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Los Angeles

Understanding the Process by Which Acute Care Nurses  
Engage in Nursing Presence with Terminally Ill Patients

A dissertation submitted in partial satisfaction of the  
requirements for the degree of Doctor of Philosophy  
in Nursing

by

Mary Nugent Hersh

2015



## ABSTRACT OF THE DISSERTATION

### Understanding the Process by Which Experienced Staff Nurses Engage in Nursing Presence with Terminally Ill Patients

by

Mary Nugent Hersh

Doctor of Philosophy in Nursing

University of California, Los Angeles, 2015

Professor Sally Maliski, Chair

Modern healthcare threatens traditional nursing ethos by placing the relational aspects of nursing at risk. Staff nurses report decreased job satisfaction amid mounting tasks and sicker patients. Many leave nursing due to an inability to address patients' social, emotional and spiritual needs, which especially surface at end of life. Considering death is an inevitable, universal outcome and the frequency by which bedside nurses play central roles in patients' terminal care, the literature is stunningly void to describe how the nursing presence process unfolds with terminal, hospitalized patients.

Constructionist Grounded Theory formed the methodology guiding the study design and data analysis. Eleven staff nurses vividly recalled very meaningful interactions with dying patients; their detailed narratives yielded 17 memorable exchanges with end-of-life patients. It was dying patients' vulnerability which triggered participants' awareness to assess patients' needs. Participants addressed these needs with a focused intentionality, spawned by participants' previous personal loss experiences or nurses' strong, professional beliefs. Many participants recalled making positive differences in previous patients' illness experiences and were

determined to do so again. Participants acknowledged having little time in their nursing roles, yet also realized their dying patients' needed their time. Such divergent realities prompted the participants to prioritize time to address patients' end-of-life needs. Participants' determination to be of help, combined with their strategic use of time fostered meaningful nurse-patient interactions. These exchanges were punctuated by a range of courageous nursing actions intended to positively influence terminal patients' illness experiences. Participants candidly offered dying patients sage advice, some participants dauntlessly advocated for patients while other participants gently prepared patients for what was to come.

This research offers insight into ways bedside nurses continue to uphold traditional nursing ethos by safeguarding the relational aspects of nursing when caring for terminal hospitalized patients. Study findings reveal assorted ways determined staff nurses creatively use time, while also demonstrating a range of courageous nursing actions that resulted in very meaningful exchanges with dying patients.

The dissertation of Mary Nugent Hersh is approved.

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2015

## Dedication

To my husband, Edward, for his unwavering love and for always believing in my abilities.

To the nurses who participated in this study, may your courage continue to inspire other nurses.

To terminally ill patients, may some aspect of your illness experience be improved as a result of this work.

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## **Chapter One: Introduction, Study Purpose, Theoretical Framework**

“My diagnosis of lung cancer has been a harrowing experience. I was subject to... news of all kinds, most of it bad. Yet, the ordeal has been punctuated by moments of exquisite compassion. I have been the recipient of an extraordinary array of humane responses to my plight. These acts of kindness, such as a simple... touch, have made the unbearable - bearable.” (Schwartz, 1995) The Schwartz Center

### **Introduction**

This research examined phenomena of nursing presence to understand the process by which staff nurses engage in meaningful interactions with end-of-life patients. This study has produced a theory grounded in the data to comprehend how nurses transition from typical nurse-patient contacts to instead engage dying patients in meaningful, person-centered exchanges. Such exchanges comprise the everyday work of many experienced staff nurses. This study sought to understand the voices of these nurses as they described the way the presence process unfolds and how these nurses managed to sustain their meaningful interactions with end-of-life patients amid hectic hospital settings.

End-of-life, as defined in 1997 by the Institute of Medicine, (IOM) is a term used to describe the entire course of terminal illness; it includes trajectories comprising both cancer and non-cancer illnesses. A trajectory begins with an incurable illness diagnosis and continues through the patient’s decline and ends in death (IOM).

It is the belief of this researcher, an expert in palliative care nursing, that end-of-life patients should be the recipients of presencing interactions with nurses. Benner (1989) defined presencing as an exchange between the nurse and the patient that acknowledges a shared humanity. Presencing is an intense level of connectedness; it is characterized by reciprocity and mutuality (Curley, 1997; Ramos, 1991). During these exchanges, presencing facilitates the nurse’s understanding of the patient’s experience (Benner). Nursing presence is therefore

helpful for suffering patients; presence is particularly supportive of patients facing death particularly supportive for patients facing death (Benner).

The relief of suffering is at the core of nurses' work (Ferrell & Coyle, 2008). Nurses caring for terminally ill patients hold a privileged proximity in responding to patients' suffering, which necessitates nurses' true presence (Doona, Chase, & Haggerty, 1999; Ferrell & Coyle). Nursing presence prompts patients' fearful expressions (Stanley, 2002). Such verbalization is particularly helpful for end-of-life patients, who frequently experience physical suffering as well as emotional, social and spiritual anguish, which threatens the intactness of the whole person (Ferrell & Coyle). Therefore, integrating presence in the care of terminally ill patients is an essential nursing action (Cassell, 1982; 1991; Ferrell & Coyle). It is during presencing interactions that nurses bear witness to the most broken states of human suffering (Ferrell & Coyle).

Moreover, incurably ill patients look to nurses during all stages of a terminal illness trajectory (Ferrell & Coyle, 2008). To patients, nurses symbolize a connectedness amid depersonalized healthcare environments (Ferrell & Coyle). Within these exchanges, nurses come to know the patient quickly and in an intimate way because terminally ill patients often disclose the most private aspects of their lives to a trusted nurse (Mok & Chiu, 2004).

The nurse-patient relationship is central to the practice of nursing (Benner & Wruble, 1989; Mok & Chiu, 2004; Ramos, 1992; Tanner, et al. 1993; Taylor, 1998; Weissman & Appleton, 1995). Nursing practice necessitates integrating the science of nursing along with the art of nursing (Iseminger, Levitt & Kirk, 2009). Yet, acute care nurses describe mounting tasks while caring for sicker patients (McKivergin & Daubenmire, 1994). During the last 50 years modern nursing has placed significant emphasis on the science of nursing, with an increased

focus on technology as well as on nurses' productively (Iseminger, et al; Chase, 2001). The expanding technological skills and the complexity of tasks involved to deliver routine nursing care leave many nurses unable to attend to the patients' emotional, spiritual, and social needs, needs which especially surface at end of life (Melnechenko, 2003). Consequently, nurses claim their mounting responsibilities decrease their ability to focus on patients' holistic needs (Melnechenko).

Such increased attention to nursing tasks and on measuring nurses' productivity is, in part, the result of payer expenditure cuts as revenues decrease, which then creates intense focus on the bottom line (Haylock, 2008). Such austerity has significantly contributed to nursing dissatisfaction due to nurses' perceived inability to address patients' holistic needs (Haylock; McNeely, 2005; Melnechenko, 2003; Rivers, Tsai, & Munchus, 2003). In fact, nurses reported hesitancy in spending time with patients especially if the use of that time did not involve a task (Melnechenko; Rex-Smith, 2007).

While the aforementioned changes in modern healthcare threaten the relational aspects of nursing, these developments also represent an opportunity for appreciating the contributions nursing presence makes in the practice of nursing. For example, nurses report greater job satisfaction and increased self-confidence following nursing presence interactions with patients (Doona, Haggerty & Chase, 1999; Duis-Nittsche, 2002; Easter, 2000; Finfgeld-Connett, 2006; Miller & Douglas, 1998; Mohnkern, 1992). Moreover, nursing presence increases patients' satisfaction scores (Finfgeld-Connett). Such evidence should prompt nursing leaders to encourage the integration of nursing presence into daily nursing practice (McCloskey & Bulechk, 2000).

It is this researcher's opinion that it is time to give equal attention to exploring aspects related to the art of nursing, such as nursing presence (Iseminger, et al., 2009). Nursing presence is an essential, albeit underutilized resource in daily nursing care; it is particularly underemployed for end-of-life patients (Iseminger, et al.). Understanding the nursing presence process is critical, for it empowers acute care nurses to integrate empiric ways of doing with humanistic ways of being (Iseminger, et al.).

The Nursing Interventions Classification, (NIC) is a system categorizing what nurses do as it relates to the art of nursing (Henry & Mead, 1997). These classifications assess the skills of active listening, engaging patients in compassionate communication, and connecting with patients by integrating the art of nursing into nursing practice (Iseminger, et al, 2009). Further understanding how nurses acquire, engage in, and perfect skills that reflect the art of nursing merits equal emphasis to those skills that relate to the science of nursing (Iseminger, et al.).

Recently the public has become very aware of the potential for terminal suffering, and has called for more integrated approaches to end-of-life situations (Singer & Bowman, 2002). To address these concerns, in 1997 the IOM began issuing reports, the first titled *Approaching Death: Improving Care at the End of Life*, that stress the importance of gaining new knowledge to improve the quality of care throughout a terminal illness trajectory, including the time of death.

The National Institute of Nursing Research (NINR) is the chief institute for end-of-life research. The NINR supports evidence promoting optimum care for terminally ill patients. The NINR encourages studies focused on patient-centered care, which includes nursing presence (Grady, 2005). Hence, this dissertation aligns with the goals set forth by the IOM and NINR by aspiring to promote quality end-of-life nursing care.



The definitions of nursing presence presented herein all acknowledge presence as an intentional and a reciprocal nurse-patient interaction (Covington, 2003; Doona, Chase & Haggerty, 1999; Finfgeld-Connett, 2008; Tavernier, 2006). The nurse regards the patient as a unique individual, attending to the patient's needs while remaining available to the patient (Finfgeld-Connett). Nurses exemplify presence by demonstrating compassion, attention to holism, and by responding quickly to patients' situations (Finfgeld-Connett; Marsden, 1990). Presencing experiences reflect honorable moments encompassing positive interactions for both nurses and patients and represent an important facet of professional nursing practice (Duis-Nittsche, 2002; Stanley, 2002).

At this time, it would be essential to state two distinctions that help to frame this study. One involves Parse's (1981, 1992, 1998) theory of human becoming, which is used as the sensitizing framework and serves as a backdrop to inform the research problem (Charmaz, 2003). Since constructionist Grounded Theory (GT) is the methodology used for this dissertation (Charmaz, 1994, 1995a, 1995b, 2000, 2005, 2006; Charmaz & Mitchell, 1996) as well as symbolic interactionism (SI) which supports GT methodology and has assumptions consistent with the sensitizing framework.

Another distinction helping to frame this study was selected for its organization in presenting the structures, processes and outcomes of nursing presence within the nursing literature. In healthcare administration, this framework is well known as Donabedian's (1969) Model. However, it is important to state Donabedian's Model is not a theory. Instead, it is often used for listing the sequence reflecting the required structures that need to be in place which prompt the processes needed that result in quality outcomes.

## **Purpose of the Study**

The study's purpose creates a theory grounded in the data to understand the process by which experienced staff nurses use nursing presence and transition from typical nurse-patient interactions to instead engage end-of-life patients in meaningful, person-centered exchanges.

## **Specific Aims**

The following specific aims guided this study:

1. To understand nurses' perceptions of the nursing presence process when caring for terminally-ill patients.
2. To describe how nurses transition from nurse-patient exchanges to meaningful person-centered interactions with terminally ill patients.
3. To understand how this meaningful nursing presence process is sustained.

## **Significance of this Study**

Research is past due that explores how experienced bedside nurses engage terminally ill patients in the nursing presence process. This study offers significant implications for nursing practice by shifting the importance currently placed on measuring nurses' productivity because such emphasis omits consideration of the equally important, yet less tangible aspects of nursing, such as nursing presence. Instead, study results urge administrators to encourage nurses to integrate nursing presence into daily nursing care, a vision that positively influences nurses' job satisfaction scores while increasing nursing retention.

Resultant knowledge also benefits nurse educators by explaining ways to address holistic needs of end-of-life patients by stressing the benefits to patients and nurses resulting from nursing presence. Moreover, research information gained herein benefits novice nurse

mentoring programs, nurse externships, as well as nursing education curricula (Haylock, 2008; Hutchings, 2002).

### **Assumptions**

The following assumptions influenced this study:

1. Experienced nurses can articulate the abstract nature and process by which they engage in nursing presence with seriously ill patients.
2. Those facing end-of-life represent a vulnerable patient population who would benefit from nursing presence.
3. Nurses who have meaningful interactions with dying patients hold strong values and/or ethical standards.
4. Nurses working with end-of-life patients are influenced by patients' situations which prompt their nursing actions.

### **Theoretical Framework**

The philosophical background of GT involves the use of pragmatism and Darwinism. The importance of incorporating pragmatism into this research lies in the way its philosophic assumptions align with the study (Charmaz, 2006). For example, pragmatists believe humans interpret their environment by selecting what they notice in every situation (Charon, 2007). The tradition posits truth comes out of human experience, emerging every time that specific truth is successfully applied (Charon). Pragmatism contends people interact as a way of learning about being human (Charon).

I integrated pragmatic assumptions in the interviews by listening as each participant relayed her/his descriptions of her/his meaningful interactive patient experiences in order to understand what the participant focused upon as the interactions unfolded. These interviews lent

insight about practical actions taken by the participant to sustain these exchanges (Charon, 2007). Likewise, I noted ways the participants demonstrated creativity by problem solving to address patients' needs (Charon). It was during these interviews that I came to understand what has meaning by examining nurses' presencing interactions (Magree, 2001).

Human development is part of an evolutionary process; it is described as the state of becoming (Charon, 2007). Rationale for integrating Darwinism into this study came from acknowledging the participants were experienced staff nurses whose stories illuminated how the presencing process unfolds, beginning with its inception to understanding how nurses sustained the nursing presence process.

### **Sensitizing Framework**

Qualitative researchers use a sensitizing framework as a tool to draw attention to ideas found in the overriding research problem (Bowen, 2006; Charmaz, 2003). As stated, this study uses Parse's (1981, 1992, 1998) theory of human becoming as the sensitizing framework.

#### **Human Becoming Theory**

The theory encourages nurses' true presence in all patient interactions, thus helping facilitate nurses' awareness of patients' becoming (Stanley & Meghani, 2001). Parse's (1981) Human becoming theory is an especially appropriate framework for end-of-life research due to its emphasis on present time, a helpful distinction when studying nurses caring for patients with uncertain futures (Lee & Pilkington, 1999). Within this theory, nurses use time by assisting patients achieve quality-of-life as defined by each individual patient (Parse). The nurse guides the patient using three dimensions of the theory, which initially involves identifying meaning, rhythmicity, and finally, transcendence.

Hence, Parse's (1981, 1992, 1998) human becoming theory provided the framework for data analysis and interpretation. In comparing Parse's three concepts of meaning, and rhythmic patterns as well as transcendence, I found that these themes reflected the essence of participants' reported experiences with patients. Namely, dying patients' vulnerability and limited time were the initial triggers drawing participants' attention to patients. As participants identified patients' needs, participants became aware of what each patient considered important and what was meaningful for the patient. For example, an elderly ventilator dependent male patient confided to the participant that he decided that wanted to be removed from the respirator. Being free of life support was extremely important to the patient. Despite knowing he would likely not survive without respiratory support, he acknowledged that no longer being attached to the ventilator was very important to the patient. Having awareness of this, the participant then helped the patient understand the ebb and flow of his decisional situation, a rhythmicity that included first making the patient aware the participant needed to advocate on the patient's behalf with the physician, who agreed this was appropriate, and then advocated for the patient with the patient's family who initially were hesitant, but days later said they respected the patient's wishes. Finally, transcendence occurred as the nurse witnessed the patient's demeanor upon hearing his family's blessing as they surrounded his bed. His awareness that he would be free of life support gave this patient an entirely new perspective of his illness situation. While this story examples how Parse's theory guided this research, the narrative also illustrates the nursing metaparadigm of the concept of health, which in this case refers to that patient's state of wellness, for it comprises the dying patient's well-being (Fawcett, 2000).

## Summary

This chapter presented an introduction to the study which examined the nursing presence process with terminally ill hospitalized patients. The need to engage end-of-life patients in meaningful presencing interactions has been discussed herein, as has the significance of the nurse-patient relationship. Key factors informing this study included the IOM directive calling for improved end-of-life care, and the NINR invitation encouraging patient-centered research. The previous pages also outlined the study's purpose and aims, while presenting the background that describes the problem necessitating this research. This section of the dissertation also defined key phrases such as nursing presence, presencing and end of life. The ways nursing presence increases nurses' job satisfaction scores and improves nursing retention have also been articulated, as has the study's promising contribution to nursing practice.

This chapter also discussed the philosophical background which guided the interview questions, and included rationale for integrating pragmatism and Darwinism in the study. The final chapter portion articulated the study's sensitizing framework, Parse's (1981) human becoming theory, and offered an example of the way its framework guided the analysis and interpretations. Selecting this theoretical framework proved an exemplar to understand process by which meaningful nurse patient interactions occur.

## **Chapter Two: Literature Review**

“We can make our minds so like still waters that beings gather about us that they may see, it may be, their own images, and so live for a moment with a clearer, perhaps even with a fiercer life because of our quiet.” (W.B. Yeats, 1883)

### **Literature Review**

This chapter presents a historic overview of the presence literature followed by several definitions of nursing presence. A discussion herein describes requisite traits of both nurse and patient that fosters presence. This section also discusses unknown aspects of the presencing process while examining benefits to both patient and nurse as a result of nursing presence. Likewise, this chapter presents several nurse theorists whose suppositions held aspects of nursing presence. The final paragraph describes ways this research contributes to nursing science.

Nursing presence involves a giving of oneself (Pettigrew, 1988). Nursing presence is one of the most significant actions nurses engage in with patients (Duis-Nittsche, 2002; Smith, 2001). The reviewed literature indicated nurses recognize presence when engaging in it and can aptly articulate previous nursing presence experiences (Duis-Nittsche). Considering the value presence holds for the nursing profession, it is critical to understand the nursing presence process in its entity, and in particular in the care of terminally ill patients (Duis-Nittsche, Smith).

#### **Historical Overview**

While nursing presence is central to professional nursing, the nursing presence literature is remarkably scant. In part, this is because a scientific examination of presence began rather recently, in the 1960's (Smith, 2001). The reviewed texts predominately reflected qualitative inquiry although some quantitative studies have emerged aimed at measuring nursing presence (Finfgeld-Connett, 2006). The reviewed manuscripts included several concept analyses, one construct analysis, and assorted nursing dissertations.

The literature on presence began with Clemence-Valliot (1966) who tangentially associated presence in research examining nurses' commitment. This scholar urged nurses to give of themselves because of the commitment nurses had to patients (Clemence-Valliot). Later, Benner (1984) observed the clinical behaviors of experienced nurses of which nursing presence was one. Subsequently, Benner considered nurses' ability to engage in presence an important nursing competency and a significant component to nursing. Meanwhile, Gardner (1985) posited presence to be at core of the nurse patient relationship. She also established a connotative delineation of the word presence. Sandelowski (2002) noted that Garner differentiated the phrase being there from being with. Gardner regarded physical presence as being there and considered psychological presence as being with a patient. Thus, the word presence began to encompass emotional undertones (Lawler, 1997).

Several nursing scholars integrated nursing presence within their theories to illuminate the nurse-patient interaction (Finfgeld-Connett, 2006). For example, the humanistic nursing theory by Paterson and Zderad, (1976) regards nursing as an intersubjective interaction between two people. In human becoming theory, Parse (1981, 1992, 1998) described true presence as the connection between the nurse and patient. Meanwhile, in the theory known as the science of unitary human beings, Rogers (1970, 1990) claimed presence occurred within mutually simultaneous nurse-patient interactions, while Watson's (1985) human science and human care theory posited nurse patient interactions involved more than physical care.

Of the aforementioned theories, Paterson and Zderad, (1976) as well as Parse (1981, 1992, 1998) made significant contributions to the presence literature. For example, after exploring works of Buber, (1970) Kierkegaard, (1846) and Marcel, (1978) Paterson and Zderad were greatly influenced by the inter-subjectivity found in Buber's I-Thou relationship. They also



acknowledged Marcel who encouraged the giving of self. The theory inspires nurses to look for the potential in each patient, which helps create meaningful nurse-patient relationships (Kaiser, 2004; Paterson & Zderad). These significant nurse-patient interactions which were founded on altruistic intent, helped nurses form meaningful moments with patients (Smith, 2001).

In human becoming theory, Parse (1981, 1992, 1998) viewed true presence as foundational to the practice of nursing. During presencing moments a co-creation occurs between nurse and patient, this interaction remains memorable for both (Parse, 1981). Parse's (1981) theory represents grand theory; it is focused on the human-universe-health process (Fawcett, 2000). The metaparadigm concepts in the theory include person, environment, and health. Within the nursing metaparadigm, the concept of person encompasses both patient and nurse (Fawcett). The concept of environment refers to physical surroundings as well as culture, values and beliefs. Finally, the concept health refers to a person's state of wellness and comprises the dying person's well-being (Fawcett). Parse (1981) argued the nursing metaparadigm is central to the discipline of nursing, which is founded on nursing presence. The focal scheme of the metaparadigm considers health of human beings; this includes the patient and nurse who continually interact with their environments (Fawcett, 2000).

### **Nursing Dissertations, Concept Analysis and Nursing Presence Definitions**

While quantitative nursing presence studies are limited, the literature uncovered several nursing dissertations on presence; most of these involving a qualitative methodology. For example, Pettigrew's (1988) researched involved presence within the context of persons' suffering experiences. Nurses demonstrated empathy by bearing witness to suffering during their presencing interactions with dying patients and families (Pettigrew). Pettigrew was the

first scholar to acknowledge nurses' feelings of vulnerability which frequently arose during presencing moments with patients.

Meanwhile, Fuller (1991) identified attributes of nursing presence, which included authenticity and an ability to relate to patients as persons rather than as objects (Fuller). Later, Duis-Nittsche (2002) identified the importance of the nurse knowing the patient as well as the significance of bonding with the patient and having an empathetic attitude toward the patient. Osterman (2002) observed how nurses' personalities influenced nurses' ability to engage in presence as did their years of nursing experience. She stressed the importance of understanding the art of engaging patients in presence and instructed nurses to use their entire self to be present to patients (Osterman). Lately, Bright (2012) posited that nurses who engaged patients in presence had strong ethical commitments and that nurses' ability to engage in presence was fostered by nurses' self-care, mediation and other healing practices. Other recent dissertations examined presence within specific clinical settings, such as Trout's (2013) manuscript, which examined hospice nurses' descriptions of presence. Hospice nurses reported key satisfaction themes that involved nurses' capacity to develop intimate patient relationships, their ability to cope well with challenges and being able to derive fulfillment in working with dying patients. Hain (2007) claimed critical care nurses who engaged in presence did so because of transitional and professional influences. Intensive care nurses developed presencing skills gradually (Hain). Moreover, nurses' skill development was influenced by their personal life experiences, lessons from which nurses integrated in their professional practice (Hain).

As a way to develop nursing presence skills in student nurses, a mid-range theory of nursing presence was recently proposed containing five relational variables which the authors considered essential to presence (McMahon & Christopher, 2011). Besides having favorable

work environments, other inter-relational elements involved intrinsic nurse characteristics as well as the unique patient traits, these shared traits then form the nurse-patient dyad (McMahon & Christopher). The combined aforementioned variables, along with the degree to which the patient required nursing presence as assessed by the nurse, comprised the key nursing presence teaching points when instructing students (McMahon & Christopher).

To summarize, doctoral studies have evolved from defining and analyzing the nursing presence concept, to developing tools to measure presence, to examining nursing presence within specific clinical settings. The intention to advance the science of nursing held by these earlier doctoral nursing students continues with this dissertation that examined ways experienced staff nurses engage in meaningful interactions with terminally ill patients.

#### Concept Analyses of Nursing Presence

A concept analysis examines the uses and meanings of a particular concept; it is the major components of theory (Teel, 2006). After stating the purpose of the analysis, scholars present concept definitions, describe how the concept is used, and impart related concepts (Travernier, 2006). Further analytical steps indicate the attributes, or dimensions frequently identified with the concept which helps differentiate the concept from similar concepts (Travernier). Researchers observed those antecedents which must be in place before the concept occurs, while noting the consequences, or outcomes that result from the concept's existence (Travernier). Final analytic steps of a concept analysis include statements referencing the empirical referents by identifying the concept's objective measurements; this analysis ends by articulating a model case (Travernier). The latter helps illuminate current understanding about the concept and include the antecedents along with defining criteria as well as the consequences of the concept (Wambach, 1998).

The reviewed literature uncovered four concept analyses and one construct analysis on presence (Doona, Chase & Haggerty, 1999; Easter, 2000; Gilje, 1992; Hines, 1992; McKivergin & Daubenmire, 1994). For example, Easter (2000) undertook a construct analysis to delineate the models, or levels of nursing presence after testing the Modes of Being Present Scale (1999). Easter (2000) had determined the latter was an invalid tool, who then undertook a construct analysis describing four distinct modes of presence; they included physical presence, therapeutic presence, holistic presence, and spiritual presence. This construct analysis also included a definition of each level of presence and indicated specific nursing and patient attributes found on each level which fostered nursing presence (Easter). Furthermore, she listed the respective outcomes for both nurse and patient resulting from presence making sure she delineated these on each of the four levels of presence (Easter). She then presented a model case relevant to each level to illustrate the aforementioned attributes, consequences, and outcomes (Easter). Her work reflected a culmination of the essence of presence while capturing the interrelatedness within the nurse-patient interaction (Easter). Of note, after completing this construct analysis Easter did not publish work testing the levels of presence.

Another subsequent scholar, Kostovich (2002) developed a scale to measure nursing presence, called the Presence in Nursing Scale (PONS). Later, Hansborough (2002) demonstrated PONS was valid measure of nursing presence within the context of the role of the bedside nurse.

In a scholarly meta-synthesis of nursing presence, Finfgeld-Connett (2006) uncovered several concept analyses on presence (Doona, Chase & Haggerty, 1999; Gilje, 1992; Hines, 1992; McKivergin & Daubenmire, 1994). For instance, Gilje clarified the holistic and spiritual processes that are involved in presence. For spiritual presence to occur, both the nurse and

patient shared comparable beliefs on spirituality or held similarly strong religious practice convictions (Gilje) ). In healthcare services research, McKivergin and Daubenmire (1994) contributed a concept analysis by identifying requisite skills nurses needed in order to engage patients in presence, these included centering, meditating and intentionality. They also identified therapeutic presence, claiming therapeutic presence addressed patients' holistic needs (McKivergin & Daubenmire). Their contributions subsequently inspired the inception of presencing skills training (McKivergin & Daubenmire).

The aforementioned analyses all listed outcomes resulting from nursing presence (Finfgeld-Connett, 2008). For example, Hines (1987, 1992) argued outcomes of nursing presence included comfort and healing, which culminated in growth for both patient and nurse. Nurses engaging in presence held positive regard for their patients and valued their encounters (Hines, 1992). In the model case, he described presence as “an action beyond the ordinary where meaning and making a difference in another's life was exchanged...presence was remembered and felt over a much longer period of time” (Hines, 1992 p. 303).

The aforesaid concept analyses identified similar antecedents, attributes, and outcomes. Antecedents most consistently noted included nurses' willing intention to be involved in patients' situations, another involved patients' openness by allowing nurses into patients' illness experiences (Doona, Chase & Haggerty, 1999). Moreover, the literature revealed comparable attributes such as being there, being with, giving of self, and making a commitment to the patient (Doona, et al.). While the presencing outcomes were unique to each encounter, in general outcomes led to growth, healing and comfort for both the nurse and patient (Hines, 1992).

In synthesizing the aforementioned concept analyses on nursing presence, presence is portrayed as is an ontological way of being with another involving reciprocity within a human-

to-human experience (Covington, 2003). Moreover, presence encompasses nurse-patient interactions spanning several levels, or ways of relating to patients (Covington). Overall, each analyses added additional clarity to the understanding of nursing presence. Yet, scholars continue to regard presence as an elusive term (Teel, 2006; Walker & Avant, 2005). While nursing presence remains an ambiguous concept, it is also a vital component of nursing practice.

#### Definition of Nursing Presence

Doona, Chase and Haggerty (1999) defined presence as an encounter between the patient and nurse, who regards the patient as an individual in a unique circumstance and chooses to focus on the patient's needs. Meanwhile, Covington (2003) delineated presence as a holistic, transpersonal and interpersonal nurse-patient exchange as the nurse remains attentive, accessible, and perceptive to the patient's needs (Covington). Later, Travernier (2006) defined presence as reciprocal nurse-patient interactions, in which the nurse gives the patient full attention while assessing the patient's needs with the intent of helping the patient. This definition portrays purposeful and mutual nurse patient interactions while also respecting the patient as an individual (Travernier).

The nursing presence definition for this dissertation lies below. Its selection stems from its portrayal of the nurse's multidimensional characteristics, or attributes, whose role includes care to suffering persons (Ferrell & Coyle, 2008). Additionally, the definition describes the process by which the nurse engages in nursing presence while referencing presence outcomes.

“Nursing presence is an interpersonal process characterized by nurses' sensitivity, holism, intimacy, vulnerability, with an ability to adapt to unique circumstances. Presence results in enhanced mental well-being for nurses and patients, and an enhanced physical well-being for patients” (Fingeld-Connett, 2008, p. 2).

## Ways Nursing Presence Develops

Scholars have debated on how one acquires nursing presence. For instance, some texts offered examples of presence as an inherent nurse characteristic by viewing one's ability to engage in presence a natural skill (Delashmutt, 2007; Finfgeld-Connett, 2006, 2008a, 2008b; Paterson and Zderad, 1976). Scholars labeled these inborn presencing abilities intuitive ways of knowing (Finfgeld-Connett, 2008a, 2008b; Marsden, 1990; Smith, 2001). Yet other scientists observed ways presence developed as nurses gained clinical expertise (Benner, 1984; Fuller, 1991; Osterman, 2002). Benner observed the extent to which clinical experience was critical in molding an expert nurse and noted that repeated clinical exposure helped nurses acquire presencing skills by having daily participation in clinical situations. Hence, Benner viewed nursing presence an important nursing competency, possessed by experienced nurses.

Still more studies demonstrated that nursing presence can be learned in presence skill training which involved informal classes and role playing (Doona, Hagerty & Chase, 1999; Finfgeld-Connett, 2006; Godkin, Godkin & Austin, 2002; Marsden, 1990; McKivergin & Daubenmire, 1994; Owen-Mills, 1998; Smith, 2001). After nurses practiced meditation and centering techniques in class, nurses reported having greater focus with patients and a deeper grasp of patients' illness situations (McKivergin & Daubenmire). Meanwhile, Owen-Mills (1998) observed nurse educators integrate aspects of nursing presence into communication lectures focused on therapeutic interactions who inferred presence skills can be taught.

## Levels of Nursing Presence

The literature consistently indicated something other than physical presence occurred during presencing interactions, suggesting a relationship between the nurse and patient (Duis-Nittsche, 2000; Easter 2000). Within that relational connection, scholars identified the types, or

levels, of presence (Duis-Nittsche; Easter; Finfgeld-Connett, 2006; Fuller, 1991; Mohnkern, 1992; Osterman, 2002; Osterman & Swartz-Barcott, 1996).

For example, McKivergen and Daubenmire (1994) identified therapeutic and psychological presence, while Osterman and Schwartz-Barcott (1996) observed four levels of nursing presence including presence, partial presence, full presence, and transcendent presence. The first level of presence involved being with another (Osterman & Swartz-Barcott). Partial presence occurred in situations when the nurse was with the patient but not fully focused on the patient and observed when the nurse is engaged in a task while attempting attention towards the patient (Osterman & Swartz-Barcott). Lastly, transcendent presence encompassed a broader, elusive quality, it occurred within a transforming energy exchange between nurse and patient (Osterman & Swartz-Barcott).

Spiritual presence ensued as the nurse engaged the patient in prayer or meditation (Duis-Nittsche, 2002). This level of nurse-patient interaction fostered a transcendent awareness for both nurse and patient (Rev, 1986). Spiritual presence occurred when both nurse and patient held similar regard over the importance of spiritual and/or religious beliefs (Easter, 2000; Rev; Savary & Burne, 1998).

Another type of nursing presence included therapeutic presence, as evidenced by the nurse being fully present to the patient in mind, body, emotions, and spirit. For therapeutic presence to occur, the patient must trust the nurse, believing the nurse truly cared about the patient (Easter, 2000; Hines, 1992). Holistic presence is still another level of presence in which the nurse views the patient as an integrated whole, greater than individual components of the self (Parse, 1987). Nursing actions that foster holistic presence include therapeutic touch, music therapy, and visual imagery (Smith, 2001).



While scholars have selected various terminologies describing levels of presence, these attempted delineations have stirred opposing factions (Smith, 2001). For example, some researchers have affirmed the importance of using classifications to label the subtle nuances of nursing presence as these create helpful distinctions (Finfgeld-Connett, 2006). Other scholars opposed such sorting, claiming these actions limit an understanding of the whole of presence (Finfgeld-Connett).

### Barriers to Nursing Presence

Nurses' perceptions centered on nurses' lack of time represented the greatest barrier to nursing presence (Iseminger, Levitt & Kirk, 2009). These perceptions resulted from low staffing ratios while nurses cared for high acuity patients (Iseminger, et al.). Furthermore, nurses' perceptions related to time appeared exacerbated in nurses who were uncomfortable with intense, meaningful communication or regarded presence a low priority in patient care (Iseminger, et al.).

### **Framework for Presenting the Literature on Nursing Presence**

As stated, the framework which categorizes the reviewed nursing presence literature comes from Donabedian (1966) and lists three requisite categories comprising structure, process, and outcome. Table 1, titled The Process of Nursing Presence, and illustrated the nursing presence process as it is described in the literature. Table 1 also noted the essential antecedents and attributes that form the structure which fosters the nursing presence process, and results in beneficial outcomes for both patient and nurse (Finfgeld-Connett). It is important to state this framework is not a nursing theory.

### **Requisite Structures, Characteristics and Outcomes of Presence**

The antecedents and attributes of nursing presence reflect traits of both the nurse and patient prior to presencing interactions. For instance, the patient must allow the nurse into the

patient's illness experience (Finfgeld-Connett, 2006). Equally important, the nurse must identify the patient has a need (Doona, Haggerty & Chase, 1999; Easter, 2000; Finfgeld-Connett; Fuller, 1991; Gilje, 1993; Pettigrew, 1998). It is then the willing nurse decides to participate in the patient's situation, an intent resulting in a reciprocal and remembered exchange between the nurse and patient (Doona et al; Finfgeld-Connett; Fuller; Duis-Nittsche, 2002; Pettigrew).

Gilje (1992) illuminated the importance of the nurse's intent as an antecedent to presence when studying mentally ill patients and psychiatric nurses and noted patients made interaction-overtures to nurses who then responded to patients with authenticity. Such responses helped patients feel comforted by their nurses' presence (Gilje).

Some nurses who engaged in presence held moral perspectives to do so (Cavendish et al., 2003; Duis-Nittsche, 2002; Easter, 2000; Finfgeld-Connett, 2006; Gilje, 1992; Hines, 1992; Mohnkern, 1992; Miller & Douglas, 1998; Pettigrew, 1988; Wilson, 1986). For example, nurses' altruistic beliefs provided rationale for involving themselves in patients' illness experiences (Mohnkern, 1992). Similarly, Pettigrew (1988) observed nurses displaying heartfelt countenance, along with compassion, empathy and a non-judgmental kindness while investing themselves in patients' situations. Bishop and Scudder (1996) argued nurses considered it their professional duty to attentively care for patients within a caring relationship.

Nurses engaging in presence also demonstrated personal and professional maturity. Nurses displayed professional maturity by conveying awareness of patients' holistic needs by addressing patients' psychosocial, spiritual and physical domains (Duis-Nittsche, 2002; Easter, 2002; Finfgeld-Connett, 2008; Fuller, 1991; Hines, 1992; Mohnkern, 1992). Another example of nurses' professional maturity involved nurses who considered patients' life situations, thus going beyond assessing patients' physical needs by checking the kinds of social support patients

received (Doona Chase & Haggerty, 1999). Other characteristics of nurses displaying professional maturity included their ability to think critically (Easter; Euswas, 1993; Finfgeld-Connett; Mohnkern; Sherwood, 1997).

Nurses exhibiting personal maturity knew themselves well (Benner, 1984; Doona, Chase & Haggerty, 1999; Duis-Nittsche; Easter; Finfgeld-Connett; Fuller, 1991; Gilje; Mohnkern). These nurses also engaged in self-care practices, subsequently they tended not to be overwhelmed in bearing witness to suffering (Euswas, 1993; Finfgeld-Connett, 2008; Forrest, 1989; Gilje; 1993; Montgomery, 1992; 1997; Osterman, 2002). To summarize, nursing attributes of those engaging in presence included personal and professional maturity and participating in self-care practices.

Lastly, a supportive work milieu was a forbearer to nursing presence (Finfgeld-Connett, 2006; 2008). Such environments included helpful colleagues who allowed nurses time to be with patients (Finfgeld-Connett, 2008). These units also had adequate staffing ratios, conditions that fostered nurses' ability to engage in presence (Finfgeld-Connett, 2008).

#### Requisite Nurse Characteristics

Presence was characterized by nurses' compassion, holism, understanding, vulnerability, and an ability to adjust to changing circumstances (Finfgeld-Connett, 2006). For instance, nurses displayed interpersonal sensitivity while remaining focused on patients' spiritual, psychological, and physical well-being (Doona, Chase & Haggerty, 1999; Duis-Nittsche 2002; Finfgeld-Connett; Gilje, 1993; Hemsley & Glass, 1999; MacKinnon, et al., 2005; McKivergin & Daubenmire, 1994; Pettigrew, 1988). Within these exchanges, nurses involved patients in sensitive verbal communication, thereby demonstrating nurses' ability to be interpersonally competent (Duis-Nittsche; Finfgeld-Connett; Hardy & Conway, 1978; Hines, 1992; MacKinnon,

et al.; Osterman, 2002; Pettigrew). Nurses who possessed interpersonal competence connected with patients' unique experiences, nurses' kind demeanor conveyed their sensitivity to patients (Doona, Chase & Haggerty; Osterman).

Nurses who engaged in presence demonstrated an ability to adapt to unique circumstances (Doona, Chase & Haggerty, 1999; Finfgeld-Connett, 2006; Gilje, 1993; MacKinnon et al., 2005). For example, nurses sensed patients' distress immediately before presencing moments occurred (Fuller, 1991; Mohnkern, 1992). Both nurses and patients reported having awareness of their vulnerable feelings during their initial interactive moments (Finfgeld-Connett; Gilje; Hemsley & Glass, 1999; Miller & Douglas, 1998; Osterman, 2002; Pettigrew, 1988).

#### Patient Outcomes Resulting from Presence

Presence has a sustained, therapeutic effect that continued long after the presencing interaction (Finfgeld-Connett, 2006; Gilje, 1992; Hines, 1992; Pettigrew, 1988). Patients' faces brightened when recalling their interactions with nurses (Pettigrew). In general, patients reported enhanced well-being following nursing presence (Finfgeld-Connett; Fuller, 1991; Gilje; Pettigrew). Presence fostered patient-nurse relationships that went beyond superficial communication (Pettigrew). Following these experiences, patients reported gaining new insights about their situations; such revelations helped patients grow as people (Doona, Chase & Haggerty, 1999; Easter, 2000; Finfgeld-Connett; Gilje, 1992, 1993).

An example of benefits to patients as a result of presence was demonstrated in a quasi-experimental design involving 39 nursing home patients who participated in coping skills training (An & Jo, 2002). The experimental patient cohort received training from nurses who integrated presence throughout sessions lasting several weeks who consistently displayed

empathic listening, attentiveness, honesty, and caring (An & Jo). Before and after the training participants in both the control and experimental groups completed a 22 item survey measuring stress levels (Alpha coefficient 0.87; Cronbach  $\alpha = 0.83$ ). When training ended, patients in the experimental group reported decreased levels of familial stress ( $p = 0.026$ ) as well as decreased levels of economic stress ( $p = 0.017$ ) (An & Jo).

Additionally, patient outcomes that resulted from presence reported improved physical well-being and diminished pain (Buchanan & Ross, 1995; Clayton, Murray, Horner & Green, 1991; Duis-Nittsche, 2002; Easter, 2000; Fuller, 1991; Monkern, 1992; Sadler, 2000; Sherwood, 1997). Pettigrew (1988) found those patients who reported reduced pain did so after spending time with their nurses, who then believed their nurses could alleviate pain called for the nurse to be with them (Pettigrew).

#### Outcomes to Nurse Resulting from Presence

Nurses described greater mental well-being following their presencing interactions with patients (Duis-Nittsche, 2002; Easter, 2000; Finfgeld-Connett, 2006). Nurses also reported increased job satisfaction (Duis-Nittsche; Easter; Miller & Douglas, 1998) and greater self-confidence (Doona, Haggerty & Chase, 1999; Finfgeld-Connett; Mohnkern, 1992). Following presence interactions, patients and nurses reported a mutual regard that each held for the other (Gilje, 1992, 1993). Nurses and patients also described feeling a sacred connection during their interactions (Hemsley & Glass, 1999).

#### **The Nurse and the Terminally Ill Patient**

In a study involving ten nurses caring for ten dying patients, Mok and Chiu (2004) found the relationship between end-of-life patients and nurses focused on trust and mutuality, as nurses acknowledged patients' limited time. Due to the trust patients had for nurses, patients openly

shared their fears with nurses (Mok & Chiu). Patients reported feeling a connectedness with their nurses who helped patients view themselves as people who mattered (Mok & Chiu). Patients indicated these experiences left them refueled and triggered their inner strength (Mok & Chiu).

Dowling (2008) interviewed 23 oncology nurses and 30 cancer patients to explore the meaning of nurse-patient intimacy. Results indicated that the nurse-patient relationship underwent a process characterized by nurses' empathic responses, which prompted reciprocal self-disclosures as nurses assumed roles of being professional friends to patients (Dowling).

May (1995) explored the nursing role of preparing patients for imminent death and concluded that nursing the dying was both a challenging and stressful function of nursing. These nurses often went beyond sitting and listening, their relationships with dying patients became somewhat pastoral, as evidenced by very honest exchanges involving confidences patients shared (May). End-of-life patients disclosed personal information involving private details about their lives (May).

Luker, Austin, Caress and Hallett (2008) adapted the critical incident technique to understand factors contributing to quality end-of-life nursing care. Researchers noted a central theme, that of knowing the patient, was pivotal to the nurse's and the terminally ill patient's relationship (Luker, et al). Nurses came to know the patient after spending time with the patient and extending more than physical nursing care (Luker, et al).

Overall, the literature pertaining to nursing care to the dying encompassed a rather small amount of evidence. Findings indicated a trusting relationship essential so as to foster an intimate professional connectedness between the dying patient and nurse. Within that interaction, patients' shared their personal feelings along with the most private details of their

lives. This connectedness involved mutuality. In addition, nurses demonstrate awareness of terminal patients' limited time.

### **Gaps in the Literature**

Gaps in the literature remain to aid in understanding how experienced staff nurses engage in the process of nursing presence with terminally ill patients. While the literature identified nursing presence antecedents and described outcomes resulting from presence for both patients and nurses, the texts revealed a paucity of knowledge that described the process by which staff nurses engage in nursing presence. This study sought to explicate this process.

The following paragraphs present three studies involving seriously ill patients, two of these involved oncology patients and another described nursing presence involving intensive care unit (ICU) patients (Doona, Chase, & Haggerty, 1999; Dunniece & Slevin, 2000; Pettigrew, 1988). Each study highlights unique distinctions about presence while providing rationale for how this study addresses the aforementioned gaps in the literature.

Dunniece and Slevin (2000) involved six staff nurses who were with patients as patients received cancer diagnoses. Nurses subsequently described their presencing moments as intense patient interactions (Dunniece & Slevin). Nurses tried to imagine what it was like to be diagnosed with cancer. In those moments, nurses reported awareness of their own mortality as they engaged patients in patient-centered interactions, rather than nurse-to-patient exchanges (Dunniece & Slevin). However, these researchers failed to explore how nurses transitioned from nurse-to-patient exchanges to engage patients in meaningful, person-centered interactions.

Likewise, Pettigrew (1988) involved six bereaved oncology families to examine aspects of nursing presence as families recalled care to deceased cancer patients. Findings validated presence as “an elusive trait that was difficult for participants to explain, (because of) the

intangible nature of presence, and, the intangible sense in which presence was recognized (by families)” (p. 281). Families recalled characteristics of nurses who valued the personhoods of those who were dying (Pettigrew). However, it appeared Pettigrew did not explicate the process by which nurses engaged patients.

A second qualitative study involved a convenience sample comprised of five oncology nurses caring for five female and five male cancer patients (Osterman, 2002). Findings revealed three types of presence including full presence, partial presence, and transcendent presence, although the latter was unobserved (Osterman). Osterman took note of how nursing presence differed in care given dying oncology patients whose nurses exhibited quiet reverence in their care. However, this researcher failed to explore why nurses came to used quiet reverence during their presencing interactions with dying patients

Another study involved nurses caring for 30 critical care patients (Doona, Chase, & Haggerty, 1999). Using secondary data, investigators identified nursing presence during weaning attempts of ventilator-dependent patients (Doona, et al.,). Nurses saw beyond the immediate moments of extubation and displayed awareness of the inherent dangers to patients during such major care transitions (Doona, et al.,) While presence facilitated nurses’ immediate recognition of patients responding poorly to extubation, researchers failed to inquire how that process occurred (Doona, et al.,).

The aforesaid nursing presence studies all involved terminally ill patients or their families. While these researchers made important contributions to the literature, it is important to state that until now, questions remained that explained how the nursing presence process unfolds and how nurses maintain these meaningful interactions amid hectic hospital settings.



### **Future Research**

Study outcomes aid in understanding the process by which staff nurses engage dying patients in nursing presence. Results inspire further research that can develop specific tools to measure levels of nursing presence, fostering much needed quantitative inquiry on this topic. Moreover, study results delineate how this process unfolds and specifically, as it applies to staff nurses and terminally ill patients.

### **Chapter Summary**

The previous chapter introduced the reader to the reviewed literature which contained several concept analyses and nursing presence definitions. This section reviewed specific nursing theories that encouraged the use of nursing presence. A historic overview of presence followed, along with a discussion that highlighted divergent scholarly opinions on the ways nurses acquired abilities to engage in nursing presence. The chapter discussed the antecedents, attributes, and outcomes resulting from presence. Lastly, this section created the reader's awareness around the paucity of evidence that existed before now which describes how the meaningful, nursing presence process unfolds with terminally ill patients.

### **Chapter Three: Research Design and Methods**

“Nursing is an art, and if it is to be made an art, it requires an exclusive devotion, as hard a preparation, as any painter’s or sculptor’s work. For what is having to do with dead canvas, or cold marble, compared to having to do with the living body, the temple of God’s spirit”  
(Nightingale, 1869)

#### **Constructionist, Theoretical Underpinnings, Grounded Theory Tenets**

This chapter describes the study’s research design and methods. Rationale for using GT and specifically, constructionist GT stems from needing to understand unexplored core concepts that were found within participants’ responses to questions posed to clinically experienced staff nurses about their meaningful dying patient interactions using nursing presence.

This section describes salient aspects of the research methodology; including SI. Additionally, the chapter describes processes known as data collection and data analysis as well as the recruitment procedures used in the study. Throughout the chapter, discussions involving ways constructionist GT methodology has been integrated are presented, as well as techniques used to safeguard rigor. Lastly, a section addresses the way human subjects were protected.

#### **Qualitative Research**

GT is an appropriate method to use when studying interpersonal processes such as nursing presence (Haylock, 2008; McCann & Clark, 2003a). The study design used constructivist GT as the research method (Charmaz, 1994, 1995a, 1995b, 2000, 2005, 2006; Charmaz & Mitchell, 1996). This methodology provided an understanding of presence and was particularly useful in exploring an under-researched topic such as nursing presence with dying hospitalized patients (Haylock; McCann & Clark). Until now, no study has examined this. Hence, a constructionist GT design provided an open lens to explore this unexamined social

phenomenon. Sociologists Glaser and Strauss (1967) conceptualized traditionalist GT. GT derives its conceptual underpinnings from symbolic interactionism (Haig, 1995).

### **Grounded Theory**

Since its inception in the 1960's, GT is one of the most popular qualitative methodologies used (Mills, Bonner & Francis, 2006b). Glaser and Strauss (1967) introduced traditional GT by challenging the then biased consensus that solidly endorsed quantitative inquiry, and considered qualitative work unscientific (Smith & Biley, 1997). Glaser and Strauss offered pioneering methodology consisting of sequential, qualitative data analysis to extract theoretical explanations out of every day social processes (Charmaz, 2006). Their work profoundly changed the face of social science (Morse, 2009).

Historically, GT joined two divergent traditions, these included positivism as contributed by Glaser, (1967), and pragmatism, offered by Strauss (1967). By implementing a positivist approach, Glaser called upon the quantitative rigor he learned at Columbia University and adapted this to qualitative codifying techniques. By integrating aspects of empiricism into this new methodology, he outlined precise methods that resulted in emergent interpretations (Charmaz, 2006). Ultimately, this new technique demystified qualitative research (Charmaz, 2006). Strauss, from the University of Chicago, held a pragmatist philosophy (Charmaz, 2006). As such, Strauss viewed reality as a fluid, indeterminate process open to multiple interpretations (Charmaz, 2006, 2009).

Glaser and Strauss (1967) sought to understand social and psychological processes (Charmaz, 2006). Their relativist positions instructed researchers to interpret participants' stories. Their directions helped investigators engage in data analysis, leading to theory formation and a process known as traditional GT (Mills, Chapman, Bonner, & Francis, 2007).

Over time traditional GT underwent change, primarily due to Strauss's shifting paradigms. While Glaser (1967) upheld his original views, Strauss's (1993, 1997) ideas moved forward (Charmaz, 2006). This change occurred as Strauss realized the researcher should be involved with the participant, a theme unsupported by traditional GT.

Strauss (1993, 1997) encouraged the researcher to focus on situated action as this was the center of analysis (Charmaz, 2006; Miles, Chapman, Bonner, & Francis, 2007). Every interaction created, and then recreated, one's world (Strauss, 1993). Strauss's evolving perceptions and new partnership with Corbin (1991, 1998) encouraged a researcher-participant relationship while also suggesting constructionist GT as another paradigm of inquiry (Miles, et al.).

### **Constructionist Grounded Theory**

Charmaz (1994, 1995a, 1995b, 2000, 2005, 2006, 2009) a sociologist and student of Glaser and Strauss developed constructionist GT. Charmaz (2006) integrated and then developed Glaser's, Strauss' and Corbin's research guidelines into an interactive and a comparative method. Constructionist GT encourages a relativist's view, so that the investigator, along with the participant, creates an interpretive theory grounded in the data (Charmaz, 2009). In essence, the constructionist co-creates the research process by continually re-situating herself/himself, while simultaneously employing a reflexive design (Charmaz, 2000; Miles, Chapman, Bonner & Francis, 2007).

Initially, the researcher takes on the role of an observant listener (Charmaz, 2006). Later, the researcher's position changes to that of an active accomplice. In that function, the researcher attempts to create and recreate interior worlds (Charmaz; Miles, Chaplain, Bonner, & Francis, 2007; Strauss, 1993). The constructionist tries to uncover the meanings participants' attach to life situations and dissect these experiences (Charmaz, 2006, 2009). It is from that center that the

investigator inductively works by going deeply into the phenomenon to its roots (Charmaz, 2009). The researcher attempts to grasp the importance participants place on their values, beliefs and ideologies (Charmaz, 2009). The resultant, albeit intense, exchange within each dyad leads to a mutual understanding of what is valued. Subsequently, there appears a shared recognition on what the participant considers truth. This mutual exchange and its resultant comprehension produce the rich data in constructionist GT (Charmaz, 1995b; Mills, Bonner & Francis, 2006a).

### **Symbolic Interactionism**

SI focuses on the self, capable of reflecting internal thoughts, emotions, and social behaviors (Wallace & Wolf, 2005). Through active participation within the self, the self interprets, defines, and maps out her/his actions (Wallace & Wolf). Such internal participation helps the self to make decisions and form opinions void of outside influences (Wallace & Wolf).

SI holds three primary premises, the first of which states individuals act upon the meanings that objects, other human beings and situations have for them (Eaves, 2001; Wallace & Wolf, 2005). Another salient point in SI is that meanings stem from one's interactions with others and occurs as one share one's symbolic interpretation with others, the act of sharing becomes meaningful for them as if they were speaking the same language (Wallace & Wolf). The third SI assertion contends the individual engages in this interpretive process through situations in her/his environment (Wallace & Wolf). Therefore, the individual, nor those in her/his world, are isolated from each another (Eaves). Rather, they continually develop through their interactions (Eaves).

Scholars credit both Mead (1934) and Blumer (1969) for informing SI. For example, Mead delineated two phases of self, the first phase he called the "I" (Wallace & Wolf, 2005). Mead viewed the "I" as the individual's impulsive, unorganized response to the attitudes of

others, guided by innovation and creativity (Wallace & Wolf). Mead called the second phase of the self the “me”. He argued that the behavior of the socialized person influences the “me.” Mead saw the “me” as part of a social process, which was comprised of the acting “I,” when the self was the subject. Moreover, when the self was the object, another social process occurred, which Mead called the “acted-upon me” (Wallace & Wolf).

Mead (1934) viewed the self as central to SI and argued that as individuals are confronted with situations, each engages in a self-interactive process. This internalized process helps the individual organize responses to actions through her/his interpretation of those actions; this ultimately guides conduct (Wallace & Wolf, 2005; Blumer, 1969; Mead).

An example of ways participants engaged in SI with dying patients is as follows. As the participant noted a dying patient’s vulnerability, according to SI, the participant became aware of their impulsive response after observing conditions that cause the participant to perceive the dying patient was vulnerable. In those moments, the participant’s “I” was also aware of having very little time. Yet, the participant’s behavior, molded by social influences, inspired the participant’s “me” to instead prompt the participant’s intention to become involved in the patients’ dire illness experience. According to SI tenets, the participant continued to remain aware of acting on their “I” whose immediate reaction indicated the “I” did not have enough time to address the dying patient’s needs. Instead, the participant’s “me” responded by remaining fully focused, intent on helping the patient. This symbolism also suggests the participant’s awareness of the patient’s response to what the patient might be experiencing or needing in those moments. Because the terminal patient had become the object of the participant’s attention, the patient’s “I”, who up until that point remained contained within her/his “I” then experiences the “acted upon me” by becoming aware of the nurse’s intention to be of help to the patient.

The Meadian concept of self-interaction is therefore applicable to this dissertation, since it provides a framework to examine participants' ability to engage in nursing presence with terminally ill patients (Mead, 1934). Through the aforementioned example, I contend that the process of self-interaction influenced participants' presencing interactions.

Blumer, (1969) a student of Mead, (1934) created the term SI while describing views on human nature (Wallace & Wolf, 2005). Blumer's ideas had profound effects on social theory for he dismissed a long held regard for the person's environment, which, before Blumer, the scholarly assumption was that setting determined the individual's conduct (Wallace & Wolf). Instead, Blumer argued that while the individual considered the environment before deciding to act, the individual first interacted with the self about the things confronting her or him, and then acted (Wallace & Wolf).

Blumer (1969) built upon Mead's (1934) ideas by arguing that SI inserted a middle word in the stimulus-response couplet, suggesting a stimulus-interpretation-response (Wallace & Wolf, 2005). In other words, when another person acts, the individual perceiving the action seeks to ascertain the other's intent. The individual responds according to the meaning that individual attached to the other person's action. In turn, the other person responds according to the meaning given to that person's response (Wallace & Wolf). Blumer referred to SI as an interactive process involving people using a common set of symbols (Wallace & Wolf). He described SI as an inductive approach to understanding human behavior. Blumer encouraged researchers to look for processes in the data, for it was within these interactions that individuals defined their world from the inside (Wallace & Wolf). To accomplish this, Blumer reminded researchers to take the role of the other (Wallace & Wolf).

The aforementioned paragraphs described the essence of what this study sought to uncover. Indeed, I have dissected the process by which an experienced nurse becomes aware of a terminally ill patient's need, (stimulus) and interprets ways to meet that need, (interpretation) and responds to the need (response). I have also uncovered the meanings these experiences had for the participants. This dissection illuminated an understanding of that process, which fostered the stimulus-interpretation-response process.

### **Ontologic and Epistemological Underpinnings**

One's paradigm is characterized by ontologic beliefs and epistemologic underpinnings that define one's reality. An individual's worldview is how one knows what one knows (Guba, 1990; Keeney, 1983). A constructionist's epistemologic view is that of a relativist, this means knowledge is socially constructed (Charmaz, 2009). This viewpoint holds that truth is found within multiple realities, influenced by individual context (Mills, Bonner & Francis, 2006a). A constructionist regards the participant's perceptions as important to those of the researcher. As a result, her/his epistemologic stance is never neutral (Charmaz). The constructionist's epistemologic position is to co-construct the data; this is done in lieu of gathering data from a singular perception (Charmaz).

I hold an interpretive worldview with a relativist epistemology, since I believe there is no single, objective reality (Lincoln & Guba, 2005). My epistemologic perspectives align with those of a constructionist. These declarations stem from a confidence that recognizes knowledge is individually and socially constructed from experiences, formed within an individual context (Merrill, 1991). As I analyzed the research data, I regarded participants' stories as segments of their unique realities, and considered these situational and relativistic (Charmaz, 2009).



## **Promoting Rigor**

An empiricist inquiry insists on unyielding objectivity (Lincoln, 2002). Unlike positivist colleagues who regard objectivity as the assurance of research excellence, qualitative scholars view objectivity as an obstacle in achieving investigative quality (Lincoln). Indeed, it is in the name of rigor that qualitative investigators seek interactions validating the researcher-participant relationship (Lincoln). Within this quest the investigator assumes responsibility for attending to voice, by accurately representing those telling their stories (Lincoln). This kind of passionate participation is a mark of quality research (Lincoln, 1987). By maintaining meticulous attention to voice, findings clarified the way experienced bedside nurses engaged in the process of nursing presence. Other ways qualitative researchers continually demonstrate rigor is by maintaining a heightened alertness for participants' subtle nuances (Lincoln, 2000). Researchers should critically assess informants' phraseology, while listening for discrepancies within their narratives (Lincoln). Such thorough and perceptive analyses ultimately produce non-fragmented knowledge (Lincoln). By integrating the aforementioned modes of rigor within this study, I have also assumed the researcher's honored role of attending to the participant's voice.

## **Tenets of Constructionist Grounded Theory**

The following section discusses GT practices foundational to its methodology (Charmaz, 2009). The discussion herein centers on tenets of constructionist GT to ensure rigorous research.

### Theoretical Sampling

Theoretical sampling is a process by which researchers develop theory (Charmaz, 2006). While investigators initially sample for heterogeneity, ultimately, the researcher samples as a way to form theory (Charmaz; Glaser & Strauss, 1967). For example, as I noted substantive areas during analysis, one involved participants' descriptions about losing a loved one. At that

point, I refined the emerging data by examining properties surrounding other loss situations, such as the loss of one's childhood as one participant referenced. By sampling for this and analyzing the compared data, this helped illuminate any conceptual refinements, of which were none (Denzin & Lincoln, 2003).

### Theoretical Sensitivity

Charmaz (2006) defined theoretical sensitivity as the researcher's skill in exposing concepts in order to move to a theoretical level. Theoretical sensitivity necessitates the constructionist's ability to identify intellectual and emotional meanings in data (Charmaz). It involves the capacity to recognize saliency and identify distinctions and intricacies heard in participants' words (Bonner & Francis, 2006b; Corbin & Strauss, 2008). Theoretical sensitivity encourages balanced findings that incorporate feelings as well as levels of abstraction within the text (Corbin & Strauss).

Theoretical sensitivity occurred during the third interview as the participant recalled poignant interactions with a young woman dying of cancer. The participant's eyes filled with tears yet she continued speaking, remembering things she and the patient had mutually shared that night. The participant admitted she was very proud of having this exchange. While remaining aware of the participant's rising emotions as she remembered the story, I quietly asked the participant: "I can see how satisfied you are with your nursing actions that night. Can you tell me what was meaningful for you as you recall your interaction with that patient?" The participant began to softly cry as she replied: "I came away knowing that I had made a difference. I never saw her again but I know my presence with her that night changed her. The interaction was meaningful because I made a difference!"

Birks and Mills (2011) stress the importance of identifying participants' emotions as this can lead to analytic breakthroughs. In this case it did. My sensitivity to the participant's emotional crescendo prompted me to ask an important question at the appropriate moment about what meaning the interaction had had for the participant. Her response that followed was, for this burgeoning researcher, a defining moment, for during it I began to wonder if making a difference was important to participants. Thus, in following interviews I integrated this question. Participants' responses indicated that making a difference was central in meaning making. This is an example of how a concept offered by a participant was used to develop a new interview question. I have quietly wondered what would happen had I not integrated theoretical sensitivity during that interview.

#### Reflexivity

Reflexivity is the explicit quest to limit researcher effects on the data by the awareness of self; in GT it is integral to both the data collection process as it is to the constant comparison method (McGhee, Marland & Ackinson, 2007). Before, during and after each interview, the researcher demonstrates a self-reflective process in writing memos expressing her/his personal thoughts, helping the investigator expose her/his processes and fosters transparency (Charmaz, 2009). Reflexivity involves the researcher's ability to adopt new perspectives, as evidenced by an agility to re-direct focus on unexpected, emerging themes (Charmaz). Reflexivity necessitates clearly articulated interpretations, while accounting for every study decision (Charmaz, 2006).

The first several participants interviewed had advanced nursing degrees; two were enrolled in doctoral nursing programs. My memo following the fifth interview reads: "These nurses are well educated and articulate, I wonder about my future interviews with participants with Associate Degrees in Nursing (AND). I must remain aware when interviewing ADN

participants of my bias about nursing education, it is my opinion that nurses holding Bachelor of Science in Nursing (BSN) degrees make more rounded nurses. Also, I must especially try to dispel power imbalances during those interviews.”

Another memo written towards the study’s end reflects my surprise after listening to another participant recount her courageous actions. “The last couple interviews surprised me. I could never begin preparing an imminently dying patient for impending unconsciousness by asking who should be permitted to visit as the patient lay dying. These nurses have courage. Some things they report saying to their terminal patients I would never express to my dying patient. I am very aware of the degree to which these interactions differ from things I say to my end-of-life patients, I must not react but be open to whatever I hear.”

### **Preparing for the Interviews**

#### Expunging Power Imbalances

In preparations before and during each interview, I made considerable effort to expunge power imbalances (Charmaz, 2006). I found this a vital consideration because nurses continue to experience imbalances of power in their work environments, which historically did not favor nurses. Consequently, nurses have been conditioned to work amid varying levels of dominance in the acute care setting. While such differences typically remain unspoken, these disparities can become quite potent, particularly if the nurse opposes power.

For example, nurses experience power imbalances working alongside patriarchal-dominated medical cultures, whose dominion until recently seeped throughout American hospital cultures (Kelly, 2006). Even within professional nursing there exist power imbalances, as evidenced in the expression nurses eat their young. This terminology conveys dominance and symbolic ways experienced nurses have, for years, exerted control by mistreating new nurses

(Cardillo, 2005). Moreover, the nursing literature increasingly reports horizontal violence among nurses, known as bullying, comprising negative, nurse-to-nurse relationships. Bullying is characterized by a nurse perpetrator attempting to exert social or political control in the work environment (Dellasega, 2009). Typically, nurses who bully employ very subtle, yet strongly received passive-aggressive actions as in ostracizing a less powerful nurse (Dellasega).

An example in which I attempted to avoid power imbalance was evidenced in my first memo on the preceding page, when I wrote about future interviews involving ADN participants. I entered this memo knowing some nurses consider highly educated nurses, like doctoral students or nurse researchers, to hold greater power (Center for American Nurses, 2007). Historically, the researcher participant dyad has been hierarchical with the participant taking an inferior position to that of the researcher (Mills, Bonner & Francis, 2006).

So that power was neutralized before and during interviews, I took steps to avoid power imbalance by proactively planning these interviews, which began by acknowledging our shared nursing profession and similar acute care clinical experiences necessitating quick responses to a patient's health crisis (Mills, Bonner & Francis, 2006). Another similarity acknowledged our mutual experiences of having meaningful moments with terminally ill patients. Simultaneously, the interviews also reflected ways informants and I differed, as exemplified by my second memo on the previous page which addressed communication differences. By remaining aware of these practice differences, our similarities and difference influenced my interactions with participants (Miles, et al.). The similarities drew me in as the interviews opened, the differences intrigued me.

Techniques aimed at leveling power imbalances included scheduling interview times and in locations matching participants' preferences (Mills, Bonner & Francis, 2006). For instance, while securing interview dates I took an unstructured approach to communicate my interest,

availability and scheduling flexibility (Mills, et al.). I shared personal details in telling some participants that I also worked full time since these actions helped foster non-hierarchical research relationships (Mills, et al.). Throughout each meeting I resisted managing the interview's content but instead listened intently, aware of being the fortunate recipient in hearing their stories which helped me gain insightful awareness of their worlds (Mills, et al.).

### Early Memo Writing

To ensure rigor, grounded theory methodology encourages memo writing before beginning a study. Hence, I wrote memos indicating my rationale for this study, one recalled clinical situations with my dying patients when I was a young nurse. “As a young graduate nurse, I did not have enough time to spend with dying patients and families, so I spent time with them after my shift ended. This was in 1975, before the influx of technology, mounting regulatory requirements, and the emphasis on measuring nurses’ productivity. How do today’s staff nurses have time for meaningful interactions with dying patients?” This memo summarized in part, the mental preparations I took before starting this research.

### **Recruitment, Sample Size, and Eligibility Criteria**

Recruitment occurred in a variety of ways including by snowball effect, a process by which participants informed prospective participants about the research (Marshall & Rossman, 2006). In order to prompt heterogeneity, initial sampling attempted to enroll assorted experienced staff nurse volunteers from multiple locations throughout Los Angeles County. Enrolled participants differed in age and religion; there was slight racial variation with several ethnicities represented, all informants were female. Rationale to select experienced nurses with three or more years of nursing experience came from Benner’s (1984) research by observing proficient nurses displayed confidence in their nursing roles after three years of clinical

experience. Reasons for selecting Los Angeles County came from the cultural diversity found throughout this location.

Following authorization from the Office for Protection of Research Subjects of the Institutional Review Board, (IRB) University of California, Los Angeles, (UCLA) study flyers were posted at the Ronald Regan Medical Center, as well as Santa Monica /UCLA Medical Center. Prior to displaying these, I contacted the administrative offices at these medical centers and obtained permission to post flyers. (See APPENDIX A: Study Flyer). The flyer was worded to draw the attention of experienced registered nurses. Flyers offered project information, and included my name and contact information. Flyers were also distributed at professional nursing conferences, such as a nursing seminar on pain, after seeking permission from conference officials to share study information during announcements.

Several nurses with who I worked indicated knowing potential participants, to which I offered the study flyer and requested they ask the individuals to contact me via telephone or email if there was interest in study participation. No potential informants emailed me, but instead called me to acknowledge study interest. During every initial conversation, I ensured each nurse met inclusion criteria and then checked if their life situations matched any exclusion criteria. (See APPENDIX B: Initial Phone Conversation and Selection). Those demonstrating candidacy I then invited to enroll in the study, by requested an interview after securing their contact information. Before ending the call, I requested permission to make a reminder call the evening before the scheduled interview.

The estimated sample size was expected between 15 to 30 participants. In keeping with GT methodology, sample size was dependent on saturation, which was the point which the researcher identifies no new themes in the data (Denzin & Lincoln, 2003). While saturation was

achieved after the ninth interview, two additional interviews, totaling 11 study participants, confirmed this finding. The study's inclusion and exclusion criteria are described below.

### **Inclusion and Exclusion Criteria**

#### **Inclusion Criteria**

- Experienced nurses employed in academic medical centers and community hospitals with more than three years full time employment as a registered nurse in acute care.
- Participants who self-report meaningful nursing presencing interactions with terminally ill patients with cancer and non-cancer diagnoses.
- English-speaking nurses only.
- Participants representing all religions, ages, racial and ethnic groups.
- Male and female participants

#### **Exclusion Criteria**

- Experienced staff nurses currently employed at Torrance Memorial Medical Center (TMMC). I did not want my employment presence at TMMC to bias participants.
- Experienced staff nurses who lost a loved one in the previous year, or those still challenged by previous loss. Rationale for this indicates the first year following a loved one's death is emotionally hard for the bereaved; some individuals continue to experience difficulty after one year (Forte, Hill, Pazder & Fuedtner, 2004).

### **Data Collection Procedures**

I met informants in safe, quiet locations selected by each participant. Often, these included participants' homes, once at the school of nursing, three interviews occurred in informants' offices and one in my home. Following the introductions at these initial meetings, I reiterated the study's purpose and described what the interview entailed while encouraging each



participant to ask questions. After answering these, I verbally reviewed the informed consent, which prepared informants for no more than two follow-up interviews. I asked participants if they had any remaining questions, which I answered. I then requested each participant to sign the informed consent form, who received a copy of this signed form.

After securing consent from every participant, I requested that each complete a Demographic Data Form, providing data pertaining to the participants' age, gender, race, ethnicity, and religion (See Appendix C: Demographic Data Form). Additional questions asked if participants held nursing certification and in what area, the level of completed nursing education while inquiring about non-nursing degrees. Other questions asked if participants were employed at an academic medical center or in a community hospital when their meaningful interactions occurred, and if these centers held magnet designation at the time. Additionally, the form assessed the type of nursing unit on which these interactions occurred so as to ensure work-related heterogeneity in the sample population, so that not all responders were critical care nurses working in community hospitals, for example.

Finally, I asked each participant for permission to begin audio recording and upon securing this verbal consent, I began audiotaping our interview using semi-structured questions aimed at understanding participants' insights brought about by everyday processes (Charmaz, 2006). (See Appendix D: Interview Guide). So that informants set the interview direction, I initially asked a central, open-ended question, called the grand tour question, which aligned with the study's purpose (Cresswell, 1994; Haylock, 2008; McCaslin & Scott, 2003). The grand tour question I initially asked every participant was "If you were to tell a new nurse what meaningful interactions were like with terminally ill patients, how would you describe these interactions?" I found that the initial participants answered the original grand tour question by describing how

they would instruct new nurses to care for terminally ill patients. In hearing these responses, I then rephrased the grand tour question during these interviews. After noting this, in subsequent interviews I reworded the grand tour question, to instead ask: “How would you describe what a meaningful interaction is like with terminally ill patient?” Rationale in revising this question stemmed from needing to clarify this analytic question, so as to eliminate conceptual gaps in the data (Charmaz).

Subsequent questions were general and prompted a range of responses (Charmaz, 2006). Throughout each interview, I followed each participant’s lead. I often asked clarifying questions so as to make sure I understood each participant’s responses. If a participant appeared unclear about any question I asked, I then rephrased the question.

In appreciation of the nurse’s time and to spur study participation, at the close of every interview each nurse received \$50 which was folded into my hand-written note thanking the participant for her time. For the two re-interviews, I telephoned each participant using a format similar to the aforementioned initial interview, explaining my need to clarify the participant’s thoughts (See Appendix E: Phone Conversation for Follow-Up Interviews). These re-interviews were requested after realizing I had omitted asking both participants about their perceptions of dying patients’ vulnerability. I had done this in other interviews. I found no other reason to re-interview other participants, since during each interview I was careful to ask clarifying questions. I requested two re-interviews because this was salient theme emerging from the data. During these re-interviews, I also engaged in member checking, which both participants validated. Follow-up interviews were an intentional part of this research design, since these subsequent meetings added rich data to the analysis containing previous information. The re-interviewed

participants again received \$50, which was folded inside a hand written thank you note expressing my appreciation for their participation. (See Appendix F: Thank You Note).

### **Data Analysis**

After transcribing and checking each transcript verbatim, all personal identifiers were removed. In the tradition of constructionist GT (Charmaz, 2006), my analysis began by taking small data sections, which is a process known as initial coding. The purpose of initial coding is to move beyond participants' words and begin data interpretation.

During the initial coding of the first several interview transcripts, I identified as many codes as possible by focusing on the participant's actions. As I coded, I stayed close to the data and often wrote gerunds in the margins of transcripts, such as "recognized patient in pain." Gerunds are verbs used as nouns to denote action (Cooney, 2011). I looked for what was happening in the data while also considering its meaning, noting themes that occurred frequently and the themes that appeared salient. These are critical steps in GT data analysis.

The first few interviews revealed frequent, similar themes such as dying patients' vulnerability; I also noted the properties of this theme. These properties reflected the ways participants perceived dying patients' to be vulnerable, who noted vulnerability when their patients were emotionally labile or physically fragile. I also noted situations in which participants considered patients to be vulnerable. These ranged from vulnerable patients who were given bad news to vulnerable patients who faced imminent, life threatening events, such as a respiratory arrest. These aspects of patients' vulnerability reflected a dimensional range, which I then labeled 'situational vulnerability'.

In focused coding, I took the initial codes to higher conceptual abstractions. Memo writing helped facilitate this process. For themes pertaining to patients, such as 'patient in pain' I

took that a step further to include “Identified Patient Needs.” As I assembled topics related to this focused code, I uncovered assorted related descriptions of patients’ needs, such as “sad patient crying” and “angry patient” to name a few.

Admittedly, I initially found the complexity of all the raw data in open and focused coding to be challenging. Gradually and with Dr. Maliski’s assistance, I abstracted categories. As I reviewed the data using the constant comparative method, I examined various types of identified patient needs from the data, and realized the collective needs of patients reflected the actual cues patients exhibited that triggered participants’ attention to the dying patient. This is how I arrived at the category titled ‘Patients’ Cues.’

As more categories emerged I began linking potential relationships between the developing categories. I analyzed subcategories, dimensions, and properties of categories. I used the constant comparative method to scrutinize and condense the data into an interpretive theory (Charmaz, 2009). It is important to state that I conducted all the interviews as well as the initial coding. Another researcher involved throughout data analysis included my Dissertation Chair, Dr. Maliski. Our collaborative coding relationship supported rigor while it also ensured credibility during data analysis. The analytic process I described above produced a theory grounded in the data, which the participants and I have co-created. Table 2 illustrates that theory which is titled: “The Courage to Make a Difference.”

It is important to state that unlike Table 1, Table 2 reflects the grounded theory this study uncovered, which describes how nursing presence unfolds as staff nurses engage dying patients in meaningful interactions. Table 2 uses the same organizational framework as Table 1, which organized the antecedents, attributes and outcomes of nursing presence as described in the general nursing presence literature.

Table 2 lists the antecedents and attributes this study identified. These antecedents and attributes comprise the intrinsic and extrinsic categories formed from the data. Collectively, they represent the structure needed to foster a meaningful interactional process between nurse and dying patient. The meaningful process that ensued is evidenced by participants' reassurance by remaining with the patient, by preparing patients for what was to come, by participants speaking truth to patients and by their courageous nursing actions. Study participants reported increased role satisfaction and received appreciation from patients and families as a result of engaging in this process.

### **Analytic Tools**

#### Memo-writing

The following describe the tools which helped me to conduct this research. The first of which is memoing, an essential, frequent practice of qualitative researchers involves memo writing. As stated, the investigator writes memos before data collection and continues until the final research paper is written (Charmaz, 2006). Memoing is a critical, reflexive method in constructionist GT; the process of memoing is for the investigator to articulate any assumptions, decisions and interpretations (Charmaz; Clark, 2005). It also provides an audit trail (Charmaz). Continuous memoing preserves the researcher's connectedness to the analyzed data, prompting recognition of increased levels of abstraction within the data (Charmaz).

After each interview, I entered a memo to maintain my awareness about my assumptions and personal perceptions. An example of one of these memos read: "Wow. What I've considered meaningful interactions with dying patients always involved situations when I came away knowing I made something better. During today's interview the participant described a life threatening situation as her patient began gurgling, gasping for breath who then stopped breathing

and died hours later. The patient never spoke to the participant, yet this interaction was very, very meaningful to the participant. I now realize meaningfulness may not solely be about influencing positive outcomes so much as the nurse comes away knowing she did everything possible to help the patient.” Hence, this memo made me aware that I could not assume any of my perceptions were like those of the participants (Mruck & Mey, 2002).

### Field Notes

Qualitative researchers use all data including field notes, completed after each interview describing the investigator’s observations (Charmaz, 2006) As such, after each interview I completed a Field Note which served as an adjunct prompting my recall of the participant’s body language, eye contact, and facial expression. For example, in one Field Note I observed there were silences within an interview which occurred in my home. Silences which I allowed as the participant became teary eyed when she described her young oncology patient who reminded her of a deceased niece. By permitting the silence, I understood these conversational pauses might trigger valuable descriptions, which indeed followed (Corbin & Strauss, 2008). My field note that day also reflected my observations about interview environment. Since this meeting occurred in my home, I wrote how much more relaxed I felt during that interview because of the quiet. In my interview preparation, I set my home phone on message after one ring. I compared this interview to two previous interviews in participants’ homes, whose telephones rang and rang several times, but which interestingly, neither participant attempted to answer during the interview.

## Diagramming

Diagramming is a visual tool representing relationships of emerging categories (Charmaz, 2006). Qualitative researchers use this to create visual markers of emerging categories; these symbols denote relationships between categories (Charmaz).

In a meeting with Dr. Maliski and after presenting to her all the emerging categories, she gave me assorted colored pens and instructed me to diagram the main categories and the relationships between them on a blank piece of paper. I began diagramming salient categories as well as relational categories fairly quickly. While I had diagrammed earlier in the research process, I experienced great satisfaction that day by diagramming the emerging theory, which I subsequently titled: “The Courage to Make a Difference” as illustrated on Table 2.

## Situational Analysis Mapping

Situational maps demonstrate inter-relationships among emerging themes and categories, helping to examine complexities within processes (Clark, 2005). For example, some participants reported being paged while interacting with dying patients; during most of these cases participants bracketed their awareness of the page and instead remained focused on their patient. However, two participants reported having to interrupt these important conversations out of a need to take an expected physician call or to administer a time-sensitive medication to another patient. In both cases, participants stopped their patient engagement to attend to the duties at hand, and then quickly returned to their patient to resume the interaction. Such nursing actions reflected a contextual element which I noted in my situational mapping. Despite having to suspend these patient interactions, participants still considered these interrupted interactions as meaningful.

## Scientific Rigor

Qualitative investigators are obligated to preserve methodological rigor throughout their study to ensure outcome trustworthiness (Haylock, 2008). Scientific rigor involves the proactive steps of credibility, transferability, dependability, and conformability (Lincoln & Guba, 2005).

Transferability relates to how well a working hypothesis is applicable or fitted to another (Haylock, 2008). Transferability includes participants' work environment or levels nursing education achieved within the study sample. While findings reported herein disclosed such data, participants' anonymity was protected by reporting data so that the reader could judge if findings reflect those generally experienced by staff nurses with dying patients (Lincoln & Guba, 2005).

This study integrated dependability by using a clearly documented auditing process. Specific audits used in this study included memoing, and detailed descriptions articulated earlier on the process I used in data collection and data analysis (Haylock; Tobin & Begley, 2004)

As reported earlier, member check was done at the beginning of two re-interviews by describing an overview of the interview and salient theme that came from the interview. During the member check process, I verified my assessment of the meeting by accurately using the participants' words. This reassures the analytic process is not imagined but derived from the data (Haylock, 2008; Tobin & Begley, 2004).

## **Human Subjects**

This study began after obtaining approval from the UCLA Office for Protection of Research Subjects of the Institutional Review Board. During our initial telephone conversation, I explained the study to the potential participants and stated my intention to protect their anonymity and gave examples of how this would be done. In addition, I asked participants to



contact me for any concerns about the research. As stated earlier, each nurse received a copy of the signed consent form before completing the Demographic Data Form.

After interviews ended, I inquired about participants' availability for subsequent interviews. Regardless of having signed consents and agreeing to later interviews, before contacting two participants and request another meeting, I quietly acknowledged that I would respect any negative responses to my request, but none came.

As I began the interviews, I realized some participants' stories might contain painful elements, which indeed occurred. During three interviews, the participants' verbal intonation changed as participants became teary eyed by recalling specific aspects of their memorable interactions with dying patients. During each of these instances, I regarded the participant's comfort as paramount (Charmaz, 2006). I also tried to understand each experience that was being described as from the view of the other (Blumer, 1969; Charmaz). After listening to each story, I validated the significance of the described experience to the participant (Charmaz). Lastly, and in every instance, my final interview questions were poised to elicit positive responses to close the interview on a positive note (Charmaz).

For example, one participants exhibited tears as she poignantly described saying goodbye to her dying unconscious patient, who earlier had decided to begin a morphine infusion after speaking with the participant, a decision the participant felt was not only appropriate but one which she very much inspired. In an attempt to view this experience from the place of the other (Blumer, 1969) I then asked the participant if the patient's decision to be made comfortable signified for the participant that the patient was no longer suffering, a clarification which the participant affirmed. I then validated the experience as being sad but also professionally satisfying by recognizing the extent to which the participant influenced how the patient died,

which was with dignity and without pain. The participant agreed this was so. I ended the interview acknowledging the many ways nurses can make profoundly positive differences in terminal patients' dire illness experiences.

### **Limitations**

While this study planned to include diversity among the informants, it is important to acknowledge that study samples in qualitative research are not generalizable since they are not population based. Just as the literature uncovered many aspects of nursing presence, informants represented views no doubt different from many other experienced staff nurses engaging in presence with terminally ill patients. Hence, my research findings are not generalized to all experienced bedside nurses working with terminally ill patients.

### **Summary**

This section presented an overview of the research design and methods. The chapter began with a historic overview of GT and its impact on qualitative inquiry. It acknowledged the sentinel contributions of Glaser and Strauss (1967) and then Corbin, (1994, 1998) as well as Charmaz, (1994, 1995a, 1995b, 2000, 2003, 2005, 2006, 2009) who moved traditional GT methodology to constructionist GT. A discussion of the ontologic and epistemological underpinnings informing this work was presented, as were the tenets of GT.

The individual's active participation with the self, the subsequent interpretations made by the self, and the resultant actions made by another have been presented. A discussion pointed to ways Parse's (1981) theory aligns with the tenets of SI, while clarifying the role the nurse's "I" and "me" have within the nursing presence interaction. Historic contributions made by Mead (1934) and Blumer, (1969) that inform SI has also been articulated. A distinction was made as to why the process known as the stimulus-interpretation-response is central to this study.

The chapter outlined the desired size of the sample population and the intended recruitment procedures. It addressed ways data was to be collected and analyzed, and presented a thorough discussion on the coding process used by constructionists. Following that, emphasis was given to the importance of the constant comparison of data, in writing memos, and completing field notes, with excerpts from each. Lastly, the chapter discussed the importance of avoiding power imbalances and offered examples on ways this was done, as well as actions taken to support scientific rigor. Explanations pertaining to credibility, transferability and dependability have been presented. The chapter ends by acknowledging the limitations in this research, and speaks to ways human subjects were protected.

## **Chapter Four: Results**

"There are two types of nurses, the glassy eyed nurse and the clear eyed. The glassy eyed nurse...completes nursing care seemingly as good as any other nurse, but one can tell... the glassy eyed nurse is not really with you. The clear eyed nurse is absolutely present, so attentive...that nurse is just right there for you. There is something about that nurse's grace of presence that makes such a difference." (Wright, 2001)

### **Results**

The purpose of this chapter is to present the inductive theory generated after examining the process by which nurses working in busy, acute care environments manage to engage terminally ill patients in meaningful nurse-patient interactions. The specific aims for this study were: (1) To understand participants' perceptions of the nursing presence process when caring for terminally-ill patients, and (2) to describe how participants transition from nurse-patient exchanges to instead engage in person-centered, meaningful interactions with terminally ill patients, and (3) to understand how the nursing presence process is sustained. Study aims are addressed at the end of this chapter.

Constructivist Grounded Theory combined with symbolic interactionism formed the methodology to guide the study design and data analysis (Charmaz, 2006). This research involved 11 staff nurses working in the same nursing roles for three years or longer in acute care institutions throughout Los Angeles County. Two participants were re-interviewed. Theoretical saturation was reached after 9 interviews. While six of the eleven participants described one meaningful terminal patient experience, the remaining participants detailed at least two memorable exchanges with dying patients, yielding a total of 17 meaningful encounters the participants distinctly described. Hence, after analyzing study data, this chapter presents a theory of the process by which busy acute care nurses manage to engage terminally ill patients in meaningful interactions. The theory is titled *The Courage to Make a Difference*.

## **Participants**

Participants represented several nursing specialties including four critical care nurses, two emergency department nurses, four oncology nurses, and one nurse working in a cardiac step down unit. One participant held a Doctor of Nursing Practice (DNP) degree. Six participants had Master of Science in Nursing (MSN) degrees. Of these, two were Doctor of Philosophy (PhD) nursing candidates. One participant had a Bachelor of Science in Nursing (BSN) and was enrolled in a MSN program. Two participants held bachelor degrees; one of these was in music and another in biology. Three participants had Associate Degree in Nursing (ADN) degrees, of these; one participant had a Master of Biology degree. Three participants chose nursing as a second career. Nine participants held nursing specialty certifications; one participant had certification in two nursing specialties.

The races represented in the participant cohort included nine Caucasian participants, one African American participant and one Hispanic participant. However, participants' ethnicity varied greatly. While four participants indicated having 'mixed' ethnicities and did not disclose additional specifics, the remaining seven participants revealed that one was German, one Norwegian, one Italian, one Mexican, one Polish and one Irish. One participant reported her ethnicity as African American. Five participants wrote 'N/A' or entered the word 'none' when asked their religion, while four participants were Christian but did not disclose their denomination of Christianity. One participant was Jewish and another Buddhist. Interestingly, during interviews two participants shared that their practice was to pray before seeing patients, one participant reported the religious symbols worn around her neck sometimes triggered patient conversations which then led to meaningful interactions. One participant spoke about the way her Judaic upbringing influenced her nursing practice now. She referenced the religious tradition

within Orthodox Judaism of never leaving the body alone before burial, and acknowledged that her upbringing prompted her to make frequent visits to patients' rooms following death, before the body was taken to the morgue.

A total of 21 nurses contacted me to indicate interest in study participation. Of these, four admitted to having lost a significant person within the past year, their collective losses involved two brothers and two mothers. These individuals were thanked for their interest but not invited into study participation, per exclusion criteria. I received a total of four calls from nurses, who left messages, one from a male nurse. However, when I returned these calls instead of being able to speak to the nurse directly, I had to leave my message on the answering machine, but none of the nurses returned my call. Because I had been sampling for male nurses, I again called the male nurse, but once more I was unable to speak directly to him and instead left my message. However, he did not return my second call and I did not call again. Lastly, while I had scheduled two upcoming interviews, unfortunately, personal health issues caused me to cancel these appointments. Months later, when my health cleared I called both participants who indicated they were not longer interested in study participation.

Participants shared a total of 17 stories, which were analyzed separately; all described meaningful interactions with terminally ill patients. The average age in the cohort was 42 years. The participants, who were all female, ranged in age from 30 years to 60 years. At the time the interactions occurred, four participants worked in academic environments while seven were employed in community hospitals. Three hospitals were Magnet designated institutions when these experiences took place.

Data were collected through individual participant interviews ranging from 60-75 minutes with the average interview lasting 68 minutes. Throughout the interviews, participants

spoke freely to this researcher and appeared comfortable. After signing consent for study participation, each participant completed a confidential demographic data form.

Following each interview, a field note was entered along with a detailed memo describing observations and impressions of the interview. To ensure accuracy and study trustworthiness, each audiotape transcript was reviewed before coding. As a way to uphold credibility, this researcher's Dissertation Chair re-checked the aggregate categories, along with the identified properties and dimensions grounded in the data.

### **Categories**

Several significant categories emerged from the data. Themes included situational as well as environmental antecedents necessary for participants to engage terminal patients in meaningful, nursing presence. Other essential categories involved the intrinsic characteristics of the participants; central to these included participants' intentionality to become involved in the illness experiences of their vulnerable, dying patients. Temporality was another major category, as described by participants' use of time, their perceptions of time along with participants' knowledge of patients' limited time. These categories as well as the dimensions and properties within each fostered participants' ability to engage in presence. Additionally, participants displayed willingness to be vulnerable. This was evidenced by participants' ability to tolerate being uncertain, unsure of what would unfold as they focused on their dying patients' needs. Indeed, participants exhibited courage in their nursing actions, traits spawned from a fervent intentionality to help their end-of-life patients. A comprehensive understanding of the presence process with hospitalized, dying patients includes discussing the outcomes, or benefits to patients as well as the participants that resulted from these meaningful nurse-patient interactions. Hence, outcomes are also be discussed herein.

## **Triggers**

### Terminal Patients' Vulnerability

The terminal patient's vulnerability was the key trigger initially prompting the participant's attention to the patient's end-of-life circumstance. Based on these interviews, vulnerability can be defined as having a susceptibility to physical, emotional, social and spiritual harm, so much that the person is in need of advocacy (Thacker, 2008).

Indeed, participants collectively perceived their dying patients as vulnerable due to physical decline or patients' unmet emotional and spiritual needs, as well as patients' limited time. For example, one participant remarked: "It was my dying patient's vulnerability, along with the inevitability of the patient's death that drew me in." Thus, participants' perceptions of dying patients' vulnerability included an understanding of patients' inability to alter their terminal course.

Other ways participants viewed end-of-life patients as vulnerable occurred when participants noted patients' inability to complete daily living activities which subsequently led to patients' increasing dependency on others. Participants also acknowledged patients' vulnerability during concerning clinical situations. For example, one participant described her jaundiced patient with advanced liver failure who emphatically told the nurse: "I'm not dying." Immediately, the participant realized her vulnerable patient was coping as best he could by denying his grave situation. Other participants recognized patients' vulnerability after reviewing critical laboratory values indicating the inability to support life; the example one participant referenced was a patient's platelet count of zero. Another participant recognized her patient's pinpoint pupils as ominous signs of a brain hemorrhage and immediately considered the patient to be vulnerable during this life threatening event. When another participant entered her



patient's room, she instantly realized the patient was vulnerable because he was gasping for breath and then stopped breathing.

Other triggers indicating terminal patients' vulnerability involved fearful, trembling patients and those speaking with quivering voices. Moreover, some participants referenced the vulnerability of overanxious patients who did not seem to absorb their answers to patients' many questions. Still another trigger indicating vulnerability involved a patient's incessant need to control by precisely folding his bed linen, who insisted on utensils exactly placed on his bedside tray. The participant realized such actions reflected the patient's attempts to control that which he still could, since cancer had taken much control of his life away.

There were obvious clues prompting participants to perceive patients as vulnerable. For instance, one patient, who developed multiple complications following transplant surgery, handed the participant a tablet which read: "I want to die." Another overt trigger involved the confidence shared by a frail, elderly gentleman whose family insisted he fight despite a failing heart. This vulnerable patient pleaded with the participant to talk to his family saying: "I've had enough."

Other reasons participants regarded dying patients as vulnerable pertained to stories shared by two participants regarding the intimate, confessional thoughts of two young adult patients; these confidences revealed the deepest parts of each patient. One exchange involved a 24-year-old dying mother of two young boys whose father was quite involved in their care. Still, the patient told the participant that she had decided "to give my boys away." The patient explained it was becoming too painful to be in her sons' presence, knowing she was leaving her children. As the participant described her vulnerable patient's irrational plan, the participant reflected: "Who else admits to giving her little boys away but a young, dying woman? She's lost

so much; she had nothing to lose by secretly telling me this.” Another private disclosure was one from a fretful, 28-year-old patient immediately after a heart biopsy. This otherwise healthy patient became quite anxious in the hours following surgery, when he secretly told the participant he feared he was dying. The participant attempted to comfort the patient by explaining the biopsy results were not yet in and therefore the patient had no reason to believe this. “You are not dying, you look amazing” she said often and reassuringly. Upon entering the unit the next evening the participant noticed his parents were crying. She was then told that earlier, the patient had a cardiac arrest and died in the hour before.

Hence, participants described situational vulnerability experienced by dying patients. Participants also acknowledged terminal patients’ physical vulnerability as evidenced by patients’ debility, increasing dependency on others as well as concerning clinical markers indicating decline. Indeed, participants observed many ways in which terminal patients displayed vulnerability. One participant said: “The dying patient’s vulnerability touches my heart, I want to become involved and maybe make a difference in the patient’s illness situation.”

#### Behavioral Triggers

At times, patients’ behavioral triggers compelled participants to initiate meaningful patient interactions. One example involved a gesture made by an end-of-life patient while in significant pain who reached for the participant’s hand. Other non-verbal behavioral triggers encompassed patients’ responses, as one participant recalled: “She just had that look in her eyes.” Other symbolic triggers signaling patients’ need involved awake patients lying in fetal positions facing the wall. One participant considered her patient’s darkened room in the midst of a bright, sunny day a trigger, who responded by sitting quietly next to the patient before engaging in presence. Other indicators involved patients who very frequently rang for help as

were the hostile remarks made by angry, dying patients, each situation prompting participants to then assess patients' needs.

Other triggers preceding meaningful interactions comprised those which participants inspired and often pertained to patients' families. For example, several participants admitted to waiting until families were no longer at bedside before trying to engage patients in meaningful exchanges. Participants rationalized these actions by noting patients tended to share more when families were not in the room. One participant aptly reflected: "Families change the dynamic of being." When another participant recognized her patient needed alone time to talk the participant requested the patient's family to leave, claiming: "He needs his rest." Upon leaving, the participant ensured the patient's door was closed before attempting to interact with the patient "so that the family would knock if they returned."

Still another participant acknowledged the degree to which patients worry about the impact a cancer diagnosis has on their families. Such was the case after one patient received devastating news that his cancer recurred; he was the family's sole breadwinner. Consequently, the participant purposefully engaged the patient in nursing presence. During their interaction the patient confessed his greatest sorrow was leaving his fledgling family.

#### Unique Triggers

Some participants reported rather unusual triggers suggesting patients' likely need for meaningful interactions. After receiving report from an annoyed nurse who described a terminal patient as difficult, the participant recalled: "When I heard this I knew the patient had not yet had a meaningful exchange with a nurse. It was time for me to do damage control." Another trigger involved a participant who worked in the emergency room, who reported events that unfolded when her patient's heart stopped. After successfully initiating chest compressions on the patient

in cardiac arrest, the patient responded quickly to her life-saving actions and awoke saying, “I think I just died.” Such awareness triggered the participant to combine critical nursing tasks while also remembering to touch and reassuringly talk to the bewildered patient. Meanwhile, two participants recollected their need to call the Rapid Response Team for terminally ill patients. The participants’ critical actions triggered awareness in each of their patients about impending death, prompting participants to then engage patients in meaningful exchanges. Another unique clue involved the overall appearance of a frail, cachectic patient just two days before his death, yet, the participant remarked: “But he still had a great spirit, he was like a glowing candle, lit from the inside.” So struck by the paradox of the patient’s vibrant life-force within a wasted, dying body, the participant began gently speaking to the patient about his end-of-life wishes.

In closing, the aforementioned triggers helped initiate numerous meaningful interactions with dying patients. Indeed, participants reported many ways terminal patients’ situations caused participants to begin focused interactions with patients. Some triggers were apparent and included words written or spoken; these were expressed as the patient’s wish to die. Other triggers were subtle, which the participant uncovered by waiting to be alone with the patient. Most importantly, it was the participant’s overall awareness of the dying patient’s vulnerability that initially drew the participant into the patient’s illness situation.

### **Extrinsic Factors**

Several extrinsic factors facilitated participants’ ability to engage terminal patients in nursing presence. These included the aforementioned variables such as the absence of the family at the bedside, talking to patients in private rooms and closing the patient’s door to ensure privacy. Additionally, having close patient proximity by sitting outside patients’ rooms often

initiated communication which led to meaningful exchanges. Participants acknowledged that knowing their nursing tasks were completed influenced their ability to engage dying patients in meaningful nursing presence without the worry of timed interruptions. These factors all helped facilitate participants' focused presence.

Two participants reported having work cultures that integrated holistic care which were led by managers who valued the time nurses spent with patients equal to the completion of nursing tasks. Additionally, several participants referenced the benefits that came from working with helpful colleagues who supported spending time alone with patients. One participant voiced gratitude for an ability to give her phone to a co-worker while another participant appreciated the peer who agreed to cover her other patients so that the participant could exclusively focus on her terminally ill patient.

While the need to debrief was mentioned in every interview, only two participants had debriefing resources within their work settings at the time these interactions occurred. Instead, the remaining participants sought out peers with whom to debrief. One participant said: "I instinctively knew which nurse to approach and who to avoid." Another participant confessed: "I look for nurses with similar nursing philosophies, who have felt attachment to a patient, who also seek meaningful patient exchanges." Still a third participant remarked: "I don't know how I would make it as a nurse, my peers are my lifeline." Participants claimed their ability to debrief, either with colleagues or within structured debriefing settings, were helpful in prompting future meaningful nurse-patient interactions.

Another extrinsic factor that fostered meaningful presence with dying patients had to do with the timing of these interactions within each shift. Although two participants could not recall when their exchanges occurred, three contacts transpired during the day. The remaining six were

reported by participants while they were working at night, who each expressed how much the nighttime fostered their ability to engage dying patients in nursing presence. For example, the participants noted that after families left, patients' fears frequently surfaced at night. One participant reported intentionally worked during the night because: "I can give of myself more at night; I really get to know my patients. I have had very meaningful talks with patients at three o'clock in the morning. There's just something about the middle of the night." Another participant said: "At nighttime, the lights are dimmer, the noise is less, the activity is diminished...and serenity unfolds."

Participants who reported meaningful daytime interactions said these exchanges occurred between noon and six p.m. In fact, one participant specifically scheduled her time to be alone with an identified dying patient, which was always after lunch and when she was recharged.

Another extrinsic factor identified as helpful in fostering meaningful patient interactions and expressed by many participants had to do with the importance of knowing the patient, in having established some connection with the dying patient. However, the participants who worked in the emergency room said that having previous relationships with patients was unnecessary for meaningful interactions to unfold. Other participants referenced continuity in caring for patients over consecutive days or night shifts as also beneficial.

These extrinsic factors and the aforesaid triggers provided the requisite structure, or framework, for the nursing presence process to unfold with dying patients. The next section discusses several critically important intrinsic factors participants exhibited, characteristics which also proved essential to the structure needing to be in place before these meaningful interactions occurred.

## **Intrinsic Factors**

During interviews, participants demonstrated significant intentionality to become involved in their dying patients' illness experiences. Besides perceiving the vulnerability of their dying patients, participants' intentionality to act on patients' behalf was fostered, in part, by participants' own difficult previous life experiences which collectively, all centered on loss or the threat of loss. Additionally, many participants acknowledged their intentionality to help patients grew from deeply held nursing philosophies; for others this impetus stemmed from intensely felt moral imperatives to be of assistance. Other participants claimed their determination to become involved with patients resulted from knowing the differences they made previously in other terminal patients' illness experiences, and were driven to do so again.

## **Experiential Learning**

Almost all the participants had personally undergone the experience of losing a loved one. In fact, several participants experienced family members' deaths during their childhoods, events which strongly influenced later nursing actions. One participant described her father's cancer death at age 12. This participant vividly recalled the exceptional support she received from "an amazing palliative care nurse" who took the time to explain the dying process to her, which her father was about to enter. "I was the recipient of that nurse's presence. I was really scared, but that nurse took the time and what a difference he made." This participant admitted: "I went into nursing because I wanted to help someone the way he helped me."

Another participant recalled the sudden loss of her brother when she was 11, who died in a motor vehicle accident. "Even at that young age, I remember denying his death... whenever the doorbell rang I would think he was at the door, or if the phone rang I believed it would be him."

From this childhood experience, the participant gained a full understanding of the stages related to end of life first identified by Kubler-Ross (1969).

Several other participants recalled their parents' deaths, many of which occurred while participants were in their twenties. One participant described her mother's slow decline from Huntington's disease: "She had ten years of horrible suffering, so that by the end, death was her friend, not her enemy. Her death made me more accepting of dying. My mother showed me that even at end-of-life people can enjoy things." Her mother's chronic, debilitating illness also formed this participant's philosophy on suffering. "The problem with dying is that patients suffer for nothing. It is not a healing suffering. When a non-terminal patient has a wound and suffers, gradually the wound closes and disappears, and there's no more suffering. But death is different. Patients suffer for nothing, because nothing gets better. I think that suffering while dying is unnecessary. When the body cannot go on and death is inevitable, we must avail the patient to the most humane practice that modern medicine offers."

Still another participant was 21-years-old and not yet in nursing when her father was diagnosed with terminal cancer, who said: "I watched the way my aunt took care of him, she kept him engaged with living. The way I am today as a nurse is a result of watching her care for him. I engage patients by encouraging them to get out of bed; if the shades are drawn I ask permission to let the light in."

Another aspect related to loss involved the way some patients reminded participants of a deceased relative, or a deceased patient with whom the participant developed a relationship, as one participant reported: "This patient reminded me of my uncle; who also said he had had enough. Like my uncle, my patient had capacity and knew the consequence of his decision to stop treatment." Still another participant described lessons learned following the cancer death of



a young niece. The participant worked in oncology and admitted to times when a younger cancer patient reminded her of a niece, who she said had such a hard time being sick. In the case of her niece, the participant referenced the importance of helping patients differentiate between their terminal time and their dying time. “During my niece’s terminal time, I reminded her that she needed to live as much as she could before she died, her dying time.” As a result of her deeply personal loss experience, the participant came to realize the unique challenges young cancer patients face in confronting their own mortality with so little life experience. Overall, the participants in this study integrated lessons from previous personal loss experiences or recalled care given earlier to other terminal patients to guide their nursing practice.

While three participants described regrettable, end-of-life experiences involving loved ones, each participant also reported growing personally from these unfortunate situations. For example, one participant described the deaths of two husbands, and remarked about the lack of emotional support from the nurses who cared for both men. This absence of meaningful engagement, especially from fellow nurses, prompted the participant to vow to address emotional needs of dying patients and also the needs of their families. Another participant described her unfortunate end-of-life experience that occurred during her first semester of nursing school when she was 24 years. For consecutive two days she was assigned to care for a 17-year-old boy with multiple sclerosis; during which time she established a relationship with this young man. Upon returning to school on Monday she was informed he died over the weekend. “It spooked me, I had no idea he was dying. He was almost my age; he wasn’t supposed to die.” The experience stunned the participant so much that she withdrew from nursing school and instead, became an illness prevention coach. Ultimately, she re-enrolled in nursing school after caring for her dying mother-in-law. The participant confessed that this intimate, end-of-life experience contained

many life lessons. “While she was dying we laughed, we loved, and spent meaningful time together. Basically, her death taught me that dying did not have to be so bad.” Today, the participant is the designated palliative care nurse champion on her unit.

Lastly, another regrettable end-of-life experience involved insensitive remarks made 30 years ago to one participant by a respiratory therapist about the participant’s dying mother. The therapist was called to suction her mother. Afterwards, the therapist spoke harshly to the participant, referencing her mother’s copious, bloody secretions. Horrified at being spoken to so callously by a caregiver, the participant vowed to remember how diminished she felt. As a result, she remains mindful while speaking compassionately to dying patients and their families.

Not all participants experienced the actual loss of a loved one. For instance, one participant lived with the threat of loss since her mother’s advanced cancer diagnosis two years earlier. A second participant conceded her loss of a normal childhood because of an alcoholic father. Like the other participants, she reported growing personally from this dismal, life experience. In fact, the participant credits her ability to note even the smallest clinical changes in patients to her childhood and her father’s drinking. “I had a God awful childhood. I quickly learned to recognize the slightest nuanced change in my father, and instinctively knew when I needed to stay away.”

The above-mentioned narratives all relating to loss were indeed life altering for each participant. Participants appeared to have personally grown from these tragic, earlier life experiences. As participants referenced intentions to help patients, their determination to be of assistance was, for some, the result of being the fortunate recipients of compassion. For other participants, their drive to become involved and make a difference came about from preparation received at a very young age on how the dying process unfolds. Yet, other participants reported

having end-of-life experiences which were not as opportune. While these participants felt the absence of meaningful end-of-life encounters, paradoxically, their unfortunate experiences appeared to mold a resolve to seek out meaningful connections with terminal patients, as well as with patients' families.

### Nursing Philosophy

Several participants acknowledged how much their nursing philosophies formed their intentions to do their utmost to positively influence patients' difficult, end-of-life situations. Their nursing philosophies fostered an ease in being around terminal patients. Participants compared their comfort in addressing dying patients' emotional, social and spiritual needs to the discomfort they often observed in colleagues, especially around the psycho-social aspects of nursing the dying. One participant remarked: "Not everyone can do this work"

Participants claimed peers' uneasiness was likely due to the emotional intensity of the work, because the needs of dying patients often differ from how the patients' families perceive patients' needs. Several participants referenced situations when patients had awareness that they were dying, which their families refused to acknowledge. Participants then reported other intense situations involving physicians, such as those who had not yet discussed goals of care with dying patients. In both situations, the participants' nursing philosophies drove their intention to help, either by explaining patients' end-of-life wishes to families or by staunchly advocating for patients with doctors.

Collectively, the study participants holding strong nursing philosophies regarded the relational aspects of nursing to be of equal importance to the science of nursing. Hence, their nursing beliefs directed participants' attention to address the holistic needs of dying patients, while also addressing the social, emotional and spiritual needs of their patients' families.

## A Moral Imperative

Some participants were driven to help terminal patients; this determination grew out of a strong moral imperative to try to make a difference for their end-of-life patients. In fact, three participants considered it their nursing duty to convey compassion when caring for end-of-life patients. One participant remarked: “I have a duty to speak to the human part of the person and not to the illness; I remind myself that this is someone’s mother, wife, daughter or friend.” One participant felt obligated to openly speak with terminal patients about dying, and very frankly remarked: “Some patients are dying to talk about dying, about what dying is like out of fear of the unknown.”

Another example feeling an obligation to be of help was offered by one participant who reported having a unique ability to intuit fearful, anxious patients and said: “I have a duty to help make these patients less anxious. When I really focus on a patient out of wanting to help the patient, there forms this human-to-human interaction, and then a connectedness develops. Any time you move your grace into the grace of somebody else, you come together, and it is always rejuvenating. I have to do this.”

## Knowing I Can Make a Difference

For seven participants, their intentionality to help to dying patients stemmed from previous clinical experiences that resulted in knowing they made a difference in other patients’ terminal situations. Such awareness prompted participants’ cyclical behaviors to do the same. “Before every shift, I ask God to help me tonight so that my nursing care makes a difference in the lives of patients I am with that evening.”

Participants recognized that many of their colleagues remain unaware of their ability to make a difference. One participant said: “Some nurses don’t realize that they just have to seize the moment and make that interaction as meaningful as you possibly can to the patient.”

#### Nurses’ Perceptions of Time

Without exception, these participants who engaged terminal patients in nursing presence remarked about the constancy of having so little time. One participant said: “I don’t think I’ve ever worked a slow shift.” Another participant recalled: “I never have the leniency of time.” Regardless of nursing specialties, participants commented that time moved quickly in their hectic, hospital environments.

Several participants noted that their meaningful connections with patients took time, for example one participant said: “It doesn’t necessarily take a lot of time, but takes some time to be fully focused on the patient.” As participants recognized terminal patients’ needs, they also acknowledged the reality of the time allotted to address these needs. Hence, a tension of time-related opposites seemed to develop within participants. Participants articulated awareness of having so little time, yet emphatically realized they needed to take time to be with identified end-of-life patients. To resolve these pressures, participants spoke about learning the importance of prioritizing time. “It is all about prioritizing, uniquely prioritizing” said one participant. Some participants cultivated personal awareness on their use time and subsequently spent less time chatting with colleagues. One participant claimed she always seemed to find time to address needs of dying patients: “Really, there is always some time a nurse can make.”

Throughout their meaningful interactions participants remained aware of their responsibilities to other patients. Upon hearing their name paged overhead, some participants stopped an important patient interaction in need to take an expected call from a physician. At

other times when hearing their names paged, participants mentally bracketed the announcement and instead, remained fully focused on their terminal patient. Hence, participants' responses to dying patients' needs while juggling other duties appeared to be situationally dependent.

Participants' awareness of patients' impending decline often triggered their immediate nursing actions, as one participant described: "I seize the power of now when I see things coming." Another recalled: "I looked at her and knew she was getting close. I vowed it had to be tonight because I doubted I would have that chance to talk to her tomorrow evening, she may not be here." Participants' mindfulness of patients' limited time was often the impetus for participants to make time to be with end-of-life patients. One participant described her perception of time during meaningful patient interactions as: "You kind of lose track of time when you are fully with a patient. These connections are really beyond time and space."

Other participants scheduled time with dying patients. "You pick the time and go into the room and see if the moment will happen." Ways participants scheduled time ranged from waiting until families left to working specifically at night so as to have additional time with terminal patients. Some participants eliminated barriers interrupting nurses' time, such as handing one's phone to a colleague so as to be with a dying patient.

When participants were asked how dying patients viewed time, participants offered a range of responses such as: "Some terminal patients are frustrated knowing they have limited time but are unable to take care of unfinished business because they are hospitalized." Another participant reported: "Time means everything to terminal patients." One participant working nights explained: "Dying patients struggle in having precious little time, some of them savor every waking hour. These are the patients who don't want to sleep because sleep robs them of

their remaining time.” Unprompted, several participants claimed that patients knew they are running out of time, and in fact, patients recognized when it was their time to die.

Indeed, time was a salient categorical theme that emerged from the data. Certainly, the ways participants used time was a central intrinsic factor the participants displayed. Participants aptly described their perceptions of having very limited time amid hectic, hospital environments. Yet participants also acknowledged the reality that dying patients needed more of their time. In response, participants managed to juggle time in order to cope with these opposing realities. Some participants simply made time; others took the time or seized time, while another participant scheduled time to address patients’ end-of-life needs.

#### Nurses’ Vulnerability

As participants described meaningful interactions with dying patients, participants held an awareness of being vulnerable themselves. For example, one participant recalled her interactions with an angry, ventilator dependent patient who tossed a notepad to the participant, which read: “I want to die. Please just kill me.” The bewildered participant said that after reading this she had to sit down. She knew the patient was improving, albeit slowly. She responded by saying: “How can I help you? How can I make your situation better? I am here for you.” Still angry, the patient wrote: “This is not what I signed up for” and threw the notebook on the floor. The participant truthfully responded: “I don’t know what to say. I don’t know how to help you.” During these intense moments the participant admitted she allowed herself to appear vulnerable to the patient and confessed that she certainly felt vulnerable.

Another participant described feelings of vulnerability when she openly shared the death of her young niece with a dying, 24-year-old patient. The participant recalled: “You know, as a nurse you worry about boundaries. During those moments I wondered if I was going too far.

Am I opening this patient up to more pain by talking to her about her impending death? Am I disclosing too much about myself?”

Nevertheless, participants exhibited an intentionality that was purposeful, which was to remain in the moment while being uncertain of what was to come and unsure of how far to go when speaking with terminal patients. Participants’ vulnerability along with their willingness to tolerate being uncomfortable comprised another intrinsic factor that led to meaningful interactions with dying patients.

In summary, the intrinsic factors of the participants included having previous types of loss experiences along with strongly held nursing philosophies or deeply felt moral imperatives to be of help. Other intrinsic elements involved participants’ wise use of time coupled with a determination to tolerate feeling vulnerable so as to positively influence dying patients’ situations. These intrinsic factors, along with the abovementioned elements, comprised the structure, or framework needing to be in place for the nursing presence process to unfold with dying patients. One participant succinctly said: “For meaningful interactions to occur with a dying patient, it requires the right nurse to be in the right place and responds to the patient at just the right moment, focused on what needs to be done for the patient.”

### **Understanding the Process of Nursing Presence**

As participants identified the above-referenced triggers in caring for terminal patients, there developed within each participant a strong resolve to be of help which was spurred, in part, by previous personal or professional loss experiences or the threat of losing a loved one. For some participants, intentionality was also spawned by needing to fulfill one’s nursing duty, an unspoken covenant the participants felt toward their dying patients. Other ways participants



were driven to become involved in dying patients' illness experiences stemmed from their nursing philosophies, which included the ability to address holistic needs of terminal patients.

Still other participants recalled making a difference for previous patients. This recall motivated their resolve to again act on opportunities to positively influence dying patients' situations. Hence, their recollections prompted participants to again attempt to make a difference by engaging patients in meaningful nursing presence interactions.

### **Descriptions of the Process Involving Meaningful Interactions with Dying Patients**

When asked what the process of meaningful interactions was like with dying patients, participants replied that making a difference during terminal patients' dire illness experiences was the essence of meaningfulness. One participant described her meaningful exchanges with dying patients as: "These are likely the most important interactions you can have with patients. It is such an important part of being a nurse when someone so vulnerable lets you in, and you can really make a difference." Another participant said: "These interactions are opportunities for the nurse to shape the last days or weeks of a patient's life, by making things as supportive as possible. Nurses offer support by reducing pain, by helping the patient reframe, or by speaking truth to the patient." Through their nursing actions, participants acknowledged their ability to change outcomes, as one participant said: "There is nothing more meaningful as a nurse but to know your patient died pain free and with dignity."

Additionally, participants reported feeling honored to be with patients during the final phase of life, as one participant said: "I think that this is one of the gifts we are given as nurses, to be there during the final chapter, to be a part of what is one of life's greatest transitions." Another participant said: "I have so much respect for the power of presence. To be with

someone in their last moments here on earth, I am humbled to be in the room with them. I find it extremely meaningful to be able to share in someone's dying.”

Clearly, participants articulated a deep respect for their ability to participate in what some considered a sacred time in patients' lives. Participants' awareness that they could make a difference in patients' remaining time was a central theme uncovered in the data. How participants made such a difference during their meaningful patient interactions with dying patients were described. The process included patient advocacy, preparing patients for what to expect, by daring to speak truthfully to patients, families or physicians, and by taking courageous nursing actions in response to patients' unique end-of-life needs.

#### Nurses as Patient Advocates

Some dying patients confided in participants, who then undauntedly advocated for patients. Advocacy was evidenced in the subsequent conversations participants had with doctors as well as with patients' families. For instance, one participant recalled conversations with her dying patient who disclosed her final wish was to see her son who lived in South America. When the participant requested the family send for the son, they refused, indicating it was not the patient's dying time. Yet, the participant persisted by explaining to the family: “She is getting close.” As a result of the participant's urgent persuasion, the son emergently traveled to see the patient who died soon after he arrived.

Another participant reported her elderly, ventilator-dependent patient wrote that he that had enough of being ventilator dependent and wanted to die. The participant had cared for the patient twice in previous months and spoke to the doctor who acknowledged the appropriateness of the patient's request. The participant prepared the family who were initially shocked, but ultimately respected the patient's wishes. The participant then arranged a bedside meeting

involving the patient and family. The patient wrote that he was tired of living on a ventilator; the family gave the patient permission to be made comfortable.

Another example of nursing advocacy was not a result of a nurse-patient interaction, but rather one that occurred due to the participant's astute nursing assessment as she realized her end stage dementia patient was, in fact, dying. The patient had been moaning and had no urine output. However, the patient's physician had a reputation for giving aggressive care, and ordered the participant to catheterize the patient for a urine specimen. The participant said she became very serious and then told the physician: "Stop, just stop. This man is dying. There is nothing more we can do but to make him comfortable. You must talk to the family." Later, the physician met with family and the patient was made comfortable, dying pain.

#### Nurses Speaking Truth

A striking feature of meaningful nurse-patient interactions had to do with the way in which participants dared to speak truthfully to dying patients. Participants spoke reassuringly, yet as honestly as possible during patients' urgent, life threatening situations. Sometimes, participants' candor was offered in the form of advice. In other situations, participants' honesty was meant to gently prepare patients for what was to come. Participants reported bravely speaking truth to create greater clarity, as a way to make a positive difference in patients' end-of-life situations.

For example, a fretful patient had visited the emergency room over three consecutive weeks following an aortic aneurysm repair the month before. During each visit, the worried patient said he was sure something was missed in surgery and certain that he was dying. Each time, his resultant laboratory work and diagnostic scans were all negative. The participant said: "I knew the patient was fearful. I prayed for guidance, it always comes. I told the patient he

was fearful because he was not living each day the way he wants to live, that his fear holds him back. The patient smiled and agreed. I then gave him a list of community resources for counseling. I have not seen him since. “

Another participant reported a very meaningful exchange she had with a Hispanic male, who before his cancer metastases and profound weight loss prided himself on his masculine physique and macho characteristics. The patriarch of a large family, he experienced increasing fatigue and was becoming more dependent on family. The participant found him lying in bed in a fetal position who then quietly sat at his bedside. The patient confided he could no longer stand his situation. He said he hated being dependent on family, he loathed his inability to shower alone. The participant listened intently and then responded: “It is important that you allow yourself to be vulnerable, for when you do, your family will be able to connect more with you. You must allow your family to care for you; this is your gift to them. It will also show you how much they love you. You have got to let them in.” Two days later, another nurse told the study participant the patient remarked how much the participant helped him.

Another participant described a poignant patient interaction she had with a terminal patient before the patient entered the dying process. Aside from reassuring the patient a dignified death, the participant gently prepared the patient for ultimate unconsciousness as a way to understand the patient’s preferences while dying. Specifically, she inquired about the patient’s wishes on being totally pain free versus maintaining some awareness so as to have interactions with loved ones. The participant also asked who to allow in the room and then clarified whether to permit the family to give the patient hands-on care, since some families ask to bathe the patient and assist in changing soiled bedding of their dying loved one. The participant’s rationale for this was so the patient’s subsequent responses then dictated the plan of

care as the patient began to die. When the time came, the participant then advocated on the patient's behalf after understanding her patient's end-of-life wishes.

After two consecutive days caring for a dying patient, the participant reported feeling she had established a relationship with the patient. Upon the participant's arrival on the third day of care, she noted the patient's condition changed. The participant leaned into her unresponsive patient and told the patient she would not be working the following day. She said: "But, if this is your dying day, I promise to be with you." The patient died a few hours later. The participant felt she made a connection with the patient, who, despite unconsciousness, seemed to respond to what the participant said.

During critical events, participants demonstrated an ability to appropriately respond to life-threatening situations while also speaking truthfully, yet as reassuringly as possible. Additionally, participants who recounted urgent situations acknowledged those events were meaningful to them. For example, when one participant noted her elderly patient was trembling and had pinpoint pupils, she tried to reassure the patient by remaining with the patient and stating: "I took time to sit with her and held her hand and called the doctor from her room. I told her that something was going on, that we were unsure just what yet, but reassured her that I would stay and take the best care of her." Another participant recalled her actions on finding her patient gurgling and gasping for breath. "I made a point of connecting with her, I kept telling her I'm here for you; I'm going to help you through this. We locked eyes, she knew I was there." Following both situations, the participants took comfort in knowing they reassured their patients so that patients were told they were not going to be abandoned.

These descriptions point to participants' willingness to confront difficult end-of-life situations with candor. Participants' unique experiences with terminal patients indicated their

intention to bear witness to dying patients' suffering while speaking honestly as a way to make a difference in patients' urgent illness experiences.

### Courageous Interactions

While the aforementioned participants bravely confronted difficult situations by speaking candidly and responding truthfully to their dying patients, other participants displayed particular courage in reacting to patients' end-of-life situations. Study participants used the following stories as examples of what they considered to be meaningful, yet no doubt memorable exchanges with dying patients.

One interaction involved a patient with end-stage liver failure, who emphatically told the participant, "I am not dying." The participant recalled the frail, cachectic patient was probably a day away from death, yet still had a great spirit within. Upon hearing the patient's remark, the participant paused, and then replied: "Why aren't you dying? What keeps you here?" The patient said he was not going to die until he could again visit Bali, where earlier in life he enjoyed happier times. The participant knew her Buddhist patient believed in reincarnation. She said looked very serious as she responded quite honestly to the patient: "You know, you probably will go to Bali, but not in this body, because this body has reached its limits. Why do you not show compassion to this body? It cannot support life, and it cannot withstand travel." The participant continued, saying: "But, as I look at you, I see a big bird with giant wings, and I can see you going to Bali on those brand new, fresh wings." The next day as the participant was receiving report, the night nurse stated that during the evening the patient said he decided to show his body some compassion, and then asked to be made comfortable. Subsequently, during that night the patient was placed on a morphine drip. When her day shift ended, the participant

said she had tears in her eyes when she said goodbye to the unresponsive patient, saying: “Good fight, now find that bird and go to Bali.”

Another courageous nursing action involved a participant working in oncology during the night. After taking the vital signs of a 24-year-old woman whose transplant failed, the participant was struck that the patient was awake yet remained utterly still and silent.

Additionally, the patient failed to make eye contact with the participant, who cared for the patient during previous admissions. “It just didn’t feel right. I knew I had to get back there,” said the participant. Upon entering the room, the participant dauntlessly asked the patient if the patient thought she was going to die that evening. The patient, somewhat bewildered, said she did not think she would die that night. The participant then asked: “Then why are you acting as if you are dead? You are not allowed death behavior until you are dead. You are not dead yet.”

Upon hearing this, the patient began to cry, expressing her sadness about leaving her family.

The participant listened to the patient’s story and recalled: “She talked most of that night.” By morning, the patient was sitting up in bed and had changed into pajamas and was wearing make-up, awaiting her family’s visit. The participant recalled: “When I said goodbye to her I knew I made a difference. I never saw her again, but her husband, along with her two young boys brought me flowers at the hospital after her death. The husband thanked me repeatedly, telling me what a difference I made by talking to her that night.”

Still another participant described her courageous interactions that involved a male patient who was told his cancer recurred. The patient acknowledged that leaving his family was his main concern. Upon hearing this, the participant then shared with the patient her deeply personal experience of her father’s cancer death when she was 21. She told the patient: “I cannot understand what you are going through as a father, but I can tell you what it was like for me to

lose my father when I was your daughter's age. I was heartbroken when he died, but my life went on. My father is always with me, he is in my heart every day. Your children will move on with their lives, just as I did, but my father's memory continues in me forever." The participant reported the crying patient grabbed her hand and thanked her for her honesty.

Another striking example of nursing courage occurred almost 30 years ago in a small Texas community hospital. The participant described her patient's wife, who always wore pearls, as "the epitome of grace and breeding." Every day, the wife sat calmly at the patient's bedside constantly knitting, but had not interacted very much with her dying husband who was in significant pain. However, the wife refused to allow this moaning, confused patient to receive any medication for pain. As this delirious patient continued to decline, finally, the participant knelt by the wife's side and intentionally cupped her hands over the wife's knitting needles to halt the wife's attention on knitting. The participant then implored the wife to allow opioids to be given to relieve her husband's pain. The wife put down her knitting needles, looked directly at the participant and said: "For years he beat me. Now it is my turn to watch him suffer." The participant was stunned. She admitted that this occurred 30 years ago in a small, community hospital in rural Texas and at a time in which bioethics was not yet strong. While the participant recalls her unique attempts at advocacy, she wonders what she would do if a similar situation occurred today.

Certainly, participants displayed unusual courage as exemplified by their intentioned nursing actions and verbal responses to terminal patients' needs. The valor displayed by these participants helped create, in almost every case, a significant difference in their terminal patients' illness experiences.



In summary, participants' collective abilities to deal with time related tensions despite perceptions of little time pointed to ways the participant solved this challenge. Participants prioritized time to make time for terminal patients. Often, this involved juggling nursing responsibilities, or purposefully scheduling time to be with specific patients, while other participants waited until the right time to be alone with identified patients. Participants' intentionality to influence dying patients' illness experiences led them to bravely engage dying patients in meaningful interactions, a process herein identified as The Courage to Make a Difference.

## **Outcomes**

### **Patient Outcomes Resulting from Nursing Presence**

As a result of using time well in to be with terminal patients, participants reported being satisfied their patients' end-of-life needs were aptly addressed. For example, after confiding in the participants, patients became the recipients of participants' nursing advocacy, who then spoke boldly to physicians and implored families to change their perspectives on behalf of patients.

The participants claimed their patients benefitted from participants' candor, whose helpful suggestions were often spawned from participants' personal life situations, or were the results of years caring for terminal patients. Participants' responses to patients may have seemed out of place, such as suggestions made to a young cancer patient to stop her dying behavior. Nonetheless, participants' intent was to offer patients other perspectives about their illness situations.

Still other dying patients received information about what to expect to prepare patients for what was to come. Sometimes, participants offered explanations to patients emergently yet at

other times, participants' information to patients was fairly detailed. As participants gently prepared their dying patients, participants made sure to reassure their patients that would not be alone.

Several participants helped patients reframe their end-of-life situations which patients thought to be hopeless. To accomplish this, sometimes participants shared their personal end-of-life experiences with patients as a way to change patients' perspectives or to help patients view situations more realistically.

#### Nursing Outcomes Resulting from Nursing Presence

Several participants received heartfelt expressions from grateful patients and families. Participants experienced satisfaction when patients expressed gratitude, including gestures made by thankful patients on ventilators. Frequently patients were too weak to speak, yet participants recognized gratitude in patients' tears, such as one patient demonstrated as he grasped the participant's hand to convey appreciation.

Participants valued assorted feedback received from grateful families, including one wife's facial expression upon seeing her husband, who had been in critical care for months, finally sitting outside in a cardiac chair. During two interviews, participants brought forth angel statues that each participant received from grateful families; symbols to how the participants were regarded. During another interview one participant read aloud a thank you letter from a family who traveled from Oregon to convey. Participants seemed especially heartened when families indicated awareness the participants did everything to help their loved one, particularly in acute, life-threatening situations. Besides receiving familial gratitude, three participants received institutional awards for compassionate care to patients' end-of-life needs.

Collectively, participants reported the accolades received from patients, families and institutions were unnecessary, but were nice to receive. Instead, participants took much satisfaction in how well they enacted their nursing roles, and in particular, in realizing they made a difference in terminal patients' illness experiences. This alone gave participants, especially those who never before had meaningful patient experiences, the impetus to repeat similar actions to again make a difference with other patients.

### **Accomplishing Study Aims**

The specific aims for this study were: (1) To understand nurses' perceptions of the nursing presence process when caring for terminally-ill patients, and (2) to describe how nurses transition from nurse-patient exchanges to person centered, meaningful interactions with terminally ill patients, and (3) to understand how the this meaningful nursing presence process is sustained. The following pages reveal conclusions in response to these study questions.

#### **Study Aim: Meaningful Interactions with Dying Patients**

The first study aim was to understand nurses' perceptions of the nursing presence process when caring for terminally-ill patients. When asked what meaningful interactions were like with dying patients, participants indicated that making a difference during terminal patients' illness experiences was the essence of meaningfulness. Through their courageous nursing actions, participants acknowledged their ability to change outcomes. Additionally, participants felt honored to be with patients during the final phase of life. Participants expressed a reverence for their ability to partake in what some participants considered a sacred time in patients' lives. Participants' awareness that they could make a difference in patients' remaining time was a central theme uncovered in the data. The way participants were able to transition from typical nurse-patient interactions to these memorable interactions were discussed.

## Study Aim: Transitioning to Meaningful Interactions

The second study aim sought to understand how nurses transition from usual nurse-patient exchanges to person-to-person, meaningful interactions with terminally ill patients. Much of this ability had to do with how the participants used time. As mentioned earlier, all participants acknowledged the time-related tensions they experienced as a result of having little time. However, the participants also recognized that they needed to make time for terminal patients. Moreover, participants admitted the needs of end-of-life patients frequently took more time, not a lot of time, but time spent focused and ideally, uninterrupted time. Consequently, participants transitioned from typical nurse-patient interactions to instead, engaging patients in fully focused, meaningful interactions by using their time well. For example, some participants reported prioritizing their time, juggling time, or scheduling time to be with terminal patients. Some participants removed barriers known to interrupt time with patients, such as turning off their phones. Still other participants instantly recognized acute needs in their patients and promptly seized time, which one participant described as “the powerful present moment.”

Once participants secured time with identified patients, participants then transitioned from typical nurse-patient interactions to instead, engage dying patients in person-centered, meaningful encounters. During the transition, participants were purposeful in their verbal responses and nursing actions while remaining fully focused on the patient. One participant described the transition in this way: “It begins as an encounter the nurse has with the patient, and slowly becomes a connection that goes beyond time and space. You are fully focused on the patient, time seems to stop.” Another participant explained: “As the interaction began to unfold, I became aware that this was special.”

Interestingly, two participants reported that during their memorable interactions they lost track of time. Most participants, however, were able to bracket their attention by remaining completely aware of their responsibility to other patients. However participants made good use of the time they were with their terminal patient to intensely focus on only that patient.

How participants dealt with the constancy of having so little time while having a determined awareness that terminal patients needed more of their time proved significant impetus for beginning these meaningful interactions. How these exchanges were sustained amid hectic healthcare environments was also discussed.

#### Study Aim: Sustaining Meaningful Interactions

The third study aim was to understand how nurses with competing time demands are able to sustain meaningful interactions. Participants' ability to sustain these exchanges while hearing their name paged was frequently driven by participants' intentionality to remain with the patient. Such resolve may have occurred when a patient reminded the participant of a person they lost. Intentionality might have been spurred by their nursing philosophy, as one participant said: "I knew I had other patients, but I wanted to focus on her. There was no question I was right where I needed to be, to help her get past what she was feeling. I had to. It's part of my nursing philosophy. I've been a nurse for thirty years. In that time, I don't remember even one enema or medication I've given, but I do remember these special interactions. I find these so fulfilling when I think that I made a difference in a person's life."

Participants' resolve was also influenced by moral imperatives nurses held in believing it their obligation to be with dying patients. One nurse said: "I was born this way. My parents taught me to treat people with respect and dignity. When I was only 12 when my father was dying, I was scared, but I knew I had to be there and hold his hand as he was dying. "

Other ways participants sustained these meaningful interactions came from participants' determination to make a difference. Seven participants reported having positively influenced similar patients' outcomes earlier, thus realizing the impact their nursing actions had on patients at end of life. Several participants reported: "I knew I could make such a difference. And I did." Participants' awareness that they had made a difference inspired them to sustain these memorable interactions, despite hearing their names paged overhead and having other patients they were responsible for.

### **Summation of Study Findings**

Several significant categories emerged from the data. Dying patients' vulnerability along with patients' inability to alter a terminal course were critical factors in drawing participants' attention to dying patients. Other essential factors involved situational and environmental antecedents such as recognizing patients' clues and having helpful nursing colleagues, respectively.

Other essential categories involved the intrinsic characteristics of the participants, such as their intentionality to become involved to positively influence patients' illness experiences was central. Such resolve resulted, in part, from participants' personal loss, or their threat of loss and by deeply held nursing philosophies or intensely felt moral imperatives to be of help. Another major intrinsic factor had to do with how participants used time, despite their perceptions having so little time. Participants' intentionality to make a difference spurred their willingness to be vulnerable and tolerate feeling uncomfortable as they focused on the needs of dying patients. Finally, participants exhibited courageous actions while caring for end-of-life patients.

These intrinsic characteristics stemmed from participants' fervent intent to become involved and make a difference in patients' dire illness experiences. This drive fostered the nursing presence process.

When asked what the meaningful interaction process was like with dying patients, participants indicated that making a difference during terminal patients' dire illness experiences was the essence of meaningfulness. Through their courageous nursing actions, participants acknowledged their ability to change outcomes. Additionally, participants were honored to be with patients during the final phase of life.

Outcomes for patients involved gaining staunch advocates as evidenced by participants' stories portraying intent to speak on patients' behalf. Some patients became the fortunate recipients of bravely bestowed wisdom, while other patients received preparation for what was to come, results brought about by participants' courage to make a difference in patients' end-of-life situations.

Outcomes for the participants included the gratitude they received from patients and families, as well as institutional accolades for compassionate patient care. While the participants remained grateful for these acknowledgements, participants were most satisfied by knowing they made a positive difference in terminal patients' illness experiences. This awareness prompted participants to seek out additional opportunities to again influence other dying patients' dire illness situations.

## **Chapter Five: Discussion**

“As a nurse, you are going to be there when a lot of people are born, and when a lot of people die. In most every culture, such moments are regarded as sacred and private, made special by a divine presence. What an honor that is.”  
(Thom Dick, 2004)

### **Discussion**

The social process that emerged from the data analysis is titled The Courage to Make a Difference (Figure 1). The courage to make a difference involved the process undertaken by 11 participants working in acute care environments who addressed the constancy of having little time to address the holistic needs of end-of-life patients who needed more of participants' time. Moreover, this process illuminates ways the participants transition from typical nurse-patient encounters to instead engage in person-centered, meaningful interactions, and sustain these encounters despite distractions. Hence, this section describes how the process titled The Courage to Make a Difference unfolds. Chapter Five also presents an interpretation of study findings while also integrating study findings with the extant literature. Implications for nursing research and practice are discussed, as well as study limitations.

### **Major Study Findings**

#### **Vulnerability**

A major study finding revealed the way participants regard terminally ill patients as vulnerable. In fact, it was dying patients' vulnerability along with participants' knowledge of patients' limited time that initially triggered participants' awareness of patients' need for nursing presence. Patients at end-of-life displayed physical vulnerabilities as evidenced by bodily decline and increased dependency. Patients also demonstrated emotional and social vulnerabilities such as despondency and used denial as a coping mechanism.



Occasionally, patients displayed unique triggers pointing to patients' need for meaningful interactions fostered. One example involved a patient who suddenly regained consciousness following cardiac compressions during a cardiac arrest. Other triggers included behavioral cues, such as the reference made to the patient in pain who reached for the participant's hand.

Aside from dying patients' vulnerability, aspects related to participants' vulnerability also emerged from the data. Participants' willingness to be vulnerable by remaining in the moment, uncertain of what was to come and unsure of how far to go when speaking with terminal patients comprised one of the essential elements that fostered meaningful nurse-patient interactions.

#### Time

Issues surrounding time was another central categorical theme ground in the data. Participants aptly described their perceptions of patients' limited time while admitting that end-of-life patients needed more of their time. In response, participants prioritized time to cope with these opposing realities. Some nurses simply made time; others scheduled time or seized time to address terminal patients' needs. Participants also removed potential barriers that may interrupt having time with their dying patients by turning off phones or having colleagues cover their other patients.

#### Intentionality

Participants' resolve to make a difference in patients' illness experiences was spawned, in part, by recalling of previous, personal losses or threats of loss. Participants' intentionality was also spurred by their nursing philosophies or deeply held moral imperatives to be of help. Lastly, participants' intentionality to positively change patients' unfortunate illness experiences was inspired, for some, by recalling positive influences participants previously made for other terminal patients, and intended to do so again.

## Courage

Another major categorical theme that arose from the data pointed to ways participants courageously responded to dying patients' needs, thus taking prompt nursing actions to benefit patients' situations. Participants demonstrated bravery by reassuring patients facing life-threatening situations and by bearing witness to patients' vulnerability and suffering. They became patient advocates by challenging members of their professional community. Participants exhibited resolve by daring to speak truth gently to patients as a way to prepare patients for what was to come. Courage was demonstrated as participants trusted their instincts and took unique nursing actions based on participants' personal or professional loss experiences or their deeply held beliefs. This section compares study results with the extant literature review presented in Chapter Two.

### **Similarities and Differences within the Literature**

#### Patients' and Nurses' Vulnerability

Indeed, multiple nursing presence scholars have identified vulnerability as an antecedent to presence while acknowledging both the patient and the nurse experience vulnerability prior to and during meaningful nursing presence (Gilje, 1993; Kostovich, 2012; Miller & Douglas, 1998; Osterman, 2002, Pettigrew, 1990). These results matched the findings in this study. Indeed, participants tolerated vulnerability in order to engage dying patients in nursing presence.

Although my study did not include patients' perceptions of vulnerability, each participant's narrative provided assorted rationale in how they perceived their dying patients to be vulnerable.

The nursing presence literature indicates patients experience vulnerability initially when patients invite their nurses into patients' illness situations. The literature also acknowledges that vulnerability is a requisite antecedent for nursing presence. Yet, few manuscripts indicate that

nurses perceive end-of-life patients as being vulnerable, and those that do offer little detail about these perceptions or provide rationale for why this occurs (Copp, 1986; Miller & Douglas, 1999; Thorup & Roberts, 2011; Pettigrew, 1988). Indeed, when compared to the aforementioned manuscripts, participants in this study offered rich, contextual descriptions on the ways they perceived dying patients to be vulnerable. Similarly, some of the reviewed literature acknowledges nurses' awareness of patients' limited time, but fail to describe the dying patients' lack of time to be an aspect of patients' vulnerability, which participants in this study reported (Mok & Chiu, 2004; Miller & Douglas, 1999; Pettigrew, 1988). Hence, participants' overall perceptions of dying patients' vulnerability, an aspect of which involved patients' limited time, comprised some of the unique research findings.

## Time

Another surprising study result involved the ways participants strategically used time to engage dying patients in nursing presence. Admittedly, previous presence scholars intermittently referenced aspects related to time and nurses ability to engage in presence. For example, the reviewed manuscripts stress the importance of nurses having adequate time to engage in presence (Duis-Nittsche, 2002; Finfgeld-Connett, 2006). Other articles acknowledged nurses' lack of time a barrier to participating in nursing presence (Iseminger, Levitt & Kirk, 2009; McMahon & Christopher, 2011). Pettigrew (1990) claimed nursing presence did not require significant amounts of time, but required nurses to make good use of time. While the aforementioned texts described various aspects related to time, none to my knowledge addressed the tensions nurses experience from having limited time within the contextual reality that dying patients needed additional nursing time.

An exception to this lies in two manuscripts that explored ways nurses rose above time constrictions (McMahon & Christopher, 2011; Pettigrew, 1990). The findings in these texts align to the results of this study. Specifically, these scholars acknowledged that time was a barrier to nursing presence that “can be controlled by nurses’ authentic intention” to engage patients in nursing presence (McMahon & Christopher, 2011, p. 79).

Certainly, the above-mentioned texts addressed some of the time-related elements often associated with nursing presence. However, to my knowledge none of these manuscripts explored, as this study demonstrates, very concrete and practical ways nurses address the ongoing challenge of having little time, especially when caring for end-of-life patients.

#### Intentionality

Most of the nursing presence literature recognized the importance of nurses’ willingness to become involved in the patients’ situations (Duis-Nittsche, 2002; Doona, et al, 1999; Finfgeld-Connett, 2006; Fuller, 1991; Hansbrough, 2011; Mohnkern, 199; Pettigrew, 1988). The ways in which previous texts describe nurses’ willingness to become involved in patients’ situations is unlike the intentionality the participants exhibited in this study who appeared more driven than willing to become involved with patients’ needs. In fact, within the nursing presence literature, only a few texts matched the intentionality exhibited by study participants who were deliberate and were determined to be involved in patients’ situations (McKivergin & Daubenmire, 1994; McMahon & Christopher, 2011; Patterson & Zderad, 1976; Stanley, 2009). The following quote from one referenced manuscript depicts the intentionality portrayed by study participants: “The nurse-patient relationship necessitates an intentional decision to invest ourselves and our time in extraordinary situations where the elemental need for connectedness with another transcends theoretical considerations” (Stanley, 2009, p. 3). Hence, study participants were more

than willing; in fact these nurses were driven to make positive differences in the illness experiences of terminally ill patients. This was another unique study finding.

### Courage

Themes pertaining to participants' courage comprised unexpected results repeatedly ground in the data. It is important to state that this researcher has been humbled to have had the opportunity to bear witness to the various ways participants displayed nursing advocacy, bravery and courage in order to create positive influences in dying patients' illness situations.

Interestingly, almost all of the nursing presence literature omits any reference to courage. One exception lies in a recently published article with findings that similarly align with this study's results (Iranmanesh, Haggstrom, Alexsson, & Savenstedt, 2009). The article acknowledges that nurses need courage, especially during difficult end-of-life situations and when speaking truthfully to dying patients (Iranmanesh, et. al, 2009). The article also noted the extent to which nurses' courage helped nurses bear witness to dying patients' needs (Iranmanesh, et al, 2009).

Since the concept of courage and synonyms such as bravery and advocacy proved to be a prominent category within the data, this researcher searched outside the nursing presence literature to understand courage within nursing. From this search, this investigator noted that nurses' demonstrations of courage are essential to the advancement of nursing practice (Spence & Smythe, 2007). Paradoxically, within the nursing literature the concept of courage is considerably unrepresented (Hawkins & Morse, 2014).

However, the general literature search on courage indicated courage is often preceded by nurses' vulnerability (Hawkins & Morse, 2014; Spence & Smythe, 2007). In fact, Thorup and Roberts (2011) found that nurses' personal and professional life experiences involving nurses'

vulnerability and suffering influenced nursing actions, shaping nurses' courage in relation to care. Moreover, courage was significant unifying phenomenon manifesting itself in nurses' courage to help patients face their own vulnerability and suffering (Thorup & Roberts). Hence, findings within the general courage literature are congruent with patterns of courage as demonstrated by nurses within this study.

To summarize, the study results reported herein hold congruence with previous findings noting patients' as well as nurses' vulnerability, which is a requisite antecedent to nursing presence. Similarly, earlier scholars admit the importance of nurses having adequate time to engage in presence. Likewise, descriptions provided in previous studies matched the deliberate, purposeful intentionality displayed by participants in this study.

The unique findings of this research include ways participants generally perceived dying patients as being vulnerable, in part due to patients' limited time. A second exceptional study result pertained to the creative ways participants used time to address dying patients' needs. Another distinctive finding involved assorted demonstrations of courage as participants advocated for patients, dared to speak truth to patients and took courageous nursing actions with the intent of making positive differences in patients' illness experiences.

### **Factors Influencing Study Findings**

It is important to provide rationale that explains the disparity between the results of this research and the findings uncovered by previous nursing scholars. One justification for these differences may lie in the study's overall uniqueness, which exclusively examines meaningful nurse-patient interactions with dying hospitalized patients. Because terminal patients have limited time, it is reasonable for study participants to exhibit unusual courage in order to help

their vulnerable patients, since participants may not have had additional opportunities to favorably influence the illness situations of dying patients under their care.

### **Implications**

Certainly, the results of this research illuminate the importance of the relational aspects of nursing, especially in hospital environments that promote science, technology and measure tangible patient outcomes. The detailed narratives of the participants as described herein offer concrete examples of the non-measurable, yet very essential aspects of nursing. Participants' narratives demonstrate ways participants used time well with their intentionality to bring benefit terminally ill patients.

This study is also significant because it begins to connect nursing presence with nurses' courage, and does so by outlining a range of courageous nursing actions. These descriptions hold potential to begin dialogue to encourage nurses' demonstrations of courage. The following sections suggest ways this research benefits nursing practice, nurse leaders as well as nurse educators.

#### **Nursing Practice**

Understanding how nurses working in busy hospitals engage dying patients in nursing presence is critical to quality nursing practice. Dying is a final life experience in which nurses play central roles. Moreover, the demand for end-of-life care continues to grow as the population ages. Population estimates that by year 2030 those individuals over 65 years will double in number to 70 million (Federal Interagency Forum on Aging Related Statistics, 2012). These figures predict nursing care needs for much larger cohorts of dying patients.

However, acute care nurses currently report decreased job satisfaction amid mounting tasks and sicker patients. Faced with the constancy of new technology while improving

outcome scores, many nurses find the relational aspects of nursing, known as the art of nursing, harder to prioritize. These nurses leave nursing due to an inability to address patients' social, emotional and spiritual needs. These needs especially surface at end of life.

Moreover, while dying is an inevitable and universal outcome, the literature is stunningly void in describing how the nursing presence process unfolds with terminal, hospitalized patients. Considering 100% of the population dies and the frequency by which bedside nurses care for patients at end of life, this omission in knowledge is striking.

This study is therefore important to nursing practice because it offers insight into how bedside nurses integrate meaningful exchanges with terminal patients amid hectic healthcare environments. This study holds significant implications for nursing for by demonstrating very concrete and practical ways staff nurses continue to uphold Nightingale's (1859) legacy and the ideals she founded.

#### Nurse Administrators

The ability to form a connection with end-of-life patients through nursing presence contributes to meaningfulness for nurses by knowing they made a difference in patient's illness experiences. Study participants experienced significant job satisfaction as evidenced by one participant's statement: "This is why I became a nurse." Nurses who find meaning in work tend to experience job satisfaction (Pavlish & Hunt, 2012). Job satisfaction affects nursing retention (Eley, Eley, Bertello & Clark, 2010). Nurse retention increases when bedside nurses are provided opportunities to demonstrate caring behaviors (Eley et al, 2010).

Hence, study findings challenge nurse administrators to implement holistic care models. To do this, nursing leaders must develop sensitivity around the relational aspects of care for the dying by establishing realistic ratios to afford staff nurses additional time to address terminal



patients' holistic needs. Indeed, study results encourage nurse administrators to become equally supportive of nurses engaging in the aesthetic art of nursing as they are of nurses who embrace the science of nursing.

#### Nursing Educators

Certainly, study findings point to the crucial roles nurse educators play throughout students' training. Results of this research should persuade educators to continue instilling Nightingale's (1859) traditional nursing ethos by consistently proving to learners why nursing is both an art and a science. Clinical instructors should pair nursing students with experienced nurse mentors who aptly model nursing presence, the art of nursing. Additionally, nursing professors must imbue end-of-life topics throughout nursing curriculums. Furthermore, instructors must begin these discussions in the first semester so that students gradually develop comfort in addressing the relational aspects of nursing care of the dying.

#### **Study Limitations**

While the study's sample size was small and relatively homogenous, it demonstrated the ability to attain a theoretical saturation of categories so as to describe The Courage to Make a Difference process. Certainly, additional research that involves male nurses, and nurses whose educations align more with national averages, as well as participant cohorts with greater cultural diversity would be ideal to test the transferability of study findings. Another limitation of this research involved the inability to observe participants engaging in presence with dying patients. Instead, findings reflected the data analyzed from participants' self-report of nursing presence with terminally ill patients.

## **Future Research and Theory Development**

The study uncovered unexpected results which included the extent to which participants exhibited courage by advocating for patients and by speaking truth to dying patients, their families and/or physicians. In almost every story, nurses' courageous actions positively influenced patients' illness situations at end-of-life. Consequently, participants realized the differences they made in dying patients' experiences. Study findings present opportunity to examine how nurses' courageous actions influence nurses' job satisfaction, and in particular, the relationship between courage and nurses' ability to engage in care. Since courage is an under-examined nursing attribute, future studies should investigate ways to encourage nurses' display of courage within various clinical settings. Certainly, study results suggest designing future research to explore patients' perceptions of nurses' courage and especially the impact that nurses' courage has on dying patients' illness experiences.

Additionally, the diagram (Figure 2) which depicts the nursing presence process with dying hospitalized patients holds prospective use in future studies. This is because there are several trajectories to end-of-life which vary significantly. For example, ongoing research is needed to investigate nursing presence with conscious dying patients, whose life expectancy may be hours to days due to unexpected trauma or the sudden consequence of a myocardial infarction. Likewise, this diagram might be applied to examine nursing presence with under-researched patient cohorts, such as dementia patients or those receiving dialysis, whose end-of-life trajectories are extended over long periods of time.

## **Conclusions**

Nurses consider dying patients a vulnerable population and are fully cognizant of terminal patients' limited time. Extrinsic factors promoting meaningful nurse-patient

interactions range from working in favorable environmental designs to having with helpful nursing colleagues. Intrinsic nurse characteristics included personal loss experiences, possessing strong nursing philosophies and/or deeply felt moral imperatives to be of help. Other intrinsic factors comprised various ways nurses used time while tolerating feelings of vulnerability. The impetus driving nurses' determination to become involved in dying patients' situations stemmed from nurses' resolve to be of help. Collectively, these factors comprised the requisite structures prior to initiating the nursing presence process.

Nurses report the essence of meaningfulness in their roles rested upon nurses' ability to positively influence dying patients' illness situations. Participants courageously responded to patients' needs by becoming patient advocates, by dauntlessly preparing patients for what to expect, by daring to speak truthfully to patients, families or physicians, and by taking courageous nursing actions in response to patients' unique end-of-life needs.

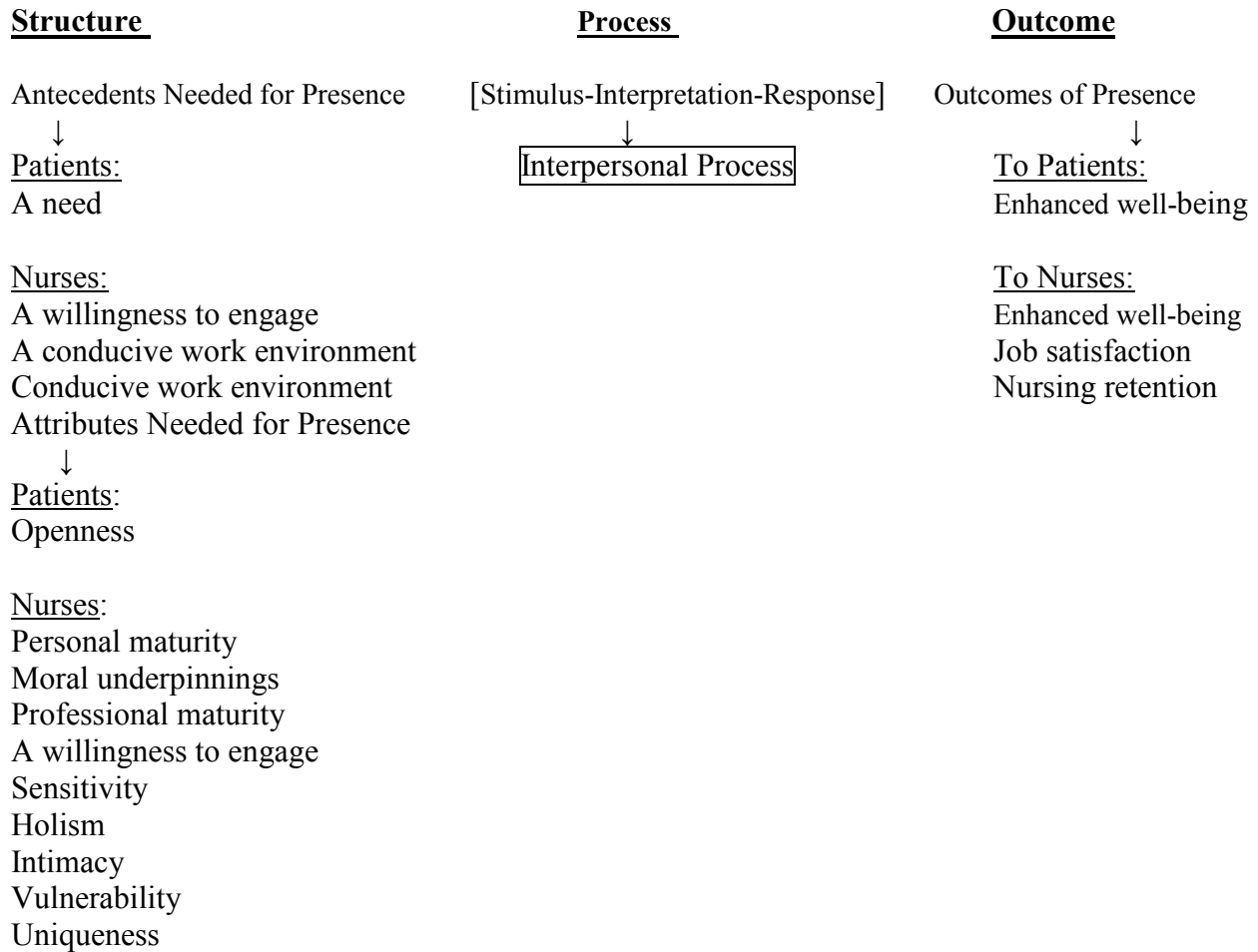
Nurses as well as patients benefit from meaningful nursing presence interactions. Patients become aware of what to expect, their feelings are validated while being helped to reframe patients' difficult end-of-life situations. Nurses report satisfaction by purposefully acting on their intentions to positively influence dying patients' illness experiences.

In closing, it is important to recognize that modern healthcare presents significant threats to nursing's traditional ethos by placing the relational work of nursing at risk. A responsibility rests for all nurses to continue Nightingale's (1859) legacy by upholding the ideals she founded. Nightingale inspired nursing's philosophic underpinnings; she viewed nursing as both an art and a science. Study findings demonstrate many concrete ways in which staff nurses are continuing Nightingale's legacy by upholding the ideals she founded. This research intends to safeguard the

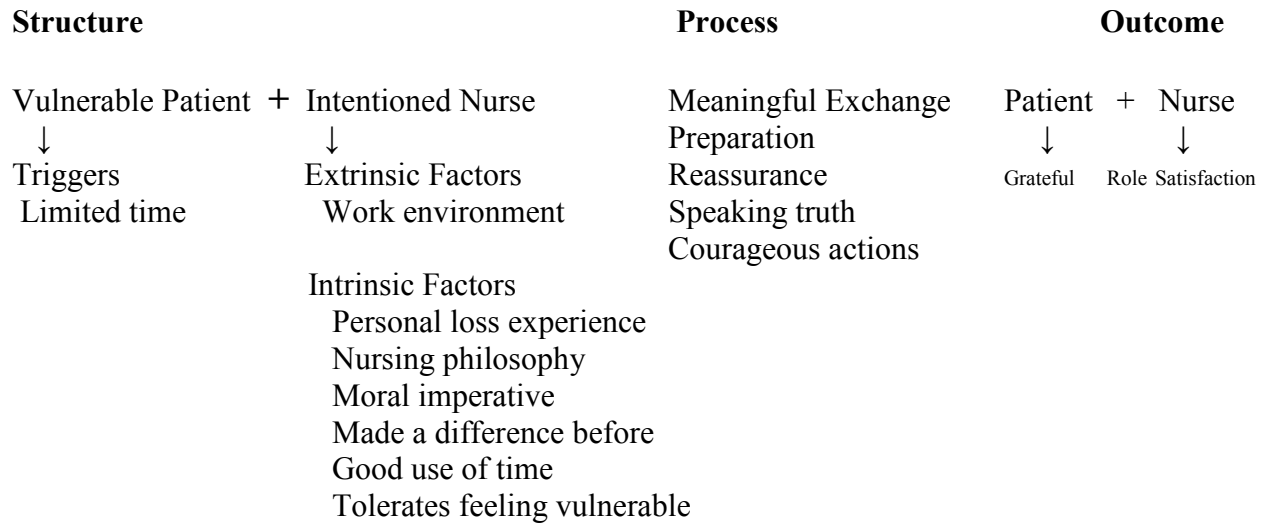
relational work of nursing, by sharing the narratives of bedside nurses as a way to continue to preserve and promote meaningful exchanges with dying, hospitalized patients.

**Table 1: The Process of Nursing Presence as Described in the Literature**

The Nursing Presence Process using Donabedian's Model (Finfgeld-Connett, 2006)



**Table 2 : The Courage to Make a Difference**



## Appendices

### Appendix A: Study Flyer

#### LOOKING FOR:

#### EXPERIENCED STAFF RN'S WHO REPORT MEANINGFUL INTERACTIONS WITH TERMINALLY ILL PATIENTS

**Registered nurses working as full time staff nurses for more than one year in acute care, who self-report a repeated ability to engage in meaningful exchanges with terminally ill patients.**

These individuals may be eligible to participate in this study.

Currently, I am in the doctoral program at UCLA School of Nursing. The purpose of my study is to understand the process by which experienced staff nurses engage in meaningful exchanges with incurably ill patients. I am happy to speak with you to give you more information about my study.

I will meet you at a time and place which is convenient for you.

**You will receive \$50.00 for your participation**

**Mary Hersh, PhDc, RN**

**Mhersh@UCLA.edu**

**(310) – 913 - 1723**

## Appendix B: Initial Phone Conversation to Select Participant

“I am a registered nurse and a doctoral student at UCLA. I am conducting this research for my dissertation.”

“The purpose of to my research is to help me understand how experienced staff nurses engage in nursing presence with terminally ill patients.”

“I would like to ask you some general clarifying questions.”

- “Are you a registered nurse working in an acute care setting with more than one year of nursing experience?”
- “Are you employed at Torrance Memorial Medical Center (TMMC)?”
- “Have you experienced the loss of a loved one within the previous year?”

If participant meets inclusion criteria I then said:

- “I would like to invite you to become part of this research, by interviewing you and asking about your experiences with very sick patients”
- “The interview is likely to last about one hour, but can go longer if you have more your would like to talk about.”
- “We can meet where it is most convenient for you, as long as it is safe and comfortable to you.”
- “You will receive \$50.00 for your participation and time.”

I then gave my phone number



### Appendix C: Demographic Data Form

Please answer the following questions.

1. Are you a RN with more than one year of full time employment as a nurse working in the acute care setting?    \_\_\_\_yes    \_\_\_\_no
2. Type of nursing unit\_\_\_\_\_ (Example: oncology, orthopedic, ICU)
3. The type of hospital\_\_\_\_\_ (Example: academic medical center, community hospital)
4. Is the institution in which you work a Nursing Magnet designated facility?    \_\_\_\_Yes    \_\_\_\_No
5. Age\_\_\_\_\_
6. Gender\_\_\_\_\_
7. Race\_\_\_\_\_
8. Ethnicity\_\_\_\_\_
9. Religion\_\_\_\_\_
10. Nursing education level\_\_\_\_\_ (Diploma, ADN, BSN, MSN)
11. Non-nursing degree, if applicable \_\_\_\_\_ (Bachelor of Arts, Bachelor in Music,)
12. Do you hold a nursing certification? \_\_\_\_\_  
If yes, in what area(s)? \_\_\_\_\_

Thank you for your time and for participating in this research.

Mary Hersh, RN, PhDc

## Appendix D: Interview Guide

1. “If you were to tell other experienced nurses what meaningful interactions are like with terminally ill patients, how would you describe these interactions?”

2. “Tell me about that what it was like for you when you realized you were engaged in a meaningful interaction with a very sick patient?”

Prompt 1: “What was that initial awareness like?”

Prompt 2: “In that moment, how did you know it?”

Prompt 3: “How do you believe this interaction was sustained?”

Prompt 4: “While this interaction occurred, what kinds of things entered your mind? For example, some nurses may think about things still needing to be done. Could you describe your experience with this?”

3. “How is your ability to interact with incurably ill patients different from the kind of interactions you observed in your colleagues?”

Prompt 1: “How would you describe the care that you give to a terminally ill patient, versus care you give to a patient the day following orthopedic surgery?”

Prompt 2: “In what ways are these meaningful interactions different for you on various days? For example, if you are not having a good day, how do you go about engaging patients when you are not feeling like yourself?”

4. What kind of clinical situations likely prompt these meaningful exchanges with terminally ill patients?

Prompt 1: “Can you describe things that come up in the clinical setting that would lead you to have meaningful interactions with seriously ill patients?”

Prompt 2: “How do you identify terminally ill patients’ needs?”

#### Appendix D: Interview Guide (Continued)

5. “Your ability to have meaningful interactions with very sick patients, where do you think it comes from?”

Prompt 1: “What in your past has enabled you, to engage in meaningful exchanges with seriously ill patients?”

Prompt 2: “Do you think that other nurses, who have had a similar life situation as yours, would also be able to have similar kinds of interactions with terminally ill patients?”

6. “What advice do you have for nurse leaders and nurse educators to encourage new nurses to have these kinds of meaningful interactions when they are with terminally ill patients?”

Prompt 1: “What advice would you give to nurse leaders when designing a nursing unit to encourage these kinds of interactions with terminally ill patients?”

Prompt 2: “What advice would you give nurse educators when they teach students about these kinds of interactions?”

Prompt 3: “What barriers would you like nurse leaders and nurse educators to be aware of, that limits nurses’ ability to have meaningful interactions with very sick patients?”

7. “Could you please talk about time as it relates to your awareness of it during the interaction? Specifically, could you talk about it from your perspective as a nurse, and then from the patient’s perspective, as you perceive the concept of time.”

Prompt 1: “What thoughts pertaining to your time as well as the patient’s concept of time, came into your mind as you were meaningfully engaged with the patient?”

Prompt 2: “Could you describe how your thoughts about time affected your interaction with the patient?”

Appendix D: **Interview Guide** (Continued)

8. “What surprised you most about this interaction?”

Prompt 1: “Was there anything that the patient did or said during your exchange that was memorable for you? In what way?”

Prompt 2: “Was there anything that the patient did or said that you were uncomfortable about? In what way did this cause you to be uncomfortable?”

9. “Is there anything else that we have not covered?”

Prompt 1: “Is there anything else that would help me understand the process by which you engage in meaningful interactions with very sick patients?”

Prompt 2: “Is there something that we discussed that you would like to return to?”

“Thank you very much for your time and for answering my questions.”

## Appendix E: **Phone Conversation for Follow-Up Interviews**

“When I studied our interview, some themes came to my attention, which were similar to other nurses in the study, and some themes were uniquely yours.”

“I am calling to ask if I may have another interview with you, in order to ask your opinion as to whether my interpretations of what you were saying in our previous interview are consistent with your experiences.”

“This next interview will probably be shorter than our first one. I am willing to meet you at a time and in a place that is convenient to you.”

“You will again receive \$50.00 for your contribution and time.”

## Appendix F: **Thank You Note**

“Dear .....,

I wanted to thank you for your time and for your participation in my research.

Sincerely,

Mary Hersh

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