiritual environment.

Patient's needs.

This factor acknowledges patient's basic internal and external needs. The patient relies heavily on the values of their attending nurse to adequately recognise and meet their needs. The DNR patient needs an atmosphere conducive to inner growth and gratification whilst existing in surroundings that are aesthetically pleasing as well as clean, comfortable and safe. This allows the patient to feel valued, supported and internally happy and at physical ease and comfort, while allowing them to comfort their inner emotions and grow through self actualisation, spiritual harmony and control. The DNR patient thus can concentrate on his or her own mental and physical well-being as effect and efficiently as the limits of his or her health -illness status permits.

Nurse's needs

Watson stresses that this eighth carative factor is ineffective in all aspects of support, protection, or correction if the assessment, plan, intervention, and evaluation are not accommodated to the socio-cultural environment. The nurse has a huge responsibility to provide a suitable environment where the patient's physical needs are being met as well as their spiritual needs. The nurse who views the patient holistically
respects the patients need for comfort, privacy and spirituality, and so enables them to achieve their own growth.

This factor presents nurses with an ideal way of treating the patient and themselves. It can be seen to be both a professional development as well as presenting values which will benefit the nurse personally. When dealing with DNR patient's in the way outlined above, the nurse knows they are contributing to the patient's quality of life by performing the simple daily rituals associated with caring nursing, such as arranging flowers, cleaning room's to produce aesthetic comfort. This helps resolve the dilemma for nurses when nursing DNR patients results in feelings of futility.

9. Assistance with the gratification of human needs.

Patient's needs

The human needs which a nurse can help include spiritual and emotional as well as physical needs. Childress (1990) believes the principle of respect for autonomy is the most important among the moral principles guiding health care practitioners. Autonomy means that one human does not have either authority or power over another human. Watson's (1979) belief in self-actualisation as the ultimate human need ties in with the patient's need for autonomy, especially DNR patients who have no hope of physical cure, but may still achieve self-actualisation and so maintain their
quality of life. The DNR patient needs to experience a subjective state of awareness, with external recognition and acceptance of their own behaviour, desires, and motivations, and need to be able to take control of their own actions. To experience self-actualisation and thus autonomy, the patient needs an environment in which his/her self concept can be developed, leading eventually to self-actualisation as his/her various physical, emotional, mental and spiritual needs are met.

Foltz (1987), argues that an individual's quality of life is dependent on that individual's self-concept. Describing the influence that a terminal state or DNR states can have on a person's self-concept (notably the body self, the interpersonal self, the achievement self and the identification self), Foltz goes on to suggest that where an individual's self-concept is diminished or undermined, so too is that individual's quality of life. Watson (1979) sees quality of life as largely based on the patient's level of comfort in all aspects of their life - physical emotional social and spiritual. The DNR patient needs their basic beliefs, dietary laws, ideas about health and illness, the body, the spirit, mysticism, pragmatism, pain, death, cleanliness, and family ties to be provided for well-being to be achieved and maintained. Also, Watson's theory suggests that autonomy and self-actualisation embody the essence of quality of life. This is supported by Germino (1987), as well as by Graham and Longman (1987) who define quality of life as "a combination of minimal anxiety, a purpose in life, and adequate self-esteem" (Germino, 1987, p.299; Graham and Longman, 1987, p.342) which contribute to a patient's human dignity.
With internal needs, physical needs, and lower order biophysical needs being met the patient is free to travel to inner heights of self actualisation, representing the attainment of the highest order intra-interpersonal needs.

Nurse's needs.

In being aware of their patients' need, nurses will also develop a sense of their own intra-interpersonal needs. The nurse can be self-assured, confident, have a good self-concept and be developing towards their own self-actualisation, if their own needs are gratified. Achievement of self-actualisation involves interpersonal interactions which contribute towards another's growth.

Thus the nurse whose own human needs are gratified is then able to develop a good relationship with his/her patients, his/her patient's family, and healthcare staff and their own sphere of family and friends and thus further meet their own higher order needs. This can lead to successful public relationships and increased professionalism, especially when the nurse is faced with new or difficult situations such as DNR status.
10. **Allowance for existential-phenomenological factors.**

*Patient's need*

This factor acknowledges the foundation of the separateness and identity of each patient. Existential-phenomenological factors focus on the value of the individual as well as on understanding the feelings involved in the human predicament. This is the main consideration in human to human caring according to Watson's theory.

The patient benefits from a nurse who understands that any problems may be related to the patient's internal human predicament and not directly related to his/her external human predicament. This helps nurture the individuality of the patient which is especially, significant for DNR patients who need to maintain their dignity, integrity, and autonomy in what may be the last days of their life.

The whole patient is valued and considered worth developing. Thus, the DNR patient may feel 'really understood' according to a existential-phenomenological perspective. Thus the DNR patient can feel validated which positively affects their disposition, quality of life, and development of self actualisation.
Nurse's needs

The nurse who allows for existential-phenomenological factors realises he/she must look at individual's values and strengths both in their patients and in themselves. Thus, he/she will respect the individuality and uniqueness of others. This also senses to stimulate recognition of defining characteristics within themselves. The nurse can find depth and meaning within their own life as a result of their relationships with their patients.

Using this philosophy and awareness in DNR nursing situation can help the nurse personally and professionally. It can be a guiding influence in turning tragic life experiences into strengths. This is true in many cases as well as when dealing with DNR patients. The nurse adopting an existential-phenomenological approach will value the need for nursing him/herself and others. Thus the nurse can have increased perceptive ability, acceptance, and thus stronger relationships with patient, which helps particularly when acting as patient advocate for DNR patients.

This carative factor helps nurses combine the cure and care domains with an emphasis on human care. The nurse is able to adopt a holistic approach to patient needs. Using existential-phenomenology nurses help DNR patients to cope with their human predicament whilst being provided with the tools to create their own coping mechanisms.
4.4 Summary

As nurses who see their patients holistically, there can be conflict with colleagues who only consider the physical needs of patients especially in DNR nursing cases. Some nurses are painfully aware of their patients needs. Unfortunately they cannot always meet these holistic needs. In my view clinically there is a lack of quality communication time nurses have to spend with each patient, as documented by Cohen (1988). This is especially true in busy acute medical surgical hospital situations. In some hospitals the patient's wishes are not even known by health care professionals, who have had insufficient time to develop an understanding of the patient's values and beliefs. Unfortunately the reality of the day to day work load can mean the patient's dignity and holistic needs are not always catered for. As a nurse it can be stressful to see the patient's wishes not being considered.

Watson's ten carative factors present nurses with philosophies and ways of living and working whilst providing patients with opportunities develop their whole being in an environment which meets and provides for all of their human needs.
Chapter 5. Conclusion

5.1 Generalisations

Watson's background in the humanities, including psychology and philosophy, is apparent in her derivation of concepts. Concepts from the field of psychology (transpersonal transaction) and philosophy (phenomenal field) have been derived and utilised in her model to explain the dynamics of the human caring process.

Watson has used qualitative methodology, especially phenomenology with data collected empirically about the lived experiences and meanings of caring, in order to classify caring interactions in her synthesis of the theory. Concept derivation can be seen in her ten carative factors that comprise the science and practice of nursing from the eleven curative factors of Yalom (1975). These curative factors stimulated Watson to think about the human components that would apply to nursing and caring and could ultimately distinguish between the care and cure ethic.

Watson has mainly used the phenomenological methods in her research but she readily acknowledges and promotes other qualitative methods (homographic methods, literary descriptions, photographic documentaries, music, dance, philosophic studies, ethno methodologies, historical research) that are reflected in her theory and are consistent with a human science philosophy. Her theory incorporates and
promotes research that recognises other ways of knowing, and modes of awareness.

Watson's theory provides direction for practice. Also her theory stresses a commitment to a holistic, humanistic nursing practice. According to Humphry and Wickett (1987), the care of DNR patients must have a holistic focus rather than a physical focus only.

DNR status patients face difficulties when being nursed in a cure-focused hospital ward. Their only hope of 'cure' lies in an holistic approach to health, and this approach is supported by Watson's theory of human to human caring. Watson's theory strongly emphasises the patients' need for autonomy and dignity. She presents an holistic approach to caring which integrates the care aspect with physical cure. Care targets the physical, mental, and spiritual being. The DNR patient is considered as a whole person and treated as such, not merely as a physical organism where physical cure is impossible.

The issue of carrying out DNR orders is also of particular concern to nurses. Simply, they are invariably left with the ultimate decision of whether or not to initiate CPR in an arrest situation. They also invariably left with the burden of having to accept the responsibility for the consequences of both their actions and omissions in arrest situations.

This is not always fully understood by attending nurse practitioners. It is absurd to suggest that nurses have no separate moral, legal or
professional responsibilities in situations where a patient's life and well being hang in the balance. Nurses also carry the personal burden of implementing DNR orders and must take a much stronger stand to ensure that sound and reliable guidelines and policies are brought into being not only to protect their own interests but equally, if not more importantly, the interests of their patients.

Watson's theory is a way of thinking and a way of life. The many dilemmas facing nurses in DNR nursing can be alleviated if they adopt Watson's approach. This makes for less stress, more positive relationships, self-actualisation and inner body harmony. A nurse with this type of disposition will be better able to care for his/her patients especially those of DNR status.

5.2 Recommendations concerning Watson's theory

5.2.1 Implications of Watson's theory for nursing practice.

As the nursing profession advances in the scientific area as well as the area of humanistic clinical practice, appropriate nursing theories need to be adopted. Quality nursing and health care to demand a humanistic respect for the functional unity of the human being. The phenomena of health-illness must be approached from a broad conceptual base. The mind is inseparable from the body and similarly, the scholarly activities of nursing should not be separated from its clinical practice. Watson's theory allows for the practical development of appropriate
philosophies for nursing care, the development of appropriate polices and can also be a guide for the daily activities involved in nursing care.

Watson's human care in the nursing process involves human-to-human contact between individuals, families, and groups. It is a major focus for nursing not only because of the dynamic human-to-human transactions, but because of the requirements for knowledge and commitment, because of the personal, social, and moral engagement of the nurse in time and space.

Watson's theory provides a focus for caring in a dynamic human-to-human transaction involving body, mind, and soul in harmony. Nowadays, nurses need to become more aware of the care that patients really want as opposed to patients receiving only every technological advantage.

Forrester (1990) expressed concern that nurses are too aggressive in delivering care to terminally ill patients at the end of their life. It should be the patient who chooses the aggressiveness of care after being informed of all of the ramifications, because nurses may not clearly understand that caring is not only for cure of the patient physically, but has to be holistic and involve the mind, body, and soul as well. Nurses can assist patients and families in evaluating the benefits of treatment versus the risks.
Economically, hospitals may not be able to continue offering procedures that prolong life due to the exorbitant cost of such care (Wadas, 1993). Therefore, in the not too distant future, patients may be fighting for the right to live as well as the right to die with dignity. Policies must be developed now to assist nurses and other health care personnel to deal with these situations.

Normhold (1986) felt policies should be developed to allow health professionals to deal with patients' decisions without compromising themselves legally or ethically. Nowadays, the laws require patients to be informed and deal with these issues. Most hospitals have ethics committees to assist with ethical dilemmas that involve end-of-life decisions. They could possibly utilise Watson's theory of human caring in their considerations. This could reduce the dilemma of nursing care for these patients and help patients achieve their rights and maintain autonomy and human dignity.

Changes in healthcare delivery have given individuals and families the power to decide about the quality of their health and health care. The nurse, guided by science and humanism, must have the patience to allow for and support the person's own healing process. Watson (1979) predicted that the emphasis for the healthcare worker would be on self-care and self-control for high-quality health and has accommodated this in her theory.
Expanded knowledge and skill and an expanded human value system are required in the changing focus of health care. Developing a philosophy that enables the caregiver to deal with the emotional crises of life such as caring for another person or facing death, can help one attain the ability to adapt to life's successes and failures. Watson's phenomenological basis supports this approach.

5.2.2 Implications of Watson's theory for nursing research

As a profession nursing must achieve a delicate balance between scientific knowledge and humanistic practice behaviours. A conscious effort on the part of the health profession to control disease, prolong life, and alleviate pain has brought dramatic results. However, little work in the area of the humanities and the behavioural sciences has addressed the deeper values of quality of living and dying. Therefore philosophical, ethical, psychosocial, and moral issues need to be better addressed and research is one way to do this based on Watson's theory.

Watson has attempted research using her framework and has used empirical data amenable to research techniques in her work. She believes that there is often a chasm between the essential qualities and subject matter of nursing and the methods the nurse uses for research. As with her concern for uniting the liberal arts with nursing education, Watson hopes nursing research will incorporate and explore aesthetics, metaphysics, empirics, and contextual methodologies.
Because of the differences between science and the humanities, it is now possible to define an outcome of scientific activity such as prolongation of life without referring to aesthetic-humanistic aspects such as quality of life and death within the arenas of the nursing profession. This dehumanises the patients, to their detriment.

Research based on Watson's theory can broaden nursing to include a more holistic care and human centred approach to nursing knowledge. Watson's theory can, of course, be itself investigated through research.

5.2.3 Implications of Watson's theory for nursing education

As a profession nursing must achieve a delicate balance between scientific knowledge and humanistic practice behaviours. Therefore it is important for nursing to realise the need for both a professional and liberal education.

Watson's curriculum of concepts is now widely used in nursing programs in Australia (Marriner-Tomey, 1989) and in some programs in Sweden, Finland, and Great Britain. Watson (1985) believes her theory will have more acceptance through a liberal arts college with a religious background than through the large university setting, unless the university curriculum is committed to liberal post-baccalaureate professional nursing education.
Watson (1979) addresses these charges in the preface of her book, where she defines her intent to describe the core of nursing, that is, those aspects of the nurse-client relationship resulting in a therapeutic outcome - rather than the trim of nursing, that is, the procedures, tasks, and techniques employed by various practice settings. Using this focus, the framework is not limited to any nursing speciality.

Watson's theory can also help nurses deal with ethical, and moral dilemmas, especially when nurses are involved with a DNR patient or acting as patient's advocate in the DNR decision making process. Watson's theory of human caring presents a framework to nurses based on ten carative factors. These factors enable the nurse to exhibit appropriate sensitivity and behaviour in dealing with patients and families, particularly in the area of DNR decision making.

5.4 Summary

In this chapter I have shown Watson's theory of human caring as applied to clinical practice to support specifically individual approaches (Wadas, 1993), directed towards the person, and in situations involving person's suffering disharmony between their mind, body, and spirit. Also, curriculum and concepts derived from Watson's theory are now widely used in nursing programs in Australia (Watson, 1985) and "other countries" (Marriner - Tomey 1989). Her theory of human to human caring is used in practice by nurses to help develop their knowledge and skills in dealing with human phenomena and to support the autonomy,
and dignity of patients and their families. Its application can help develop nursing perceptions of the ethical dilemmas which inevitably arise in practice.

The view in Australia of the status of DNR is as varied as its practice. The reasons for nurses' ethical dilemmas concerning such decision making have been discussed. Because of these dilemmas nurses are reluctant to undertake a subservient role in healthcare and want to take more interest in ethical questions (and hence answers). The decision making process surrounding DNR has been discussed in relation to the patient, family, nurses, and medical officers. DNR nursing raises many dilemmas as outlined previously for nursing practice which are addressed in this investigative report by the theoretical application of Watson's theory. However Watson's theory still suffers from a lack of consideration of unconscious patients. More study concerning DNR status patients and Watson's theory needs to be conducted.
References


Aids Council of NSW. (1994). *Choosing to die*. Darlinghurst: ACON.


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INVESTIGATIVE REPORT

DO NOT RESUSCITATE: BIOETHICAL AND NURSING PERSPECTIVES.

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Submission date: 25/9/1995
PLEASE NOTE

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APPROVAL

I, A. J. Walters, as the academic supervisor of Kyung Hae Lee's (Helena) Investigative Report, acknowledge that this work may proceed to examination

[Signature]

Dr. A. J. Walters
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Abstract

This report focuses on the use of Watson's theory of human caring for Do Not Resuscitate (DNR) patients in acute medical - surgical wards. It discusses the dilemmas facing DNR patients and their nurses and explores the solutions to these dilemmas offered by Watson's theory. Traditional nursing practice places the nurse in an difficult situation by focusing on physical health.

The report discusses the philosophical assumptions underlying Watson's theory. These assumptions lead Watson to focus on nursing holistically, and to emphasise an integrated approach to nursing, which promotes the comfort of the patient physically, spiritually and emotionally. Her focus is on the broader aspects of caring such as involving the care domain of nursing, instead of the narrower view of nursing which focuses on care for the 'cure' only. This approach is particularly relevant to DNR situations because these situations involve patients for whom there is no physical cure. Watson's holistic approach to caring offers the nurses of DNR patients guidelines for their nursing practice and meaning for their nursing actions.

Because current DNR decisions are often made by medical officers but implemented by nurses, it is the nurse who may be legally liable for the patient's death. This can cause anxiety for the nurses involved. Another cause of anxiety can be the traditional focus in nursing on physical cure. In the care of DNR patients, no such cure is possible. This can leave the nurse feeling distressed and incompetent. DNR the
patients, may lack of autonomy and suffer feelings of insecurity. It is in these areas that Watson's ten carative factors can offer support, for both patients and nurses.
**Introduction**

This investigative report considers the benefits of applying a nursing theory - Watson's science of human to human caring - to the nursing of DNR patients, with particular focus on acute medical - surgical hospital ward contexts. It does this through an analysis of the present situation with respect to DNR orders, and an analysis of Watson's theory - its conceptualisations, and philosophical underpinnings - and a discussion of how these can meet the requirements of both patients and nurses in the context of DNR nursing. Specifically, the report follows the structure outlined below:

The first chapter deals with the numerous related phenomena associated with DNR patients. The matters considered include patients' rights and needs, the family's wishes, the nurse's values, time constraints in nursing, legal problems and ethical considerations for nurses. Jean Watson's presents a theory which can help alleviate many of the problems arising in a DNR situation. Her theory is aimed at preserving and developing patients' autonomy and providing nurses with an appropriate outlook which can have far reaching benefits for themselves and for those they come into contact with.

Chapter two, discusses Watson's theoretical framework. She proposes ten carative factors as her framework for the implementation of her theory of human to human caring. These factors are explained at length
and their basic assumptions are explored. Patient autonomy is central to Watson's theory and a goal of holistic health care.

Chapter three contains a review of the philosophical underpinnings of Watson's theory. It describes how Watson's theory was developed and constructed from a basis of a human science and human caring and as such it is qualitatively continuous with an existential-phenomenological view of understanding human feelings and actions. Also Watson used in her methodology traditional, scientific evidence, and human science. This explains her concept of nursing, which incorporates actions, and other behavioural aspects of nursing, but which also allows for some relativistic notions such as the meaning that nursing may have for the experiencing patient. It explores the nursing presence as it exists in a patient's mind, even if the nurse is not present physically.
Her underpinning philosophies of empiricism, existential phenomenology, transcendental phenomenology, traditional and human science are discussed.

Chapter four, applies Watson's theory to DNR status patients in clinical practice in acute medical-surgical contexts. Watson's theory of human caring is applied to several dilemmas for DNR patients and nurses identified in chapter one. Her ten carative factors are applied theoretically in clinical contexts involving DNR patients and their nurses. Nurses must seek to respect their patients' autonomy, develop
self actualisation, and ensure the patient is experiencing quality care which leads to a quality life.

Chapter five summarises the outcomes of this investigative report and outlines the implications of Watson's theory as applied to practice, research, and education. The problems relating to DNR status nursing are shown to be lessened when Watson's theory is in practice. However more research is needed to document the results obtained by nurses using Watson's theory - thus lending the theory more concrete and irrefutable support.