

**Caring as the Essence of Moral Imagination in Nursing**  
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My thesis in this presentation is that caring is fundamental to—in fact, it is the essence of—morality in nursing. According to prominent nurse theorists, Jean Watson (1998) and Madeline Leininger (1991), caring is nursing's moral imperative. Now before you tune me out because you think caring sounds too soft, too easy, or too nonacademic, I hope you'll give me a chance to convince you that caring is none of those things. Caring is substantive, it's difficult, and it encompasses both the science (the knowledge, judgment and critical thinking) and the art of nursing.

Bear with me while I provide a very brief orientation to the discipline of nursing as a backdrop for this discussion. According to Nursing's Social Policy Statement (ANA, 2003), nursing attends to the full range of human experiences and responses to health and illness. Nursing practice encompasses the prevention of illness, the alleviation of suffering, and the protection, promotion and restoration of health in the care of individuals, families, groups and communities; so nursing's central emphasis is health. With respect to the notion of nursing as a science and an art, I would suggest that it is relatively easy to recognize, articulate, and evaluate the scientific component. For example, we can determine the extent to which students and practicing nurses understand health and illness (including the application of pathophysiology, psychology, chemistry, and anatomy); we can assess how well they apply the principles of pharmacology to the administration of specific drugs and to the evaluation of desired and untoward effects in particular patients. We can evaluate to what extent they have mastered the skills of health assessment, diagnosis, and intervention; and we can measure the degree to which they use critical thinking and clinical judgment to apply what they know. It's a great deal more challenging to recognize, articulate, and evaluate the artistic (or moral) components of caring, such as the presence or absence of genuine concern for others and the art of being truly present to another in an interaction. To a large extent, the art of

nursing reflects attributes of the individual nurse and is sometimes most evident in its absence.

So why isn't caring soft? Why isn't it something anyone can do? Why does it require a college level education and more? I would assert that caring represents the living out of both our epistemology and our ontology in the real world—with real people in real contexts and real time. Caring encompasses competence in the generation and application of our knowledge and our science as well as a fully conscious, reflective learning of **how to be** in relationship with the recipients of health care.

And is it easy? Does it come naturally? In one sense, you could credibly argue, 'yes'; some elements of caring may be part of our socialization to being human. For example, most parents care deeply and almost naturally for their children—from their anticipated arrival before birth to their own or their children's deaths. And how (mostly) easy it is to care for another in an intimate relationship. Caring for and about those who are our soul mates is easy. But I'm talking about a call to care not only for those who are like us and for the "beautiful people" to whom we are attracted but to provide care and caring to those whose lives, values, and cultural backgrounds are very unlike our own. Entering into a caring space and inviting relationship with those who are different, with those who espouse values not only different from but often in conflict with our own, with those who have different standards of health and hygiene (who may be dirty, disheveled and may even smell bad)—this is the true test of caring. Even caring in an intimate loving relationship is not all that easy. Joseph Campbell (Campbell and Moyers, 1988) has said that "all meaningful relationships are ordeals." Think, then, of how difficult it may be to enter into a caring relationship with someone who alienates or repulses you in some way. Nurses' call to caring asks us to do this almost daily.

I'll try to paint an even clearer picture of what I mean by caring. In short, it is a genuine concern and desire to optimize the quality of life for another individual, a family, or a community. Because of the contexts in which nurses encounter people—in places where life begins and ends, in circumstances of joy

and hope as well as suffering, in states of confusion about the language of health care and about health care choices, of bewilderment about how to navigate our labyrinthine health care system, and of turmoil in the face of difficult decisions—nurses are privileged to enter what I have referred to as an intimate and sacred space with people. Some elements of this intimacy reflect a common stereotype about nursing—that it's all about doing things to people's bodies. I'm not ashamed to say that, yes, some aspects of physical care (comfort, therapeutic and hygienic care) provide an important avenue through which a nurse is privileged to encounter the wholeness of another. Jean Watson (1998) asserts that contact with people's bodies is extremely important, since all of us are embodied souls. Caring for people's bodies is indeed an intimate and holistic act.

I remember a colleague scoffing when I commented about Sandra Looney's holistic approach to literature and suggested that we don't all live consciously as the whole, integrated beings that we are. My colleague asserted that we've all moved well beyond the notion of separate components of the self (e.g. mind, body and spirit as separate entities). I would counter that while we may espouse that there is no separation among mind, body, and spirit, most of us live our daily lives in a way that clearly relegates awareness of our bodies to the background. We take the physical aspects of our being for granted—largely ignoring them until they have the audacity to stop functioning smoothly and invisibly. When some aspect of our bodily function sabotages us by refusing to remain invisible and innocuous, when our bodies thrust themselves into the foreground, we are forced to acknowledge our unitary nature in a new way. This may put a different spin on the significance of encountering people through caring for their bodies, as a way of affirming their wholeness.

But caring in nursing is a great deal more than caring for bodies. Nursing and caring are fundamentally rooted in relationships (authentic, interactive connections). And relationships are, in large part, grounded in the quality of presence. Presence, according to Jean Watson (1998), can be described as a genuine "showing up" for people in the fullness of who we are, engaging with the

wholeness of the other in the relationship. Presence, as I mentioned earlier about the art of caring, may be most recognizable by its absence. I think we've all been in situations with someone who **appeared** to be present—in class or in a conversation—but was clearly not fully attentive or engaged. Real presence is showing up fully in our interactions with people, being wholly there in the moment, accessible, intentional, and genuinely concerned about the other in the interaction. And I think we all realize, at an intuitive level, that the presence of another human being can be experienced in either helpful, healing ways or in harmful, destructive ways. You've no doubt been with people who exude these different influences (positive, uplifting, and healing or negative, oppressive, and depleting). This relational element is what I refer to as nursing's ontology—our way of being with people—our way of communicating through our presence.

To further illustrate caring, nurses have an extensive arsenal of skills to respond to the suffering of individuals and families, but there are times when our ability to provide relief is not adequate; we've exhausted all the options for diminishing pain and other symptoms. In those instances, we can still “bear witness” (Parse, 1999) to others' suffering, validating their experiences, having the courage to journey with them, being fully present. When I talk about suffering, I'm not referring to suffering that is exclusively or necessarily corporeal (bodily) in nature. According to Rodgers and Cowles (1997), suffering is the “inner experience of losing a part of the self” (p. 227). Any profound loss or threat of loss may be experienced as suffering: a physiological change that alters one's way of interacting with the world (This may be precipitated by physical illness, disability, or an altered sense of self.); pain; disconnection (through loss of employment, disrupted interpersonal relationships, homelessness, poverty, or isolation from society in general); or an extreme discrepancy between one's ideals and one's reality. Nursing's ethic of caring acknowledges our human interconnections in such a way that, at some fundamental level, the suffering of another individual and even of collective humanity becomes our own.

According to Glaser (1994), the fundamental principle of ethics is beneficence (doing good, loving, or caring). Ethics, the conscious and intentional

reflection upon and taking action congruent with our deepest values and beliefs, helps us come to know a right or a good thing to do in a particular situation and then, further, to **do** the right thing. Nursing's code of ethics (ANA, 2001) delineates some specific ways in which nurses are mandated to do the right thing: by respecting clients' dignity and rights to informed self determination, by maintaining competence and accountability for safe practice, and by more broadly safeguarding the health and welfare of individuals and communities, for example. The duty to safeguard clients and the public at large entails both genuine communication with members of other disciplines and responsibility for intervening when another practitioner's incompetent, unethical, or illegal behavior becomes apparent.

With the current emphasis on efficiency, technology and cost containment, in an environment that is moving rapidly toward drive-through health care delivery, nurses frequently provide human touch to bridge the gulf between technology and the recipients of health care. You may remember John Naisbitt's high tech/high touch challenge: to maintain meaningful connections as technology threatens to erode them. That challenge has been renewed (Naisbitt, Naisbitt & Philips, 1999), and nurses frequently stand in the epicenter of the response to this renewed challenge.

Caring and being cared for can be transformative, and even life-giving. Through caring, nurses can facilitate individuals' connections with each other and their families and communities at times when their fears and vulnerabilities make them most accessible to connections, not just with each other but with new or hidden aspects of themselves and with their God. At the same time, caring experiences transform the person of the nurse as well—both personally and professionally. The profound interactions that we as humans share with each other contribute to the evolving ontology of the student, of the nurse, and of each of us as human beings.

As I said earlier, true caring actually subsumes knowledge, competence, critical thinking, and technical skill—whether one is caring for a child with a serious illness, for a family experiencing the lingering death of a loved one, for a

woman coping with a recurrence of cancer, for a community group redefining its health in light of a recent disaster, or for a person and family in their day-to-day living with the pervasiveness of a chronic health condition. I would further suggest that at the heart of the nursing profession there is a calling. It is a calling to care, to accept the sacred trust of entry into people's lives, often when they are most vulnerable, and frequently in very intimate ways.

So no, nursing's moral imperative to care is not soft nor is it easy. The question that plagues me as a nurse educator is whether we can teach this caring aspect of nursing, or do some people simply have it and some not? We have developed some ways to cultivate caring or moral imagination in our students, but do we always succeed? I'm not sure, and I've concluded that getting a handle on the caring art is a bit like trying to grab hold of a running stream of water or nailing jello to the wall.

In a practice discipline like nursing, one of the important ways we cultivate caring as moral imagination is by providing opportunities for students to encounter real people with real issues and real needs through their clinical experiences. And they do this in the presence of faculty and practice mentors who challenge, affirm, and partner with them in integrating the art and science of caring and in evaluating their progress toward that end. But it's more than just a simulation or a dress rehearsal. It's the real thing, even though a mentoring safety net is there.

We also invite students into discussions of practice vignettes (simulations and case studies), of current issues in nursing and health care, and of frameworks for "doing" ethics and for focusing on the well being of the community as the primary concern of nursing. The curriculum is richly infiltrated with opportunities for students to consider health from the perspective of individuals, families, special groups in the community, and even the community at large. And I believe we, as faculty, both teach and live the notion of ethics as "communitarian conversation." Glaser (1994) recommends this kind of conversation as essential to ethics in order to lift up community as "the keystone of beneficence (ethics)" and as the "ocean in which we swim." (p. 26). So have

we arrived? No. The ongoing challenge is that if we want students to participate—and even become leaders—in community dialogue, we need to not only provide them with a theoretical basis for ethical, community-focused practice but also take them into the world to try this on. The curriculum should do this, right? And what is the curriculum? I would assert that any curriculum is grounded in relationships. Bohm and Nichols (1996) describe relationship as “a stream of meaning flowing among and through us and between us.” (p.6) I believe, therefore, that the curriculum is everything that a student experiences in relationship with faculty, with other students, with staff, with professionals in their clinical experiences, with recipients of health care, with members of the community in which they live, and with themselves. If students are to learn how to invite and participate in community dialogue, they also need to experience membership in a community where **their** voices are invited and considered as relevant contributions to the dialogue.

This expectation of curriculum as a path to ontology fits well with Wolford's (2003) assertion that a part of the institutional vocation of Lutheran colleges is “to create an environment that encourages students to explore their beliefs, values and personal vocations...(and invite them) to live with purpose in all dimensions of our human existence.” (p. 10) Wolford suggests an even broader “global vocation” for institutions like Augustana to invite, encourage, even “nudge” students beyond their comfort zones, equipping them to move into diverse and even global dialogues.

I think many of these curricular enticements are here at Augustana in our liberal arts curriculum (How could we educate nurses with that?), in classrooms and faculty offices (where we teach by who we are and how we show up for students), in residence halls, in college and community-wide forums, in chapel activities, in internships and international experiences. In all of these arenas, possibilities are created for students to learn how to apply what they know and discover who they want to be in relationship with others. In essence, they hopefully **live into** their moral imagination.

A recent development in nursing, the nursing shortage, has complicated the educational commitment to caring as nursing's moral imperative. In response to that shortage, nursing has become a more financially appealing career with plentiful job opportunities in a growing variety of roles and geographical locations. For me, this raises a concern about who is now being "called" to nursing and for what reasons. So I return to my earlier question, embellishing it with a few more: Is our curriculum strong enough to compel students to care? Can anyone learn to care? Is it a personal attribute that is either present or absent? Is it a choice? Now that we have the luxury of more applicants to our nursing program, I worry about how to evaluate the caring potential of would-be nurses as we look at applicants and as we continue to evaluate students in the major. We have academic requirements and support course requirements for admission into the program and continued academic criteria for progression. In most respects those are pretty straightforward, but the caring/ethical/artistic components are still pretty intangible. I've been considering whether my legacy to nursing education should be the development of some kind of litmus test for genuine caring, perhaps a "Nelson Caring Scale" or, more crassly a "Nelson Give-a-Damn Factor" scale.

Many years ago, when I was fairly new to nursing management, a supervisor showed me a button that she wore underneath her lapel. It was a humorous coping strategy for the multitude of demands that came her way. She could just turn the collar up and peek at it when her frustration level was rising into the danger zone. What the button said was, "Surely you have mistaken me for someone who cares." Well, I've encountered some nurses in my professional life (thankfully very few students so far) who really should wear that button on the top side of their lapel, visible for all the world to see. One example is the night nurse who was always there with her claws sharpened early in the morning when my group of students came to the hospital unit for their clinical experiences. No matter what they did in that brief time before she went home, she could find a reason to berate them or offend them or blame them just for being there. If that wasn't enough, one of our graduates went to work on that unit and still has scars

from the abuse she incurred as a new graduate. This nurse was a living example of an intraprofessional debate about whether nurses eat their young. As you can imagine, that nurse's lack of caring spilled over into her relationships with patients as well. One night--very early in the morning actually, not long before the end of this nurse's shift--a young man with hemophilia was admitted to the unit with a painful bleed into a knee joint. She scolded him for the inconvenience he caused her because his clotting factor was sluggish in running into his intravenous line, delaying her report to the next shift.

Another nurse who qualifies for the lapel pin is really a composite or an exemplar: the nurse for whom the primary concern is that a patient not die "on my shift" because of the burden of work involved rather than whether the patient dies with the greatest comfort possible and in a way that is most authentic for the patient and family. These brief examples are illustrations of ways in which nursing's moral imperative to care was notable by its absence, and thankfully they are rare.

Fortunately, there are many more anecdotal stories of nurses who weave together the art and science of caring in ways that respect the values, privacy, and dignity of others; who provide appropriate and intelligible information about health and illness so that people can make decisions and learn to care for themselves; who assure that the voices of individuals, families and communities are heard by health care providers and policy makers; who create and protect a sacred space for healing; and who maintain true presence in the face of suffering. As educators, I believe we are called to cultivate, nurture, and be vigilant in holding sacred caring spaces at Augustana so that students can live into the moral imagination they need to contribute to the quality of life and health in our communities.

## References

American Nurses Association. (2001). Code of ethics for nurses with interpretive statements. Washington, DC: American Nurses Publishing.

- American Nurses Association. (2003). *Nursing's Social Policy Statement*, 2<sup>nd</sup> Edition. Washington, DC: American Nurses Publishing
- Bohm, D. & Nichols, L. (1996). *On Dialogue*. Routledge.
- Campbell, J. & Moyers, B. (1988). *The Power of Myth*. Doubleday, New York.
- Glaser, J.W. (1994). *Three Realms of Ethics: Individual, Institutional, Societal*. Kansas City, Mo., Sheed & Ward.
- Leininger, M. (1991). *Culture Care Diversity and Universality: A Theory of Nursing*. New York: National League of Nursing Press.
- Maeve, M.K. (1994). The carrier bag theory of nursing practice. *Advances in Nursing Science*, 16, 9-22.
- Naisbitt, J., Naisbitt, N., & Philips, D. (1999). *High Tech/High Touch: Technology and our Search for Meaning*. Bantam Books.
- Parse, R.R. (1999). *Illuminations: The Human Becoming Theory in Practice and Research*. Jones & Bartlett.
- Rodgers, B.L. & Cowles, K.V. (1997). A conceptual framework for human suffering in nursing care and research. *Journal of Advanced Nursing*, 25, 1048-1053.
- Watson, J. (1998). *Postmodern Nursing: Redefining Nursing*. Elsevier.
- Wolford, K. (2003) Service beyond the comfort zone. *Intersections: Faith + Live + Learning*, 18, 9-13.