Enhancing palliative care through Watson's carative factors

By Patricia McKay, Dale Rajacich, and Janet Rosenbaum

Abstract

Palliative care is aimed at alleviating the suffering of patients with terminal illnesses. As more patients make the decision to die at home, community palliative care has become an alternative to hospitalization. The literature was examined in relation to the needs of terminally ill patients in the community and their families to determine their priority needs. Patients were found to have physical, psychosocial, and spiritual needs, while families had needs in relation to the physical care of their loved ones, as well as information and psychosocial needs. The use of Watson's theory of human caring, and in particular her carative factors, was found to be an appropriate nursing model to direct palliative care nurses in meeting the needs of both patients and their families.

Palliative care is aimed at alleviating the suffering of patients with incurable diseases, such as cancer, and begins when active cure or containment of the disease is no longer possible (Rose, 1995). The number of patients with incurable disease remains significant as cancer incidence rates are rising with the aging of the population (Mount, Scott, & Cohen, 1993). Consequently, a significant number of people with terminal illness will be encountered in the future. Despite advances in treatment, 50% of patients referred to regional cancer centres still die of their disease (Roe, 1992). Quality of care for palliative patients is becoming more challenging as health care costs continue to rise and budgets shrink (Deachman, 1995).

Palliative care is recognized as a viable community care option as hospital beds are decreasing and more patients are choosing to die at home. With advances in technology, informal caregivers of cancer patients may well need emotional and practical support for meeting increasingly complex treatment demands (Silveira & Winstead-Fry, 1997). This paper will discuss how Watson's theory of human caring may be utilized to meet the needs of palliative care patients and their families. Specifically, the use of the carative factors in palliative care delivery will be demonstrated (see Table One).

The literature related to the needs of palliative care patients and their families was examined. The main categories of patient needs identified were physical, psychosocial, and spiritual. This is consistent with the needs identified by the Canadian Palliative Care Association [CPCA] (1995). In many areas of the palliative care literature, the family, as well as the patient, is considered the unit of care, especially if the patient is cared for at home. The needs of families, as cited in the literature, can be categorized as needs related to the physical care of family members, as well as psychosocial, and information needs.

Watson's theory of human caring (1985, 1988) was chosen as a framework for the delivery of palliative care because of its compatibility with the philosophy of palliative care nursing. Roe (1992) explained that there is a special knowledge and skill level (the science), along with compassionate caring (the art) that is required to meet the needs of palliative care patients. Watson (1985, 1988) is committed to the art and science of nursing and believes that both must be present within the practice of nursing. Furthermore, Watson (1989) states that humans have survival (physical) needs, functional (activity) needs, integrative (affiliation) needs, and growth-seeking (spiritual, self-actualization) needs. These needs are congruent with those previously stated and were found in the palliative care literature.

Watson's theory (1985, 1988) is based on values that are associated with a deep respect for the wonders and mysteries of human life, as well as an acknowledgement of a spiritual dimension to life. There is a high value placed on the subjective-internal world of the experiencing person and how the person is coping with his or her health/illness condition (Watson, 1989). The assumptions related to human caring values in nursing are related to caring as being the essence of nursing and the most central and unifying focus for nursing practice. Watson (1996) postulates that caring values in nursing have been submerged and threatened by an increasing medical technology and a proliferation of curing and radical treatment techniques.

The goal of nursing is to help persons gain a higher degree of harmony within the mind, body, and soul (Watson, 1988). The nurse pursues this goal by responding to the person's subjective world in a way that individuals can find meaning through exploring their disharmony, suffering, and turmoil. Achieving this goal can potentiate health and healing (Watson, 1989). Both the patient and the nurse are central to the process of change and growth. In terms of palliative care, Watson speaks of a movement towards wholeness that is not dependent on cure outcomes, but rather can mean a peaceful death. While caring must be present when curing is called for, certainly caring must be present when curing has failed, and death with dignity is the desired result (Watson, 1988).

Transpersonal caring is required in order for the individual to feel cared for. This takes place during an "event or actual caring occasion." This occurs when two people (nurse and other) come together with their unique life histories or phenomenal fields, which are the totality of one's experiences in the world and all the feelings and thoughts that go along with it. There is an authenticity of being, an ability to be present and to attend to caring, healing, and wholeness rather than disease, problems, and illness (Watson, 1997). Watson (1996) identified 10 carative factors that are enabling actions embedded in the human caring process. They become actualized as the nurse cares for patients in day-to-day interactions. The carative factors help define nursing knowledge and practices as distinct from, but complementary to, the curing knowledge and practices associated with traditional medicine. Watson's carative factors (Watson, 1996) will be discussed in relation to examples from the literature that support their use.

Carative factors

Formation of a humanistic-altruistic system of values

Caring must be grounded in a set of universal human values: kindness, concern, and love of self and others. This value system involves the commitment to and satisfaction of receiving through giving. It also involves an appreciation of different ideas and tastes, as well as divergent views of life and death (Watson, 1985).

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The importance of valuing palliative care patients cannot be overestimated. This valuing has been mentioned by other researchers in relation to palliative care, but has not been previously linked to Watson's carative factors. Davies and Oberle (1990), in their descriptive study of the supportive role of the palliative care nurse, discussed how important it is to respect the inherent worth of others regardless of individual characteristics. The CPCA (1995) also includes this value of respect in its principles of care which state that there will be equal availability to care regardless of diagnosis, age, gender, race, colour, sexual determination, language, creed, religion, or ability to pay.

Enabling and sustaining faith-hope

Regardless of what scientific regimen is required for the care of a patient, the nurse discovers what is meaningful and significant for that particular person. The nurse who practises the science of caring transcends the restrictions of the medical model with his or her respect for and appreciation of the whole person (Watson, 1985).

Table One: Watson's Carative Factors	
Factor	Description
Forming a humanistic-altruistic system of values	Caring is grounded in the basic human values of kindness, concern, of self and others
Enabling and sustaining faith-hope	Patients' hopes must be encouraged and respected
Being sensitive to self and others	The nurse must acknowledge her own feelings so she can be sensitive to others
Developing a helping-trusting caring relationship	The human caring relationship involves both the nurse and the one being cared for and requires excellent communication skills
Promoting and accepting the expression of positive and negative feelings and emotions	The one being cared for must be allowed to express all feelings and emotions
Engaging in creative, individualized, problem-solving caring processes	Creative problem-solving with a focus on the uniqueness of each person or family
Promoting transpersonal teaching-learning	It is important to find out what people want to know and assess their perceptions and concerns
Attending to supportive, protective, and/or corrective mental, physical, societal and spiritual environments	The main purpose of this factor is the provision of holistic health care
Assisting with gratification of basic needs while preserving human dignity and wholeness	It is important to allow persons to identify their unique needs and then meet the needs as much as possible
Allowing for, and being open to, existential, phenomenological, and spiritual dimensions of caring and healing	Attention to these allows the nurse to truly understand the personal meanings and experience of the one being cared for

The importance of maintaining hope was discussed in Hall's (1989) qualitative study with terminally ill men. Her results showed that patients needed to maintain hope until they drew their last breath. These men did not want to use up their lives preparing for death, rather they wanted to live for as long as possible. Cherny, Coyle, and Foley (1994) articulated that a patient's ongoing physical and emotional distress as the days pass slowly until death may be manifested in feelings of hopelessness and futility. Herth (1995) conducted a study of hospice nurses to determine which interventions to engender hope were most effective and used most often. The nurses identified that providing comfort and pain relief were of most significance. The other most common interventions were "assisting to devise or revise manageable goals, facilitating a sense of sustained connectedness with others, and helping the patient to see the positive small joys in the present" (p.35). In practice, it would be salient for the nurse to find out what is foremost for patients and then help them set some realistic goals; for example, conserving enough energy to attend a particular social event.

Being sensitive to self and others

This carative factor can only be actualized if one recognizes and feels one's feelings. Nurses who are sensitive to others are better able to learn about another's view of the world and show concern for others' comfort, recovery, and wellness. Degner, Gow, and Thompson (1991), in their study of critical nursing behaviours in the care of the dying, discussed enhancing personal growth as one of those behaviours. They found that it

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was important for nurses to confront their anxieties and feelings about caring for the dying before they could define a personal role for themselves in caring for the dying. Montgomery (1997) stated that in order for nurses to have a positive effect on dying clients, they must be able to create positive meanings out of the experience of caring for them. These meanings are drawn from inner personal resources and the resources from each unique context in which caring occurs. In her article, Montgomery discussed how one palliative care nurse dealt with her sadness over the loss of young clients. The nurse felt that the images of the clients she had lost were like spirits to her, and passed life on to her. Because they were not able to continue to live, she had a responsibility to live life to the fullest. Consequently, she was able to continue caring for other terminally ill clients and to enjoy many other aspects of her life.

Developing a helping, trusting, caring relationship (Seeking transpersonal connection)

The human caring relationship is transpersonal and involves a high regard for the whole person. Patients who feel that a nurse truly cares about and is sensitive to their needs are likely to establish trust in the nurse. Attributes of the nurse necessary to carry out this factor are congruence, empathy, non-possessive warmth, and good communication skills (Watson, 1989). Davies and Oberle (1990) discussed connecting as one of the dimensions of the supportive role of the palliative care nurse. Connecting means spending time with the patient, finding a common bond, and establishing rapport. Central to the concept of making the connection is establishing trust.

Excellent communication skills are also an integral aspect of this carative factor. The nurse must be totally attentive to both the patient and family members since the literature demonstrates how very much the illness of one family member impacts on the entire family unit. Communication skills include not only imparting information, but also attentively listening and responding appropriately to the issues and concerns of patients and families. As the literature states (e.g., Dudgeon, Raubertas, Doerner, & Tobin, 1995), patients often report that "there was no one to talk to who really understood" (Dudgeon et al., p.7).

Promoting and accepting the expression of positive and negative feelings and emotions

This carative factor may be considered an inherent part in the development of a helping-trusting relationship. Because feelings alter thoughts, behaviours, and experiences, they need to be acknowledged and considered in the human caring process. A focus on feelings and the emotional aspects of an illness may allow a caring relationship to move to an even deeper level. As pointed out in the literature, palliative care patients may express very negative feelings. Degner et al. (1991) discussed responding to anger as being one of the critical nursing behaviours in caring for the dying. The anger could be from either the patient or family member and may be directed at the nurse. Degner and colleagues stated that experienced palliative care nurses understand the source of anger without taking it personally. As one nurse noted, "Their loved one is dying. It's like kicking the cat, they need to vent their anger at someone" (p.249).

Gomas (1993) also reminded us that not all patients accept their disease or impending death. Until the end, some shout and cry about their fear of dying, their anger at not recovering, and their regrets at not having filled their lives as they would have liked. Although difficult, it is important that the nurse accept the patient's anger and still provide the required support.

Engaging in creative, individualized problem-solving caring processes

The sixth carative factor employs the nursing process to help with decision-making. A creative problem-solving approach is the nurse's invaluable tool for putting together all the information about the patient. The nursing process includes assessment, planning, intervention, and evaluation. Watson (1989) offers no clear-cut assessment guide to use, but because her emphasis is on mind/body/spirit unity, one can assume the necessity of completing an assessment that takes all of these aspects into account. It would be important to obtain information from patients that is based on their own description of their illness.

Because the patient is considered very much a partner in his or her care, once this information is obtained the nurse and patient would work together, both using their knowledge and creative imaginations as well as the nurse's skills and clinical judgment. Together they would determine strategies to deal with difficulties being encountered.

The promotion of transpersonal teaching-learning

The imparting of information has always been important to nursing, but the transpersonal aspect of the relationship is often overlooked. Teaching and learning are more than just the giving and receiving of information. Both depend on an assessment of the patient's and family's perceptions, feelings, concerns, and understandings (Watson, 1989).

A review of the palliative care literature indicated that the need for information is one of the main categories of family needs. Rose (1995) also described how patients may experience isolation, especially if they lack information about their condition. In relation to families, both Kristjanson (1989) and Hull (1989) found that families requested information about the patient's prognosis, the side effects of treatments and drugs, the patient's tests, and how to manage the patient's pain at home. Hull also found that families desired clear, honest information about signs of imminent death. Brown, Davies, and Martens (1990) reported that families expressed the need to learn the necessary skills of effective pain and symptom management through being taught by health professionals, rather than through trial and error.

Therefore, it is important for the nurse to determine both the patient's and the family's perceptions and concerns, as well as their knowledge and skill level. The nurse can then work with them to obtain the information they want and need. By giving them this information, they will be empowered to do for themselves and to meet their loved one's needs. The palliative care nurse must also strive to prevent crises in the home. One way is to ensure that family members know what to expect in the final few hours before death. The nurse should explain what signs and symptoms are expected and what can be done to help to control them. Finally, families must be instructed where they can call for help both day and night.

Attending to supportive, protective and/or corrective mental, physical, societal, and spiritual environments

The eighth carative factor has quality holistic health care as its purpose. This is congruent with the literature and the CPCA (1995) which indicate that terminally ill patients have biopsychosocial and spiritual needs, and that care should be directed towards meeting these needs. This factor involves assessing and facilitating patients' coping abilities to allow them to maintain their mental and physical well-being.

Providing comfort involves physical, mental, social, and spiritual measures. Physical and spiritual comfort measures will be discussed under the next carative factors. Several authors

have documented the presence of emotional distress concomitant with physical symptoms. Vachon, Kristjanson, and Higginson (1995) presented a synopsis of the psychosocial needs of terminally ill patients, based on four different studies. They found that 50-60% of patients experienced depression, 21-43% reported anxiety, and 29-61% experienced frustration. Hinton (1994), in his study of terminally ill adults, found that ongoing self-reported anxiety and depression were apparent in up to 50% of patients. Cherny et al. (1994) stated that psychiatric problems can occur in upwards of 60% of patients with advanced cancer. Dudgeon et al. (1995) reported that 18 patients or 20% of those studied with advanced disease acknowledged suicidal ideation.

Psychosocial needs in families were also identified in the literature as a main category of family needs. Hinton (1994) conducted a prospective study that reviewed the degree of current problems faced by terminal cancer patients and their families. Between 10-40% of relatives reported problems with caregiver strain, fatigue, anxiety, and depression. The relatives also stated that they consciously disguised their feelings so as not to distress their loved one. Miller and Walsh (1991) also found that families reported they needed to be able to keep a handle on their own grief and, consequently, they kept their feelings to themselves. Hinds (1992), in her descriptive study of terminally ill patients and their families, reported that family members described a need for assistance in dealing with their own fears and the anguish they felt as they watched their loved one gradually deteriorate.

Psychosocial comfort measures may involve attentively listening to both the patient and family as they vent their fears and concerns, and helping them understand what to expect. In addition, the palliative care nurse must be continually aware of how the patient and family are coping by making ongoing assessments and then ensuring that appropriate assistance is offered, whether it be a volunteer to sit with the patient for respite for the family, or increasing homemaking or nursing hours.

Another aspect of providing mental and social comfort for the family is the provision of bereavement care. Ideally, at the time of loss, the family needs the support from a health care member who has provided care to their loved one and with whom they have established a therapeutic relationship. Usually, this person is the nurse who must, therefore, be adept at dealing with the bereaved by being knowledgeable about the grieving process and who must also be aware of interventions and community resources that will promote grief resolution among families.

Assisting with the gratification of basic human needs while preserving human dignity and wholeness

As stated previously, terminally ill patients have biopsychosocial and spiritual needs. The literature identifies that advanced cancer patients experience many physical symptoms. Several authors (e.g., Brown et al., 1990; Cherny et al., 1994; Dudgeon et al., 1995) have discussed how pain is the primary physical symptom associated with terminal cancer. Other frequent symptoms are fatigue, asthenia, dyspnea, nausea, vomiting, constipation, diarrhea, weight loss, weakness, sleep disturbances, bowel and bladder incontinence, and ambulation difficulties (Corless, 1994; Coyle, Adelhart, Foley, & Portenoy, 1990; Dudgeon et al.).

In a prospective study, Curtis, Krech, and Walsh (1991), examined the presenting symptoms of 100 patients with advanced cancer. The authors found that the eight most frequent physical symptoms were pain (40%), weight loss (58%), anorexia (55%), dyspnea (41%), constipation (40%), early

satiety (40%), fatigue (40%), and xerostomia (40%). Corless (1994) explicated that the key to treating palliative care patients is adequate symptom control. The palliative care nurse must, therefore, be well-informed about these symptoms and their treatments, and be prepared to advocate for the patient to request treatment orders.

The review of the literature also indicated that families needed assurance that their loved ones' physical needs were being well cared for. Kristjanson (1989) conducted a qualitative study with 210 family members caring for 120 terminally ill loved ones to determine family satisfaction with terminal care. The most important patient care items reported were that the patient's pain and other symptoms be treated quickly and thoroughly and that the patient be treated in an holistic manner. Cherny et al. (1994) reported similar findings related to the desire for prompt medical attention.

Steele and Fitch (1996) identified the barrier needs of family caregivers attending to dying patients. Barrier needs were identified as needs that were important, but were not being met. Family caregivers reported that they needed time away from the house for themselves and their personal needs, time for rest and adequate sleep, and a caregiver hotline. Hinds (1992) carried out a descriptive study of the perceived needs of families as they met the care requirements of patients. More than 50% reported they were having problems providing care related to nutrition, pain control, nausea, vomiting, and, most of all, carrying out treatments, such as giving medications, particularly injections.

In order to meet these needs, the palliative care nurse must determine the family's perception of the situation, as well as their knowledge and skill level, and problem-solve with them to help alleviate the stress of the situation. The nurse must also be aware of and make use of whatever resources are available in the community.

Allowing for and being open to existential-phenomenological and spiritual dimensions of caring and healing that cannot be fully explained through western medicine

The existential concept is based on the assumption that each person must find his or her own meaning to the problems of existence. A phenomenological orientation emphasizes understanding people from their own frame of reference. The spiritual dimension allows for the development of a higher degree of consciousness and inner strength (Watson, 1989). Spiritual and existential issues have certainly been cited in the literature. Millison (1995) reviewed the literature on spiritual care in hospice and found that many of the articles stressed the desire of the dying to find meaning and purpose in their lives. Cherny et al. (1994) articulated that a patient's ongoing physical and emotional distress as the days pass slowly until death may manifest itself in feelings of hopelessness and futility. The CPCA (1995) also identified spiritual issues as being important. They believe that spirituality is concerned with the transcendental, inspirational, and existential way a person lives his/her life and consider that organized religion may also be a part of an individual's spirituality.

Smith (1993) conducted a survey among directors of hospice programs asking them to describe what helped patients achieve a "healthy death" which was defined as "a death in which there were psychological benefits to the dying person and the dying person's family" (p.71). Of those achieving a healthy death, 79% made reference to the dying person's need for some form of religious-spiritual dialogue.

Attention to these needs within this last carative factor refers to the nurse attempting to truly understand and accept the patient's internal human predicament and then attempting through the transpersonal caring process to help the patient achieve inner peace

and harmony before death. The nurse must also recognize the unique needs of the family and use whatever resources are available to meet them.

Another aspect of respecting the individual's uniqueness would be to identify strategies that might enhance the patient's quality of life. Davies and Oberle (1990) identified finding meaning by focusing on living as one of the important dimensions of the supportive role of the palliative care nurse. They also state that, as the disease progresses, acknowledging death is important in finding meaning. The nurse must not avoid the topic of death, but rather allow the patient to talk about death or the remaining time left and attempt to help both the patient and the family come to terms with dying.

Meeting the spiritual needs of patients and their families is the final aspect of this carative factor. Most often, spiritual care is relegated to the clergy, but it does not mean that nurses cannot assist

in the process. O'Connor (1988) found that spiritual healing was promoted through presence, compassion, hopefulness, and the recognition that although life may no longer be productive, it remains nonetheless fruitful. She explained that these elements help to form an understanding partnership between the health professional and the incurable patient that helps prevent the patient from dying alone and the family from feeling alone.

From the above examples in the literature, it can be seen that implementing Watson's carative factors in palliative nursing is certainly appropriate and is congruent with the principles of the CPCA (1995). By using these factors, palliative community nurses will be able to more fully meet the needs of terminally ill patients and their families. The congruence between the needs cited in the literature and the needs that can be met through the implementation of the carative factors attests to the usefulness of Watson's theory in palliative care nursing.

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