TEACHING CARING IN NURSING: A NEEDS ASSESSMENT

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Abstract

Despite the fact that caring is the heart of nursing, there is growing evidence that nurses are not as effective as they ought to be in their caring role. This signifies that more attention needs to be given to the teaching of caring. The aim of this study was to pave the way to initiate the process of research on teaching caring, by suggesting priority areas. The needs assessment design was used for the study. Five steps were involved to achieve the aims. The first was to explore the nature and meaning of caring as presented in the literature. The second was to review completed research on aspects of caring within the nursing context. The third was to investigate the position of caring in the present nursing education system. The fourth was to investigate ways of promoting the teaching of caring as advocated in the literature and the final step based on inferences made from the first four steps was to suggest priority areas for research on teaching caring in nursing.

Opsomming

Nieteenstaande die feit dat sorg en omgee die hart van verpleging is, is daar toenemende bewyse dat verpleegkundiges nie genoegsame aandag aan hierdie rol gee nie. Die aanduiding is dat meer aandag aan die onderrig vàn sorg en omgee gegee moet word. Die doel van hierdie studie is om die weg te baan vir navorsing rakende die leer van sorg en omgee deur prioriteitsareas voor te stel. Die behoeftebepaling ontwerp is gebruik vir die studie. Vyf stappe is gevolg om die doelwit te bereik. Ten eerste is die aard en wese van sorg en omgee soos aangebied in die literatuur verken. Tweedens is aandag gegee aan voltooide navorsing met betrekking tot sorg en omgee binne die verpleegkundige verband. Derdens is die stand van sorg en omgee in die huidige verpleegonderwysstelsel ondersoek. Vierdens is aandag gegee aan onderrigmetodes om die leer van sorg en

In nursing education the main fundamental goal is to learn to care for the human person integrally as well as individually. To care for implies something more than taking care of and being technically and clinically competent. It entreats us to be humane, compassionate and sensitive in preserving the person's identity and integrity, in other words to be caring.

Caring serves as a measure of our commitment as nurses to provide distinguished service to people (Levine 1978:845). Leininger (1981) has called caring "the essence of nursing . . . the central and unifying domain for the body of knowledge and practices in nursing". Bendall (1977), Bevis (1982), Gaut (1968), Searle (1986), Watson (1979) and other nurses have concurred with this position. Leininger (1977:2) claims that "caring acts and decisions make the crucial differences in effective caring consequences. Therefore it is caring that is the most essential and critical ingredient for any curative process". Hyde (1977: Part IV)) posits that nurses can be life giving by caring for others. Care is vital to recovery from illness and to maintenance of healthy life-ways — it is part of healing. Reeder (1972:406) indicates that caring has a marked effect on the client utilisation of services, adherence to treatment regimens and satisfaction with services.

Yet, despite the fact that caring is a central theme in nursing (one can even purchase coffee mugs inscribed "nursing is the gentle art of caring") there is a growing body of evidence that nurses are not as effective as they ought to be in their caring roles. The literature amply documents the lack of caring that is evident in the health care system today. (Howard and Strauss 1975; Leininger 1988). Health care professionals themselves have examined the highly institutionalised bureaucracy of modern health-care facilities and describe these centres as "no-care" societies. They have identified three factors, pertinent especially in the physical environments created by highly intensive medically specialised units which have attributed to the sharp erosion of the "value of caring", namely the team approach, specialisation and the increasing use of high technology. (Goldborough 1969:66) The whole technical revolution in medicine has tended to increase the trend toward impersonal treatment.

It may be argued that these statements were made 20 years ago and no longer hold. Sufficient evidence however exists that these statements are just as pertinent today as they were two decades ago. Increasing numbers of patients and/or relatives and friends are voicing discontent over the care they received or the non-caring attitudes of care-givers. Patients charge health-care providers with dehumanisation and claim that the hospital or clinic experience is depersonalising. A person becomes just another patient, another disease, another medication order, another name on the daily operating room schedule . . . He is required to discard his identity as a unique person and become a patient who has to comply with the wishes of the care-givers. If he objects he is branded as difficult. To diminish a person's identity and sense of self by failing to respect an individual's values is to interfere with the person's healing and to obstruct a therapeutic nurse-patient relationship. It is also demeaning and unethical because the individual is not respected as a unique person. Levine

(1978:845) reminds us that caring is best exemplified ". . . when no act diminishes another person and no moment of indifference leaves him with less of himself."

Many complaints are heard about care-giver's indifference towards patient's needs and about nurses being impatient or snappy with relatives or displaying actions or manners of speaking that belittle or degrade patients or relatives, or who are not really listening to what patients are saying or appearing too busy to pay attention to the patient as an individual and ignoring his questions or requests.

My own personal experience as a patient and as a relative of patients, as well as reports from friends and acquaintances have confirmed this shortfall, as have incidental observations made by colleagues and myself in general wards of three different hospitals while researching some other nursing aspects. It needs to be emphasised though that non-caring attitudes are not limited to nursing students. Unfortunately we also see these attitudes in practising nurses, administrators and even among nurse educators who socialise the students. Such non-caring interactions and attitudes are often dismissed as isolated events or an exception rather than the rule. Granted, many of our nurses do care, and I sincerely hope the greater majority do so, but the fact remains that non-caring interactions and attitudes are a reality. In fact it seems that nursing has more than its fair share of non-caring individuals. As stated by Harrison (1980:39) "That indefinable attitude of mind of nursing personnel is so *often* lacking — the ability to demonstrate care by the tone of voice, the touch of hand, the expression of face." The question is — what can this state of affairs be attributed to? What can we do to improve it? Have we nurse educators in our concern with curriculum development and the setting of clear aims, goals and objectives or our preoccupation with professionalisation and public visibility unwittingly de-emphasised caring in nursing. Are we overlooking the process whereby one becomes a nurse in our striving for a product well endowed with terminal behaviours and clinical competencies? Are we perhaps viewing caring as less worthy than high tech and therefore not essential? Are we, nurse educators, the role-models for students perhaps modelling uncaring attitudes? Is it the organisation of the system that should get all the blame or is it perhaps the type of students we admit into nursing?

Such questions are not simple to answer and give rise to further questions such as : What research has already been done in this regard? What is the best approach to utilise for obtaining answers to the questions? and where does one start?

The aim of the study

The aim of this study was to pave the way to initiate the process of research on teaching caring in nursing by suggesting priority areas based on inferences from literature findings, documents, records and incidental observations.

The Research Design

The needs assessment design which is classified as a type of applied research approach, aimed at providing useful information by Polit and Hungler (1987:163) and Seaman (1987:221) was utilised for this study. According to Polit and Hungler (1987:63) "A needs assessment represents an effort to provide a decision maker with information for action. In other words a needs assessment serves as a primary source to provide informational input in a planning process. Smith (1982:13) states that formalised needs assessments can be used to establish priorities among possible content areas. In the case of this study the informational input required was priority areas for research on teaching caring in nursing.

In a needs assessment approach the researcher may use one or a combination of several techniques for collecting data. The techniques quoted by both Polit and Hungler (1987) and Seaman (1987) are: the key informant; the survey and the indicators technique. The latter technique combined with incidental observation was used for this study. The indicators technique relies on existing documents from which the researcher can conduct a secondary analysis of data in order to make inferences on "indicators of needs." (Seaman 1987:221). Polit and Hungler (1987:163) state: "The indicators technique is very flexible and may also be quite economical because the data are generally available but need organisation and interpretation."

Available literature on caring both non-nursing and nursing, theoretical as well as empirical; curricula from a purposively collected sample of five nursing colleges and two universities and a purposive sample of examination papers from these institutions constituted the documents from which inferences were made. Incidental observations were made in 6 general and 3 midwifery wards of three different hospitals by four observers, over a period of five days.

There were several steps involved to achieve the aims stated previously.

The first was to explore the nature and meaning of caring as presented in the literature. The second was to review completed research on aspects of caring within the nursing context. The third was to investigate the position of caring in the present nursing education system. The fourth was to investigate ways of promoting the teaching of caring as advocated in the literature and the final step based on inferences made from the first four steps was to suggest priority areas for research on teaching caring in nursing.

Step 1: Exploration of the meaning and nature of caring as presented in the literature

Before one can deal with the question about caring competency or educating for caring an adequate theoretic description of caring is required. Selected writings from philosophers, behavioural scientists and nurse theorists were reviewed to obtain greater insight into the meaning and nature of caring.

From the non-nursing literature Mayeroff's philosophical treatise on caring, Pellegrino's moral obligation model of caring and the descriptors of care and caring by existential philosophers in particular Marcel, Buber and Heidegger have contributed notably insights about the nature of caring. Mayeroff (1971:1) describes caring as "a process, a way of relating to someone that involves development in time through mutual trust and a deepening and qualitative transformation of the relationship. Caring for another one is helping him to grow and actualise himself, understanding him and his world as if he were inside it, seeing with another's eyes what the world is like for him." He identified and described eight major ingredients of caring. 1. Knowing and understanding the other's need both generally and specifically. 2. Alternating rhythms of help based on maintaining and modifying behaviour. 3. Patience. 4. Honesty. 5. Trust. 6. Humility. 7. Hope and 8. Courage (1971:9).

Pellegrino a humanist and a physician notes that there are at least four senses in which the word "care" is understood by the practice of medicine. The first is care as compassion or concern for another person. This is a feeling of sharing someone's experience of illness and pain or of simply being touched by the plight of the other person. The second sense of caring is related to doing for others what they cannot do themselves. This entails assisting others with the activities of daily living that are compromised by illness. The third is taking charge of the problems experienced by patients. It is a type of caring that assures that knowledge and skill will be directed to the patient's problem. The fourth has to do with ensuring that all necessary procedures (personal and technical) in patient care are carried out with conscientious attention to detail and with exemplary skill. Together the third and fourth aspects of caring make up what most physicians understand to be competence. According to Pellegrino care that conforms to all four definitions is called integral care. This type of care is a moral obligation of health professionals. (Pellegrino 1985: 9-13).

Martin Buber's I-thou relationship is the essence of an existential caring relationship, while Marcel's themes of presence, presensing and availability are particularly pertinent as a framework for a caring relationship. (Buber 1958:50; Marcel 1971:24,26).

Several nurse theorists in particular Leininger, Watson and Benner and Wrubel have explicated the phenomenon of caring in nursing. Leininger (1988:46) defines caring as "Those human acts and processes that provide assistance to another individual or group based on an interest in or concern for that human being or to meet an expressed, obvious or anticipated need. Professional caring embodies the cognitive and deliberate goals, processes and acts of professional persons or groups providing assistance to others and expressing attitudes and actions of concern for them in order to support their well being, alleviate undue discomforts and meet obvious or anticipated needs." Leininger (1988:8) furthermore states that human caring is a universal phenomenon but that characteristics behaviours and values relating to caring differ within and between cultures. Her research on transcultural caring has led to the identification of 85 ethno caring and nursing

care constructs including among others comfort, empathy, succour, surveillance, tenderness and compassion (1988:15).

Watson (1985:29) posits caring as a human value that involves "a will and a commitment to care, knowledge, caring actions and consequences. Such a view of caring requires a commitment on the part of the nurse to protect human dignity and preserve humanity. Watson speaks of caring as the moral ideal that is rooted in our notions of human dignity and that guides the nurse through the care-giver process.

She delineated ten "carative factors" that combine science and the humanities to analyse the care processes.

1. Formation of a humanistic-altruistic system of values
2. Instillation of faith-hope
3. Cultivation of sensitivity to oneself and to others
4. Development of a helping-trust relationship
5. Promotion and acceptance of the expression of positive and negative feelings
6. Systematic use of the scientific problem-solving method for decision making
7. Promotion of interpersonal teaching learning
8. Provision for a supportive protective, and/or corrective mental, physical sociocultural and spiritual environment
9. Assistance with the gratification of human needs and
10. Allowance for existential-phenomenological forces.

Benner and Wrubel in their book "The primacy of caring" state that caring means that persons, events, projects and things matter to people and create personal concerns (89:1).

They view caring as primary in a nurse patient relationship because it sets up the possibility of giving help and receiving help, and point out that the same act done in a caring and non-caring way may have quite different consequences. A caring relationship sets up the conditions of trust that enable the one cared for to appropriate the help and feel cared for. This is why nursing can never be reduced to mere technique.

The ability to presence oneself (this term comes from Heideggers Being and Time translated from German to English), to be with a patient in a way that acknowledges your shared humanity is the base of much of nursing as a caring practice. Simons (1987:2) has captured this sense of presensing in her review of research on caring.

"The presence of the nurse who pays attention was interpreted as caring by patients. Such attention includes more than a physical presence. It reflects a being "in tune" with each other. An awareness of unique personhood. Specific actions such as eye contact, body language and tone of voice are indications of caring as perceived by patients. These actions take no additional time and yet may make a difference in patient well-being".

From these writings it becomes clear that the phenomenon of caring is complex and multi-dimensional. It encompasses several aspects namely

1. certain feelings or dispositions within a person
2. the doing of certain activities that seem to identify the person as a caring individual or
3. a combination of both attitudes and actions in which caring about the other disposes the one to carry out activities for the other.

Caring is viewed as a process, product, condition, attitude and an activity. Universal concepts associated with the phenomenon of caring as found in this literature review — include concern, commitment, empathy, involvement, listening, honesty trust, sharing, person-centredness and verbal, nonverbal and technical skills.

Step 2: Review of research on caring within the nursing context

The first and earliest studies of care as an explicit, generic professional phenomenon began with Leininger in the early 1960's with the Gadsups of New Guinea, when she discovered various expressions of care such as protection, nuturance and surveillance (1977: 2-14). Since that time a small core of nurse researchers have been involved in the study of the meanings, expressions, symbols, interpretations and cultural contexts of human care. These studies have led to new insights about human caring, which can be incorporated in the teaching of caring. Findings from studies on transcultural care differences and similarities have clearly highlighted differences in caring and health values and have indicated the need for providing culture-specific care.

A brief description of a few selected studies on caring behaviours and constructs are given.

Rieman (1986) used a phenomenological qualitative approach to study caring and non-caring behaviours of nurses as perceived by clients. She interviewed non-hospitalised adults over 18 years who had prior interactions with a registered nurse, and were willing to share verbally their encounters and feelings. Three common themes appeared to describe nurse's behaviour in the caring and non-caring sense:nurse presence, patient uniqueness and care consequences. Caring nurses were described as those who physically and mentally made themselves available to the patient and listened and responded to the patient as a valued human being. The nurses individualised concern allowed the patient to feel comfortable, secure, at peace and relaxed. In contrast non-caring nurses were described as merely being physically present in terms of getting the job done. Non-caring nurses did not listen and appeared too busy to pay attention to the patient as a unique individual. The non-caring nurses behaviour resulted in the patient feeling frustrated, scared, depressed, angry and upset. Of note is the fact that clumsily performed technical procedures were not raised as instances of non-caring.

Swanson-Kaufman (1986) found five kinds of caring wanted by women who had suffered miscarriages. Caring involved "knowing that the woman's loss is unique to her as person" "being with the woman in an engaged manner" "doing for" the woman by providing comforting and supporting measures "enabling" the woman to grieve for the loss and finally "maintaining the belief" that the woman could bear a child. Brown's (1986) study of patient's perceptions of caring demonstrates another central aspect of caring. *Caring is always understood in a context.* In other words when the situation calls for technical proficiency, then technical proficiency (swift accurate actions) is experienced as caring. When the patient does not require technical actions, expressive actions such as recognition of the patient's uniqueness are identified as caring. Larson's study (1985) on oncological patients perceptions of caring reinforces this.

The responses from 57 patients undergoing one or more treatments for malignant solid tumours and using the Q sort method to rank the importance of nurses caring behaviours gave highest priority to having skilful care organised and on schedule. In another study Larson (1987) found that oncology patients and nurses had significantly different perceptions of the importance of 19 of 50 previously identified nursing caring behaviours.

Kahn and Steeves study (1985) of the meaning of caring from the perspective of the nurse in practice revealed certain complexities and paradoxes that exist about caring among nurses — for example on the one hand the nurses in the study asserted that "caring is part and parcel of everything I do; because I am able to see the patients as unique individuals — I can care about them" and on the other hand they relate caring to be somewhat dependent on liking, or in other words they see caring responses as elicited by patients. Patients who exhibit "unlikable" behaviour will not elicit caring responses from nurses. Such nursing practices can however be viewed as unethical. As Noddings (1988:7) puts it "An ethic of caring prefers acts done out of love or natural inclination; however acting out of caring also calls upon a sense of duty or special obligation if love or inclination to like fails. A recent statement by Cooper (1988:55) lends further support to Noddings view. Cooper stated "The nurses duty of fidelity to the patient is dictated by his or her choice to become a nurse and then to embrace the professional and moral responsibility inherent in such a choice".

Ford (1982) established caring behaviour categories listed by three sub-samples of professional nurses as to how they modelled nursing caring behaviour. Listening was the only category listed by all three sub-samples.

Besides perspectives from patients and nurses on their perception of caring, several nurse researchers investigated specific caring constructs. Gardner and Wheeler (1981) studied support and its meaning as a function of care with nurses in selected hospital units in the United States. Critical incidents and a Likert type scale rating approach were used. They found that support was a central concept of care as perceived by nurse respondent. Velazques (1969) found that nurses do not listen with all their senses to what patients tell them. She proposed that nurses who listen become involved in caring and committed to providing quality nursing service. Wallston et al (1978) studied the effects of intervention designed to enhance the person-centredness of nurses responses. A two phase design was used in which nurses in Group I did not

receive the intervention which consisted of a review accompanied by illustrative examples of helpful responses while nurses in Group II did receive the intervention. The data showed that the intervention was effective in increasing Group II's person centredness. This research indicated that significant improvement in judged person-centredness could be obtained. Amacher (1973) associated the notion of touch as caring with the notion of tenderness. McCorkle (1974) conducted an investigation of the effects of touch on seriously ill patients. She concluded that not only did touch promote physiological changes but it also conveyed to patients that they are not alone, that the nurse is there and has time to listen.

Step 3: The position of caring in the present nursing education system

The discussion in this section is based on inferences made from a variety of documents and incidental observations, some of which were purposively selected. The inferences serve merely as indicators of a trend which needs to be researched. Validation of these inferences in various settings should thus be seen as one of the priority areas of research on teaching caring.

Working on the assumption that professional literature serves as a mirror of what is of importance to the profession at a particular point of time a minicontent analysis was done of both South African professional nursing journals. All issues of "Curationis" and "Nursing RSA Verpleging" beginning with Vol. No 1 were examined. It was found that during the twelve years of Curationis' existence caring was referred to in only four articles and in only one case as a major concept (Harrison 1980), and in another case as an implied concept (Goodchild Brown 1987). Caring concepts were not incorporated in research on "Checking the quality of care" or "Standards of nursing care" — a sad sign, considering that caring is the heart of nursing. Caring as a major concept was not included in any article of Nursing RSA Verpleging. The conclusion is thus drawn that caring values are submerged in the nursing education system in this country. This conclusion was reinforced when the priority areas for nursing research as identified by 37 South African nurses leaders (Paton 1987:14) were examined. The phenomenon of caring was conspicuous by its absence in the rankorder assigned to the priority areas.

A similar trend was found when the common textbooks generally prescribed for the course leading to registration as a nurse and midwife were reviewed. No notable references to caring components, other than physical nursing care of various patient categories could be found. Searle's book on professional practice is an exception though. In this book four paragraphs are devoted to caring and it is emphasised that the caring aspect is the central concern of nursing (1986: 58-59).

The programme objectives for the course leading to registration as a nurse and midwife as laid down by the South African Nursing Council (No. R 425 of 22 February 1985) are also not completely devoid of aspects related to caring. For example students completing their course of study are expected to show respect for the dignity and uniqueness of man . . .; to direct and control the interaction with health service consumers in such a way that *sympathetic and emphatic interaction* takes place and to be able to maintain the ethical and moral codes of the profession. It is of course not known to what extent these components are related to or integrated in caring behaviours in the practice area. Research in this area is thus indicated. A number of aspects related to caring were included in the curricula for the course leading to registration as a nurse and midwife which were examined, particularly in the psychiatric component. Aspects such as interpersonal skills, therapeutic use of the self, empathy and stress alleviation were included, as was a component of the ethical foundations of nursing. It is however not known whether the ethics and values of caring were included. It furthermore appears as though these aspects are offered piecemeal and no evidence could be obtained that they were applied in practice.

Knowledge learned in isolation and not applied is rapidly forgotten and thus worth very little.

Examination papers included minimal reference to caring if any at all. Practical examinations focused on procedural skills. If aspects of caring were included they were negligible. Incidental observations revealed that the dominant focus in clinical nursing was on procedures tasks and technical skills. Very little evidence of caring was found.

From these findings the following conclusions regarding the position of caring in the present nursing education system were made.

- Nursing educators have adopted a rationalist objectivist model of education as well as an objectivist model of medical science, and have come to neglect the philosophical moral content of health and human caring.
- Behavioural objectives, factual information, techniques procedures or skills dominate the teaching-learning scene. With an already overloaded programme time is scarce and caring components such as valuing caring and moral reasoning are neglected. Many technical and physical nursing skills are taught, but they are rarely taught in relation to the use of generic and professional care concepts.
- Caring is not rewarded. The focus in evaluation appears to be on cognitive-technical outcomes or clinically competent professionals, thereby creating competency without compassion or caring.
- Doing is separated from knowing and from being. This encourages an atomistic mode of conceiving. Caring however requires a holistic orientation and integration.
- There is very little evidence of a caring environment in which nurses have to function. Students appear to be treated as objects rather than unique individuals, yet they are expected to show respect for the dignity and uniqueness of man. Power-dependence roles exist for teachers and learners. This is contrary to humanistic and caring philosophy. The caring approach is clearly underpresented and the preparation of caring professionals appears to be a somewhat neglected factor in the curriculum.
- A question which was posed by Leininger (1988:17) appears appropriate here. The question is: "If generic and professional caring is not taught and modelled in nursing, how can the nursing profession continue to make claims of being a "caring profession". How can patients be assured of getting care if nurses have not learnt caring principles and skills? Even more importantly, can the nursing profession ensure the transmission of care knowledge and skills to subsequent generations of nurses, if the present generation is not enculturated to use care knowledge and skills?".

Step 4: Ways of promoting the teaching of caring as advocated in literature

If nursing is to remain a caring profession in today's world of turmoil and catastrophe, then it is imperative to teach nursing students a way to be caring.

In order to identify indicators with regard to research that needs to be done in respect of teaching caring the existing literature was reviewed for completed research on the matter and suggested ways of developing caring in nursing students. There have been studies to determine effective methods to teach and evaluate individual caring constructs (La Monica 1983; Kalish 1971); on the teaching of caring (Gaut 1979) and to establish major components of a caring teacher (Bush 1988). The position of nurse educators attributes and modelling on student caring behaviours has also been the subject of investigation. (Layton 1979; Watson 1979)

Bush (1988:169) posits that student nurses must grow in insight about themselves as caring persons before they can understand the person who needs care.

The nursing teacher, by being an example of care, can effect a caring posture in the nursing student. For the student to learn caring, the nurse-educator must first exhibit and practice caring in other words she must role-model caring behaviours. In explaining the formation of a humanistic-altruistic value system, Watson (1979) has stated that an exchange of values may take place when the educator serves as a role model.

Because the student-teacher relationship is similar in some ways to the patient-nurse relationship concepts from the literature on caring within nursing practice are applicable to the teaching situation. In both cases there is one person who generally needs assistance and one person supposedly capable of giving that help. When the nursing teacher deals with the student in an effective manner, the student may experience a care feeling that should pervade the students own being. In turn the student can be caring when interacting with patients and others.

But what is a caring teacher? How can the caring teacher be recognised? What are the criteria by which to assess caring in a teacher of nursing? Bush (1988) suggested a model of a caring teacher based on findings from her research. According to the model a care teacher becomes caring through actions, mode

of reflection and personal writing (the latter includes writing down his personal beliefs on reality values etc. and his perceptions of himself as a caring teacher). This person needs a cognitive philosophy of nursing education, of what nursing is and of what the professional care person is. There must be an awareness and understanding of the self to be an effective caring teacher, a person who reaches out to *learn* with others. The teacher must have developed a philosophy of caring and should develop the following characteristics spirituality, presence, mutual respect, sensitivity, communion with the other and organisation of teaching-learning (the latter should be generated from Leiningers ethno care constructs and Watson's carative factors). Specific focus should be on provision for a supportive, protective and/or corrective mental physical sociocultural and spiritual environment, on coping behaviours, enabling, facilitating and stress alleviation and assistance with achievement (Bush 1985:182). This model could be used as a caring assessment guide. The model should however not be limited to the theoretical nurse-educator. It applies equally to the nurse educators in the clinical situation. A question which arises is — "Is the overburdened and overstressed ward sister able to be a caring role model? Some students may select other nurses who may perhaps be authoritarian or super-skilled nurse technicians as ones to be emulated. As a result the student may incorporate non-caring rather than caring behaviours. The use of carefully selected nurse preceptors who are relieved of some of their ward duties may help to remedy such a situation. When correctly selected a nurse preceptor serves as role model, friend and mentor, as well as a skilled practitioner for students. The students interpret this as caring. The University of Colorado School of Nursing Centre for Human Caring has introduced a consultation service "caring for the caregivers" to help nurses bring the satisfaction of caring back into their ward environment and to provide them with new knowledge insights and skills with which to create an environment that supports and sustains their commitment to human caring. Groups of nurses interested in taking charge of the context of their profession through this programme begin by meeting with the co-ordinator of the programme. This care group then establishes a "community of caring" within the floor, unit or organisation by planning specific short and long term goals, projects and strategies. The group learns to use strategies of human caring to nurture, support and care for its members and identify the values that are important to them as a group and utilise these to develop the type of environment they work in. This programme is at present receiving national attention in the U.S.A. (U.C.S.N. 1989).

Bush (1988:173) refers to research done by Bender (1978) Sizemore (1979) Benedict (1979) and Trimborn (1983) which reveals that a caring attitude on the part of the teacher was important to students in terms of their achievement, performance and self-esteem. Explanations of material and willingness to help students were priorities to them. The difference in what students perceived as important and what their teachers designated as important was significant.

Watson and her colleagues from the University of Colorado School of Nursing are engaged in research aimed at contributing to the development of a new health and human caring science model and a new educational model for preparing professional caring nurses. The moral context of health and human caring in nursing within a humanitarian paradigm is the starting point and is guiding the school in its research.

Educators acknowledge and act on caring as a moral ideal and incorporate philosophical theories of human caring, health and healing into their currricula. They acknowledge and act on their commitment to prepare nurses as both educated persons and full health and human caring professionals. They include aspects of health healing and human caring knowledge practices that are not yet considered part of the standard nursing curricula.

They have adopted a humanitarian paradigm that identifies the humanities, social-biomedical science and human caring content and process as the core of scholarly academic activities and clinical care practices.

They adopt a contextual approach in teaching the subjective philosophical and ethical/caring responsibilities of nurses.

They teach philosophical and ethical decision making skills based on ethics of human caring. They emphasise the nurse educator's role as expert learners rather than expert givers of information.

They foster nurse educators and student creativity in finding new and different approaches to in-depth study of concepts of caring in human health and healing and examine new caring-healing modalities (Watson 1988:424).

Gaut (1988) studied the teaching of caring to nursing students and developed a framework to assist the teacher in choosing goals and objectives related to caring action. She has indicated three conditions both necessary and sufficient for caring to occur in relation to nursing: knowledge, choice and the welfare of x criterion. She combined awareness with knowledge, intention with choice and a non-arbitrary judgment principle with the welfare of x criterion. Weiss (1988) presented a model which can be used to teach care in nursing or as a research or evaluation guide. The model contains seven video taped scenarios based on single patient care events that display various combinations of nurse care or caring features. The ideal situation presents the process of caring that exists when verbal and non-verbal caring and technically competent behaviour components are all present. Verbally the nurse shares her observations with the patient and addresses him by name and title. The nurse uses reflection as a communication technique and gives the patient a choice of care. Non-verbally the nurse uses attending behaviour to make herself available to the patients. She sits down establishes eye contact and actively listens. Technically the nurse shows competent behaviour in procedural skill without needless discomfort to the patient. The ideal situationis followed by a contrary situation that lacks the three necessary caring and competence components. Five borderline situations are presented which portray various combinations of caring, uncaring, competent and incompetent levels of the three components.

Slevin and Harter (1987:25) advocate that caring focused course work should begin on commencement of training and not in the more senior years. They furthermore advocate consistent practice feedback and self-discovery over time to take on or enhance caring attitudes and behaviours. They also believe that patient evaluation of student's caring behaviours be incorporated into each practicum evaluation process.

Step 5: Suggestions of priority areas for research on caring

Systematic research on caring is clearly needed so that incorporation of that knowledge into the nursing education and practice systems can take place, if caring is to remain the heart of nursing. Leininger's transcultural studies of care (1988:5) have revealed that though caring is a universal phenomenon there are diverse care values and patterns of care in different cultural and subcultural groups in the world. As far as could be established no such research has been done in South Africa. It appears obvious therefore that in a multicultural country like ours, transcultural specific and universal care knowledge is greatly needed to guide nursing decisions in caring for individuals, families and communities. Such knowledge would be essentially new and would provide rich bases guiding nursing education and practice. The primary priority areas for caring research as identified are

- Identification and validation of the meaning, characteristics, proce types and divergent expressions of caring in patients, members of the public, adolescents and nurses in the various cultural and subcultural groups.
- Analysing caring and non-caring behaviours as perceived by persons in different groups.
- Establishing whether nurses still value care and want to have it as a central focus and unique domain of nursing.
- Establishing what nurse educators are teaching and practising as care.
- Establishing whether registered nurses are practising care or predominantly medical curing practice.
- Establishing what care content and experience nursing students learn about in schools of nursing.
- Establishing what values and norms regarding caring practices nurses are taught.
- Establishing what strategies are used for teaching caring.
- Establishing what strategies are used to evaluate caring.
- Establishing creative ways of teaching care constructs principles, processes and intervention modes.
- Verifying therapeutic and non-therapeutic care practices.
- Testing theories of specific care phenomena.
- Exploring linguistic usage of caring.
- Finding ways of resocialising nurses towards caring where this is a missing ingredient.

- Assessing the caring characteristics of nurse educators against criteria obtained from the literature.
- Assessing the caring environment of the practice situations.

The suggestions above are just the tip of an iceberg, but are regarded essential if the nursing profession is not to be faced with a central dilemma of non-caring individuals. In today's world of turmoil where technology and materialism has taken over, where self-interest is replacing altruism and violence is the order of the day attention to caring is desperately needed.

To study care, nurse researchers need to be prepared in the use of qualitative research methods and strategies (Leininger 1985:133). Human care is difficult to study as an "object" to be dissected into parts and measured in a mechanistic way while still retaining its holistic contextual and unique features. It is also difficult to study care from only its physical and emotional aspects as care is constituted and expressed within cultural contexts. Qualitative research methodologies accommodate these important conditions to know and understand fully human care — its essence, expressions and interpretations.

I would like to conclude with the words of Leininger (1988:8) "No concept or line of research could be more important to nurses and the nursing profession than care. Will we meet this challenge?" Lets breathe life into these words during the nineties and make them a reality.

REFERENCES

Amacher, N.J. 1973. Touch is a way of caring. *American Journal of Nursing*, 73 (s) 852-854.

Bendall, E. 1977. The future of British nurse education. *Journal of Advanced Nursing*, 2 (2) 171-181.

Benner, P., Wrubel J. 1989. *The Primacy of Caring*. Menlo Park: Addison Wesley.

Bevis, E.O. 1982. *Curriculum Building in Nursing*. St. Louis: Mosby.

Brown, L. 1986. The experience of care/Patient perspectives.

Buber, M. 1988. *I and thou* 2nd edition (R. Gr. Smith ed. and transl.) New York : Charles Scribners Sons.

Bush, H.A. 1988. The caring teacher of nursing in Leininger, M. (ed). *Care: Discovery and uses in clinical and community nursing*. Detroit : Wayne State University Press.

Cooper, M.C. 1988. Covenantal relationships: Grounding for the nursing ethic. *Advances in Nursing Science*, 10(4) 48-59.

Curtin, L. 1982. The nurse patient relationship: Foundation purposes, responsibilities and rights in L. Curtin, M.J. Flaherty (ed). *Nursing ethics: theories and pragmatics*. Bowie Maryland: Brady Publications.

Ford, M.B. 1982. *Nurse professional and the care process*. Dissertation abstracts international 1982 42 (3) 967-8.

Fry, S.T. 1988. The Ethics of Caring: Can it survive in nursing. *Nursing Outlook* 36 (1).

Gardener, K., Wheeler, E. 1981. Nurses perception of the meaning of support in nursing. *Issues in Mental Health Nursing* 3,13-28.

Gaut, D. 1988. A theoretical description of caring as action in Leininger, M. (ed). *Care: the Essence of Nursing and health*. Detroit: Wayne State University Press.

Goldsborough, J. 1969. Involvement. *American Journal of Nursing* 69 (1) 66.

Goodchild-Brown, B. 1987. Accompaniment of students by nurse teachers — A brief didactic study. *Curationis* 9 (2) 5-9.

Harrison, P. 1980. Caring for our patients — fact or legend. *Curationis* 2 (4) 39.

Heidegger, M. 1962. *Being and time* (Macquarie, S., Robison, E. transl.) New York: Harper, G. Row.

Howard, J., Strauss, A. 1975. *Humanising health care*. New York: Wiley.

Hyde, A. 1977. The phenomenon of caring. *Part VI American Nurses Foundation* 12 (1) 2.

Kahn, D.L., Steeves, R.H. 1988. Caring and Practice: Construction of the nurse's world. *Scholarly Inquiry for nursing practice* 2 (3) 201-216.

Kalish, B.J. 1971. Strategics for developing nurse empathy. *Nursing Outlook* 19 (11) 714-718.

La Monica, E.L. 1983. Empathy can be learned. *Nurse Educator* 8 (1) 19-23.

Larson, P. 1985. Is competence an essential for caring. *American Journal of Nursing* 85 (1) 14.

Larson, P. 1987. Comparison of Cancer patient's and professional nurses, perceptions of important nursing caring behaviours. *Heart Lung* 16,187-192

Layton, J.M. 1979. The use of modelling to teach empathy to nursing students. *Research in Nursing and Health* 2: 163-176.

Leininger, M. 1977 Caring: The essence and central focus of nursing. *Nursing Research Reports*: American Nurses Foundation Inc. 12 (1) 2-14.

Leininger, M. 1980 Caring: a central focus of nursing and health care services. *Nursing and Health Care* 1 (3) 135-143.

Leininger, M. 1981. *Caring: An essential human need*. New Jersey: Charles Slack.

Leininger, M. 1985. *Qualitative research methods in nursing*. New York: Grune and Stratton.

Leininger, M. (ed) 1988. *Care: Discovery and uses in Clinical and Community Nursing*. Detroit: Wayne State University Press.

Leininger, M. (ed) 1988. *Care the essence of nursing and health*. Detroit: Wayne State University Press.

Levine, M. 1978. Nursing ethics and the ethical nurse. *American Journal of Nursing* 78(8) 845.

Marcel, G. 1971. *The philosophy of existence*. (R.F. Grabow ed. and transl.) Philadelphia: University of Pennsylvania Press.

Mayeroff, M. 1971. *On caring*. New York: Harper and Row.

McCorkle, R. 1974. Effects of touch on seriously ill patients. *Nursing Research* 34 (2) 125-132.

Noddings, N. 1988. An ethic of caring and its implication for instructional arrangements. *American Journal of Education* 96 (2) 215-230.

Paton, F. 1987. Priority areas for Nursing Research. *Curationis* 9 (2) 13-14.

Pellegrino, E.D. 1985. The caring ethic: The relationship of physician to patient in Bishop, A.H. Sudder, J.R. (eds.) *Caring Curing Coping Nurse Physician Patient relationship*. Birmingham Al: University of Alabama Press.

Polit, D.F., Hungler, B.P. 1987. *Nursing Research: Principles and methods*. Philadelphia: Hippiccott.

Reeder, L.C. 1972. The Patient-client as consumer: some observations on the changing professional client relationship. *Journal of Health and Social Behaviour* 13 (10) 406-412.

Rieman, D. 1986. Non-caring and caring in the clinical setting: Patient's descriptions. *Top Clinical Nurses* 8(1) 30-36.

Seaman, C.H.C. 1987. *Research methods: Principles practice and theory for nursing*. Norwalk: Appleton-Lange.

Searle, C. 1986. *Professional Practice A South African Nursing perspective*. Durban: Butterworth.

Sevin, A.D., Harter, M.V. 1987. The teaching of caring. A survey report. *Nurse educator*, 12(6), 23-26.

Simons, J.E. 1987. Science update: Patients and nurses perception of caring. *The Research Review: Practice Studies for Nursing*, 4: 2.

Smith, I. 1982. Needs assessment: An overview for health educators. *A Journal for continuing education professionals in Health Science*, 14 (1), 13-15.

Swanson-Kaufman, K. 1986. Caring in the instance of unexpected pregnancy loss. *Top Clinical Nursing*, 8 (1), 37-46.

Velazquez, J.M. 1969. Alienation. *Nursing*, 69: 66-68.

Wallston, K.A., Cohen, B.D., Wallston, B.S. *et al.* 1978. Increasing nursing person centredness. *Nursing Research*,17: 156-159.

Watson, J. 1979. *The Philosophy and Science of Caring*. Boston: Little Brown.

Watson, J. 1985. *Nursing: Human Science and human care: A theory of nursing*. Connecticut: Appleton Century-Crofts.

Watson, J. 1988. Human Caring as Moral Context for Nursing Education. *Nursing and Health Care*, 9 (8) 423-425.

Weiss, C.J. 1988. Model to discover, validate and use care in nursing in Leininger, M. (ed). *Care: Discovery and uses in clinical and community nursing*. Detroit: Wayne State University Press.

University of Colorado School of Nursing News 1989.

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