I am a nurse

By Beth Perry

Abstract
The focus of this study was an exploration of the nature of exceptionally competent oncology nursing practice. Through a combination of data gathering approaches - conversation, observation and narrative exchange - the beliefs, actions and effects of the actions of eight exemplary nurse informants were studied. Analysis revealed three themes related to the actions of the exemplary nurses: Dialogue in silence, mutual touch and sharing the lighter side of life. Additional analysis led to a category called effects of nursing actions. Again, three themes were highlighted as effects: Affirmation of the nurse and patient, connecting and joint transcendence.

Introduction
I am delighted to share what I believe is a message of joy and hope and love and competence and challenge. It is all about becoming and being and continuing to be an exemplary cancer nurse.

Within most disciplines, there are those who are recognized by their colleagues as being exceptionally competent practitioners. These people are sometimes called "expert", "unsurprisingly competent" or "extraordinary". Their commonality is that they do their work in a remarkable way and their actions and interpersonal interactions are regarded as highly successful. I am certain that as I recount the results of my research, you will recognize your own approaches to caring for your patients. In a way, these stories are about all nurses; about you and your patients; about the exceptional nurses you already are, or are becoming.

Purpose and data gathering
The purpose of the research study was to explore the beliefs and actions of some of these exemplary oncology nurses. This investigation centred on the broad question: What is the nature of exceptionally competent nursing practice? The study participants, all clinical nurses who worked in a cancer facility, were chosen by peer nomination. I asked all the nurses on an oncology unit in a large hospital in western Canada - "Who are the nurses you work with whom you would want to have care for you or your family member if they had a diagnosis of cancer?" The nominations were received anonymously and the most frequently nominated nurses were invited to participate in the study. Altogether, eight nurses participated in the study. Data were gathered through observation, conversation and narrative exchange. In other words, I watched, talked with and exchanged stories of memorable practice moments with these nurses who were considered by our peers to be exceptional practitioners. Their narrative exchanges proved to be the most revealing channel of data gathering. I asked the nurses to write for me their stories of the patients they would always remember, patients who changed them or their practice in some way.

Data analysis
A combination of two qualitative research methodologies, hermeneutic phenomenology and grounded theory approaches to data analysis, were used. Grounded theory guided the conceptual analysis while hermeneutic phenomenology furnished the descriptive elements. In other words, grounded theory drew the lines for the picture of exemplary practice I will share with you, and hermeneutic analysis gave the picture colour.

The hermeneutic analysis took the form of poetic interpretations of the nurses' stories and of my observations. These poems provide a summary of the veiled meaning contained in the stories. In some ways, poems expose the tacit and communicate the emotion of the situation within the limitation of words. Poems are a bridge between verbal and non-verbal expression; they expose the tacit, that which is difficult to express otherwise. In other words, poems are the unsayable said.

The actions
Analysis revealed three themes related to the actions of the exceptionally competent nurses: "dialogue in silence", "mutual touch", and "sharing the lighter side of life". The reciprocal nature of each of these themes provides their primary commonality. These actions were not done to the other, they are shared experiences, done with another, nurse with patient, patient with nurse and in some cases, nurse with nurse.

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SECONDE ANNUALE HELENE HUDSON MEMORIAL LECTURE

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2e conférence annuelle à la mémoire de Helene Hudson

ABRÉGÉ
JE SUIS INFRMIÈRE

La présente étude vise l’exploration de la nature de la prestation de soins infirmiers d’une compétence exceptionnelle. La combinaison de méthodes de collecte de données - conversations, observations et échanges descriptifs - a permis d’étudier les croyances, les actions et les effets des actions des huit infirmières modèles interrogées. L’analyse a permis de dégager trois thèmes reliés à l’action des infirmières exemplaires soit le dialogue silencieux, le toucher mutuel et les échanges sur les aspects moins sérieux de la vie. Une analyse plus poussée a révélé l’existence d’une autre catégorie qu’on a intitulée "effets des interventions infirmières". Ici encore, on a mis en évidence trois thèmes au sein des effets: l’affirmation de l’infirmière et du patient, l’établissement d’un rapport et la transcendance mutuelle.

Helene Hudson
1945 - 1993

Dr. Beth Perry, right, following the Helene Hudson Memorial Lecture.

Beth Perry, RN, PhD, is a sessional lecturer in the department of educational policy studies at the University of Alberta where she is also pursuing post-doctoral studies.

CONJ: 6/1/96
doi:10.5737/11811912x61613

RCSIO: 6/1/96
Additional analysis led to a category called effects of nursing actions. Three themes were highlighted as effects: "affirmation of value of the nurse and patient", "connecting", and "joint transcendence". I begin by talking about the dialogue in silence.

The dialogue in silence

Silence: Pure, precise, and, in a sense, perfect. There is little written about it. Silence is seldom a direct focus of research because silence is difficult to observe, record and write about. Yet, silence emerged repeatedly as an approach used by the exceptionally competent nurses. They often used silence during emotional or difficult patient interactions. Beyond these more extraordinary times, silence also played an important part in their everyday nurse-patient encounters.

Most times these silences were rich in non-verbal communication. Messages that were difficult or even impossible to speak were sent from nurse to patient and patient to nurse in silence. When everything that needed to be said had been said, when cultural or language barriers inhibited spoken communication, when the patient was confused, when the news was bad, when there were no "right" words and when no words were necessary, silence was used.

There were many benefits or gifts that resulted from the silence. Specifically, patients received the gift of the nurse’s presence and the gift of being listened to with openness. Through providing these silent gifts the nurses also received, making this silent dialogue beneficial to both.

The following is a story that illustrates the power of silent dialogue in communicating across cultures:

One elderly fellow I will always remember. He was a hermit. He lived in the mountains. Every day he would get up at 4:30 a.m. He would find him up in the lounge just sitting and smiling. The first time I saw him there I said, "You're up. Why can't you sleep? Do you have pain? Would you like some warm milk? Shall I have the doctor order you a sleeping pill?" He just said politely, "No, no, no. I always get up early at home. You know, the birds sing their best songs in the morning." So I just let him go on with his agenda. What was I going to do, put him back to bed? He was 88 years old, and he had seen many early mornings.

I remember him because he was a man of many words. I just sat with him for a little while each morning. We both knew darn well there weren't any birds to hear, but we just sat there, listening. We didn't talk much. I thought, if I had been living alone those years I wouldn't have much to say either.

Reflective silence

Meet my silence with silence. Reflect your ways with your own.

See the me that I am,
not the me that you want me to be.
Sit with me
and let the silent notes of the birds’ songs
sing to us.

Sometimes there are no words available that will be the right words.

When this happens, the nurses in the study relied on silence. This story is an example of such a situation:

Code one, one. One. It was 02:00 hours and staffing was minimal. My heart was pounding, adrenaline pumping. It was my patient who had arrested.

Fortunately, the cardiac response was strong and the arrest was primarily respiratory. He was in stable condition within 45 minutes of the beginning of CPR. I would give him one-to-one nursing care for the remainder of the night.

The next day I went to see him, as I felt I should share with him some of my thoughts during the code. I told him that I was very frightened that we might have lost him and that I was glad that he responded so well. He revealed that he was very much aware of our actions during the code... Then he pulled out a very carefully folded letter he had written to his adult son. It contained instructions that he should not be resuscitated should this happen again.

Tears dripped slowly down his cheeks as he read it to me. I listened intently, for this was a very precious "sharing" gift to me. When he finished we enjoyed a few moments of quiet togetherness. No verbal response was needed.

Unspoken words

The most powerful words
in the human language
may be those
that are
never
said.

Still another story, written by the exceptional nurse I called Julie, illustrates the power of silent presence. From this story we can see that many times words are unnecessary and may even inhibit the sense of being truly present to one another. Here is the story.

My first encounter with Paul was on the phone. He had heard about palliative care but wanted to clarify a few things. I could hear young children playing happily in the background. I explained about symptom management, admission criteria, etc. I thought perhaps he had an ill parent. Who knows, maybe he was a reporter, a philanthropist, or maybe he wanted to volunteer? His questions were well-prepared and specific. The closest I could get to asking, "Why do you want to know this anyway?" without feeling I had intruded was saying, "We are here to help. Please feel free to call back if we can be of any further assistance."

Some weeks later a man named Paul was admitted to room 6. The door was always shut, his wife and his two children visited daily. He was waiting to die. He withdrew from everyone.

I could almost guarantee that when I was on duty he would be part of my assignment, as the other nurses sometimes find this kind of patient frustrating. It seems no matter what you give, nothing comes back.

Finally, one day in sheer desperation, I heard myself saying, "Paul, this is Julie your nurse. Yes, I'm your nurse again today. And I know this isn't fair but you're just going to have to put up with me. You see I am your nurse and you deserve just as much time as any of my other patients."

As the scenario evolved, I spent time with him. Sometimes I would read to him, mostly we would just be together in silence. It eventually got to be really peaceful, actually quite comfortable. In one way, Paul was still waiting for the promised miracle.

One day we did discuss the whole thing of miracles. Yes, there was a miracle there, it wasn't the one he had hoped for, but it was there nevertheless. We celebrated his daughter's fourth and son's first birthday on the unit. It was clear as the days passed that this little boy was his dad's miracle. The spitting image of his dad, he learned to walk in our long hallway. Both kids and dad would take over our Jacuzzi tub with mountains and mountains of bubbles. You see, that little boy was conceived after Paul's diagnosis and was born with the astrological sign of Cancer. The odds said that Paul should have never seen his child born, never mind walk, say "Daddy", or demonstrate his dad's incredible shyness.

Paul continued to be "my patient". The door was still closed most of the time and we still spent a lot of our time together without exchanging many words. But one day, I will never forget as long as I have the privilege of living. I opened his door, not knowing what I was going to encounter that day, to see him lying there with a single yellow rose in his hand and a card that said, "For Julie". We didn't say anything, we just hugged. I came out of that room and totally lost it. I don't usually hesitate to share tears with my patients, but for some reason, that day, I really lost it. The sheer intensity of that moment, even as I write it down, still makes me cry.
Mutual touch

The second theme I call mutual touch. Touch by its nature is reciprocal, it affects both the person initiating the touch and the person being touched. It is impossible to touch someone without also being touched yourself.

Eight types of touch were identified and described in this study. These categories build on earlier discussions of types of touch provided by other researchers. New categories of non-physical touch, trigger touch, talking touch, diagnostic touch, and the final touch were also described and defined in this study. I will give you examples of stories and poems that illustrate three of these - trigger touch, comforting touch and the final touch.

Trigger touch

The following story provides an example of a trigger touch, a touch that elicits the release of pent-up emotion in the person touched. One nurse, Moria, observed, "Anger, sadness or despair may come rushing out as a hand is laid on a shoulder or a hug says, 'I'm here for you, I care about you, you can trust me with yourself.'" Watson (1989) supports this observation, saying touch may release a person from self-absorption or suffering. Here's the story:

Her husband was only 30, dying a slow, painful death from stomach cancer. She was so strong, sitting by his bed all day, sleeping by his side at night, eating all of her meals next to him. The days stretched into weeks and still she stoically sat, asking the nurses and doctors for very little as she met most of her husband's physical and emotional needs. I wondered about her pain and I worried about her... I sought an opportunity to get inside, and finally one day it came. His supper tray was late, and she was pacing the halls awaiting its arrival. Her forehead was riven with strain and anger. I approached her slowly, silently, and when we were close in physical distance I touched her elbow and said, "It looks to me like you are sitting on the edge of tears. Can you share them?" In a guttural cry the weeks of frustration and anguish poured freely.

The imprint

Your touch,
a gentle brush across my cheek,
how can something
so light,
so soft,
so subtle,
leave such an indelible imprint
on our souls?

Comforting touch

Touching was a means used by these exemplary nurses to comfort their patients. As Benner (1984) tells us, "Nurses frequently use touch to provide comfort... Often, this human warmth contact is the only avenue of comfort and communication available" (p.63). Montagu (1986) agrees and explains that, "Taking almost anyone's hand under conditions of stress is likely to exert a soothing effect, and by reducing anxiety it gives both the receiver and the giver a feeling of greater security" (p.284).

One day on the nursing unit I watched a nurse giving this physical comfort and at the same time helping to restore control to a patient who was struggling to breathe. This is the field note that described the situation:

Even before we entered the room, I could hear the desperate gasps for air. As I laid my eyes on him I could see his struggle. Starved for oxygen, physiologically by his disease, and psychologically by his mind, he fought for every breath. I watched as the nurse walked to his side and took his hand. In a very soft, almost silent voice, she said to him over and over, "Take it easy, relax, take it slower." Her repetitive words were matched by repetitive strokes on his forehead. She was so calm herself, and as his eyes fixed on her, together they slowed his breathing down until the desperation left.

Repetitive touch

I move my hand over yours,
over and over and over.
I don't want to just say,
"I am here for you."
I want to say it very loudly.

The final touch

Many of the nurses in this study expressed the belief that the sense of touch of one is the last of the, perhaps the last to leave the dying person. Because of this belief, the exceptional nurses used touch, sometimes exclusively, in communicating with patients during their last days. When I asked her about her approach to caring for patients near death, one nurse, Julie, told me this story:

A young man was dying, in a coma and totally non-responsive. I called his mom and dad (they lived out of town) and they arrived just in time for their son's dying day. I encouraged them to help me with his care, to touch him and talk to him. I got them chairs and coffee, and checked on them often. When I cared for him myself, I reminded him of the presence of his family and I tried to set an example for them to follow. Near the end they were doing really well and I witnessed something I will never forget. His mom was washing his face, probably just like she had when he was a little boy. For just one short moment he opened his eyes. He hadn't done that for many days. I knew he saw her and she saw him. It was a wonderful moment, a last good-bye.

Sharing the lighter side of life

The third theme in the trilogy I called sharing the lighter side of life. A review of the data collected revealed that a light-hearted attitude was common among the exceptionally competent nurses. Despite tragic circumstances in their work lives, these nurses deliberately choose most times to see the positive and humorous side of situations. Importantly, they were able to share this orientation to life effectively and appropriately with their colleagues and patients. There were five different types or styles of humour used by the nurses: surprise, word play, black humour, situational humour and divergent humour.

The following is an example of one situation in which the nurse chose to see the situational humour in an encounter. The result - a strong bond was formed between the nurse, the patient and the patient's family.

I enjoy laughing with my patients, but one of my unforgettable moments began by being laughed at. The patient was newly admitted. He did not want to be here, he wanted to die at home. After all, he owned a funeral home and he knew about dying. He seemed to have a dozen children. They really didn't want him here either. The room was always packed with people, but it was not necessarily a friendly place to be. When I walked in, the hostility was thick, but my nametag said "nurse" and that gave me license to be there. Besides, the man was definitely end-stage and it would have been totally wrong for him to die without even having his blood pressure recorded! So in a feeble attempt to give him care, that's what I did. I took his pressure.

As my stethoscope was plugging my ears, I only picked up pieces of a conversation that was occurring in the room around me. "I don't think she could walk this far." "Maybe they have visiting hours." "She's old you know, and so fat." Having finally found his blood pressure and wanting to make a significant contribution to the overheard puzzle pieces, I very innocently said, "I couldn't help overhearing. If there is anything we can do to help with the visit we would be glad to. We have wheelchairs. Feel free to borrow one."

Whereupon the room was filled to overflowing with gales of laughter. Tissues that once held tears of sadness were now wiping away drops of hilarity. It turned out the elderly,
crippled, maiden aunt that I had envisioned was an old, arthritis, overweight English bulldog who probably wouldn’t have even fit in the wheelchair!!

Yes, the dog did visit. In fact, she monopolized the patient’s bed, by this time far outweighing her cachetic master. There were many more smiles and yes, many more tears, both happy and sad, but the bond created by the original faux pas remained strong.

Social climate change
Laughing together makes the social climate, summer or winter, ideal.

The exemplary nurses made a conscious decision to look on the bright side of life. One exceptional nurse, Marie, said, “When I was thinking of stories to write for you, I found that many of the most significant made me chuckle.” The following stories are examples of how Marie chose to see the humour in unusual and difficult patient encounters.

There was this male patient, he was in isolation for radiation therapy so no one could go into his room unless it was really necessary. Often, I would just stop by the door of his room to say, “Hi!” and see how he was doing.

On one visit he mentioned he was cold. I said I would try to get help, but that it was unlikely a repair man could go in to fix his radiator. He smiled and said, “Not a problem, I happen to be a repair man myself.” I jokingly said, “Do what you can,” and left.

The next time I walked by his room, I peeked in and he had the whole radiator panel off. Parts of the radiator were on the floor. I said, “What are you doing?” He answered, “No, it’s not a problem, I’ve got it under control.” What could I do? He was so happy, passing the time, his hands were covered in grease but he was safe and smiling. So I just said, “That’s great, but we won’t be able to pay you.” By the time he was discharged, it was all cleaned up, the room was warm, and until now it has been our secret.

This is another difficult situation Marie described to me as “humorous”. I was calling this “gentleman” patient for seven consecutive days at home. He was on a research protocol and as part of the procedure, I had to phone him and find out how he was doing with his medication and what his pain level was. He was just a really coarse sort of guy. You know, he had frayed edges. When I’d call he’d say, “How the hell do you think I am? I’m not taking this dumb stuff anymore.” When I’d ask about his pain level it would always be 10 out of 10.

One night when I had to call him I was not at the hospital, I was at the local fair and exhibition. The only phone I could find was in the Silver Slipper Saloon. Phoning him was the last thing I wanted to do. When I called, he characteristically said, “Where the hell are you, at the bar or something?” I said, “You’re right, I’m at a saloon.”

At the time he was shocked, but we laughed about it together even a day later. I heard that he died, but I was happy that I had this wonderful memory of him. It wasn’t tender. We were never close and we certainly never touched each other physically, but maybe I touched him with my “humour” and he did touch me with his.

Finally, this story is of a demanding moment the nurse described as “the kind that really challenges your funny bone”:

Sarah was a native woman from the reserve. She hadn’t been to the city many times and now she had to be hospitalized and was totally overwhelmed by the whole thing. She was my patient and she had to go for a cervical radiation implant. I had to get her ready to go. She didn’t know English, and I didn’t know Cree, but I did my best to demonstrate what would be happening to her. She finally understood that she had to take her clothes off and go to the procedure wearing just a hospital gown. I just smiled every time I went to her room. She was just a joy to me, no teeth, beaded moccasins, skin of feather… She had really lived the tee-pee life.

The vision I have is of me trying to coax this woman onto a stretcher to go for the procedure. Here I am, a white woman, coming into her room, demanding her clothes, trying to give her an injection in her buttocks… It was just against her whole tradition, her whole culture, it was just too much for her.

In a swift decisive move, Sarah jumped off the stretcher and ran in her mocassins slippers down the hall. Most of the staff were running after her. I was trying to stay calm, saying to myself, “You can handle this,” but another part of me was just so tickled by her spunk I was cheering, “Way to go Sarah!!”

Maintaining the attitude
When things are going well, it’s easy to keep the rhythm in your step, the enthusiasm in your face, and the shine in your eyes. But when life gets challenging, ordinary people lose it. You don’t.

The effects of nursing actions
Three themes related to the effects of nursing actions were also identified. These were: connecting, affirming the value of the patient and the nurse, and joint transcendence. These themes will be described and discussed using the exemplary nurses’ stories.

Connecting
Clayton, Murray, Horner and Green (1991) define connecting as “the transpersonal experiences and feelings that lead to the sense of connection, attachment, or bonding between a nurse and a patient” (p.155). This connection is a complex and important part of the phenomenon of exemplary nursing practice. As described by the nurses studied, the connection involves several components: 1) recognizing the similarities, 2) seeing the former illness patient, and 3) participating in the patient’s experience. I’ll talk for a moment about each of these.

Recognizing the similarities. Marie told me this story about a connection that occurred very naturally with one patient when they came to recognize that they had some things in common. Often this recognition, by both the nurse and the patient, that they have commonalities, is the first step in the establishment of a connection.

I remember Kenny because he called the hospital from his home up north and said he was never coming back to the hospital in the city again. He was a typical teenager, rebelled all the time, didn’t do the things he was asked to do; he was non-compliant through and through.

After some coaxing he did come back to see us for a treatment. I was his nurse. The only thing he really liked was fishing and I thought, “Bingo… I can relate to fishing.” I told him I liked to fish too and he said, “You like fishing?” with total disbelief in his voice. I said, “Yeah, I can get into it.” He tried some lingo on me about hooks and jigs and I passed. Then he said, “I’ve got something to show you.” It was a home video of ice fishing. The whole movie was of a hole in the ice. The odd thing he would say, “Did you see that?” Then he would rewind until we both saw the fish. That was our connection. On each visit I’d always start with, “How was the fishing?” There is always a connection possible. If it isn’t going to be with me, maybe another nurse can do it for that patient.

Seeing the former you
The nurses described the ability to envision the patients in their minds as the people they were before they became ill as an important prerequisite to, and part of, connecting.

In a sense, knowing about the pre-illness person facilitates establishing a nurse-patient connection. Jane commented: “It’s just easier somehow to connect with the patients if you have known them since their initial diagnosis, or at least if you see pictures of them from before they got sick. Then you have the total picture of that patient.” She went on to tell me this story:
I think the patient I will always remember is a woman named Heather. She was young, only 34, and she had flawless olive skin and waist-length, thick, black hair. Heather was one of the most physically beautiful people I had ever cared for. Her recent diagnosis meant that her chemotherapy treatments had only just begun. I was the nurse responsible for administering her chemo. She was being treated with a combination of drugs known to cause hair loss. I saw her often and we would share a lot. We became really close.

Heather had just been hospitalized for her second course of chemotherapy. When I asked her how she had been since her last treatment, she talked about some nausea and mentioned that her hair was starting to fall out. She was noticing many strands on her pillow every morning. As the days went by, the hair loss became greater until it got so that she could pull her hair out by handfuls.

The night I remember, she rang her bell and asked if I could help remove the remainder of her hair. I did. We sat together on her bed, with a green garbage bag between us, stuffing it full of her beautiful hair. I was speechless. In fact, I couldn’t believe what was happening. I felt so guilty having hair and being well.

When we were finished, we tied the bag closed. We sat together quietly for a while and then I looked right into her eyes, took both her hands and said, “Heather, I think you are still beautiful.” We cried and we comforted each other. We hugged for a while and then I took the bag and walked away.

The nurse who wrote this story, Jane, talked with me about the experience. She said, “It was the first time that I saw so vividly the physical transformation that a cancer patient undergoes. I realized intensely, that night, that the people we care for do have a past being, a being that was them before they got sick, and that is still there trapped inside that diseased body.”

When I asked her what she was trying to say to Heather that night, she gave me the comments that became the substance for this poem:

**Beauty**
You are a goddess,
a beauty in body and spirit.
No matter how this disease ravishes you,
a beauty you will always be.
The temporary and transient beauty
of your face,
your hair,
your body,
pale against the permanent beauty of
your soul.

The following is a story written by Maureen describing both the importance of seeing the former person, prior to becoming a patient, and the discovery of a common bond that facilitates connection.

The patient in room 18 was a 16-year-old girl with an astrocytoma. I knew she had been admitted many times before and had become a favorite of the staff, although I had never met her. I knocked on her door and entered the room. There in the bed lay a person. It was hard to know the age or even the sex of the body lying there staring at me with wide eyes. Her face was swollen, typical of the Cushingsoid syndrome that develops with prolonged steroid use. Her hair was sparse and patchy revealing her scalp. Her facial features drooped and her mouth sagged in one corner. Her body was swollen and her arm movements uncoordinated. There was evidence of anxiety in her eyes as she looked at my unfamiliar face.

I approached her, gently laying my hand on her arm, and said, “My name’s Maureen, I will be your nurse tonight.” Some incoherent noises came from her mouth as she acknowledged what I was saying. She pointed towards a list with words on it, showing me her name, Maureen. I nodded and said, “I know, your name is Maureen too. You know Maureens are the best people. We should have a great time tonight.” She grinned and pointed to a picture on her bedside table. The picture was of a beautiful young woman, with long, brown hair and a gorgeous smile. Maureen watched me, waiting for me to make the connection that this picture was of her.

I looked at her and smiled. “Is this a picture of you?” I asked. Tears filled her eyes as she nodded. Then I realized how important it was to her that I knew who she was before she got sick, and that she was still that person. She taught me something that night that I will never forget.

When I asked Maureen about this story she elaborated on the lesson she received that night saying, “I learned that to provide the very best care I need to know who that person was before becoming sick and to realize that person and their history is very important to the patient I am now caring for.”

Another nurse, Morsa, gave me the same message when she said, “You have to see past the smells, cachexia, crumpled, broken and misshapen bodies to see the former radiance.”

**Inside the pebble**

Every pebble,
no matter how chipped and broken,
potentially contains
a dusting of gold.

**Participating in the patient’s experience**
When I asked Mindy how she defined a "good day," she said, "I know I have had a good day when I make the connection with a patient, when I feel comfortable sitting on his bed or giving him a hug... when I am part of his experience." Many of the nurses’ stories describe times when they made this connection with their patients by participating in their experience through sharing their pain, suffering, joy or an intimate moment with them. The following is one of Marie’s examples of such an encounter:

"I want to tell you about one of my patients. William was a doctor himself; very ill, very upright, very much in need of control over his care. I had known him only vaguely in his previous role as a doctor on the unit, and now here he was, my patient. I was called to perform a difficult procedure on William and I remember purposely thinking, how can I handle this, how can I make a connection with him? Before I brought in all of my materials for the procedure, I went in and sat down with him. I told William my name and said, "You probably don’t remember me, but I do remember when you were a doctor here." I said that I really remembered him and that he stood out in my mind because he was so personable and that I was impressed by how he had treated the nurses and his patients. I would have never been able to tell him these things except for the situation. At that moment, he was in a more vulnerable position than I was. I just said what I felt, that I was really sorry that he had cancer. That time together was important. It made both of us feel at ease and I was able to do the procedure then without anxiety. When he came back for another treatment a week later, he asked for me. I was glad I had taken the time to make that personal bond. He talked to me about his plans, the things he could never do that he wanted to do. Even after he knew that he was going on with his disease and he stopped the treatments, he would always stop by and talk to me. I really miss him.

In this example, Marie participated in her patient’s experience by spending time with him, sharing “secrets” with him, and giving of her self. All of these, according to Davies and Oberle (1990), are part of sustaining the nurse-patient connection.

**Affirming the value of the patient**

The connection between patient and nurse is related to affirming the value of the patient. An underlying focus of the care given by the exemplary nurses is an acknowledgement of the patient as an important and worthy individual, as someone of value.
From the data, it appears that there are at least four major means by which nurses communicate to patients that they are valued. Specifically, nurses help the patients feel they will be remembered; they help the patients to create meaning out of their experience; they treat the patients with respect and help them maintain dignity; and they help the patients see their possibilities, to find hope.

Helping the patients feel they will be remembered
In an interview Julie said:

People can take almost anything, but they can’t take being forgotten. Anybody, if they have one wish, they want to be remembered. Every person wants to make some significant contribution. Sometimes it is part of my role to help them with this.

Julie then went on to tell me this story about helping her patient to be remembered by her young daughter:

A young mother of a three-year-old was facing her own death. She had brain metastases that were interfering with her cognitive and motor abilities and she was unable to complete the many handcraft projects she wanted to finish and bequeath to her child. The disease was progressing quickly, she was overcome more and more with fatigue and confusion. She asked me to finish a counted cross-stitch picture for her, but instead we packaged up the partially finished picture, thread and all, with a note that said: “My dear, dear child...when you want to, please finish this picture and it will be something you can say we did together...my hand will guide you. Love, Mom.”

Helping patients find meaning in their experience
In an interview Marie stated, “Probably the hardest question I am asked is, ‘Why me?’ and all the patients ask it in their own way, in their own time. What can I say? It’s really, really hard.”

What she was addressing is the role the nurses play in helping their patients create meaning out of their cancer experience. In a similar vein, Burke (1985) writes, “Each person strives to create meaning out of his existence in the world and attempts to gain freedom from crippling fear, anxiety and guilt” (p.95).

Some nurses suggested that when confronted with the possibility of death, the urgency of this search is accelerated. Simultaneously, due to the devastating nature of the disease, this quest becomes more difficult. As Lans said, “How can a person be expected to find meaning in suffering and death? How much more difficult can it get?”

Although the nurses acknowledged that it was a difficult task, they recognized their role in helping the patients with their search for meaning within the limits of their individual circumstances. Julie told me this story of a man she helped to find meaning in a life that had been devastated by more than cancer:

He was a tall, good-looking man. At his request, there was a “No Visitors” sign on his door. He drew pictures, he discussed world politics. He didn’t cry...he didn’t laugh. He watched. He gave single-word answers. His patient history report said he was an atheist. He had attempted suicide because he did not wish to put his wife through the excruciating process of slowly watching him die. He was admitted to prevent any subsequent suicide attempts.

I am good at making people feel comfortable. I enjoy helping them get rid of a lot of emotional garbage. I knew he needed to have his inner fears affirmed, to come to terms with the grief and the multitude of losses he was encountering. He needed at least to search for answers to the question “Why?”. I recognized his loneliness and his fear. How was I going to let him know I was there to help? The opportunity finally arrived one evening. He, all of a sudden, said, “Do you believe in God?” I answered carefully, not wanting to shut the doors. I said, “I really don’t know about God per se. But I do believe in angels.”

Regardless of my attempts, his part of the conversation quickly changed to the practical matters at hand. Like the size of his pajamas. However, with the passing weeks, we did discuss angels, a little bit about God, grief, anger, hate and how unfair this was.

He told me a lot about his life. He had been a young family man during the war, an army officer. One day he and his wife went for groceries leaving their two boys at home. While they were gone, their home was bombed. Their home and family were destroyed. As post-war refugees to Canada, his wife bore another son who died shortly after birth. In an attempt to gather some semblance of normality after all this heartache, they adopted an infant. This child was now in his mid 30s and mentally handicapped.

I think of him often. I was fortunate to be with him in his last moments. I held his hand. All I could do was stand there and hope that he was seeing his kids. I prayed, “Please, if there is a God, this man deserves to see his kids”.

I don’t know if it was just the side-effects of the narcotics or what, but when I said to him as he was dying, “Your sons are there,” he squeezed my hand. He really did. He squeezed my hand and died. And I sobbed.

Finding the meaning: The first step
You listened to me with openness.
Into your willing heart I poured my fears, my sadness, my guilt.
Now that I am free of these chains there is a chance I may find peace.

Treating patients with respect and helping them maintain dignity
Patient dignity was also maintained through nursing actions that helped the patients know that they were still important, that their lives still mattered. The following is an excerpt from a letter I wrote to one of the exceptional nurses documenting my observations of her in such a situation:

Dear Moria:

Today I watched in reverence as you cared for your patient. So gently you removed the mountain of bandages that covered what once was his back and buttocks. You respected his privacy by placing a tiny towel over his chest, the only part of his body that didn’t need to be exposed during the procedure. I was moved by this symbolic gesture. You respected him, he was more than a patient to you, he was someone you cared about. The odour, when you removed the dressings, was so bad I wanted to turn away, but you showed no sign that it bothered you at all. In fact, you moved closer, carrying on a cheerful conversation with him about his life, his work, his grandchildren.

In doing these things, you maintained the dignity of a man who probably had only a thread of it left.

Privacy in a very public space
Masterful creation of the illusion of privacy does wonders to protect the last remaining grains of pride and self-respect.

Helping patients find and maintain hope
By helping the patients find and maintain hope, the nurses caused the patients to feel they still mattered. Hope is a belief that something good lies ahead. It is not denying reality. Realistic hope can help the dying person face reality, while it also gives them strength to go on living. In another journal entry, I recorded an encounter where a dying man was helped to find the strength to continue hoping for what McHutchon (1987) calls “the miracle of care”:

A physician approached the nurse I was observing and asked her to come to take a look at Mr. Bill Selby. Entering the room, we find a man lying in bed, silent and staring at the wall. The doctor concludes that the patient is close to death, and that the diagnostic test scheduled for Mr. Selby that day should be cancelled.

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After the physician leaves, the nurse does her own assessment of the patient. She goes close to him and studies him very intently. Placing her hand on his forehead, she says, "Bill are you sad? Are you sad because today is your birthday?" She says in this pose for a few minutes, waiting for a response, a signal, a clue from the patient. I see nothing. She sees what she needs to see.

Leaving the room, the nurse walks up to the doctor and says, "I think you are wrong about Mr. Selby... He isn't dying yet. He's just down and he's depressed."

During the day as we visit Bill's room he becomes more and more responsive. The nurse talks to him about his life, asking him questions about his children and his birthday wishes. At first he doesn't say much, but eventually he begins to talk. Just before change of shift, the nurse gathers her colleagues together to help her surprise Bill with a cake. Together they sing the most rousing and sincere happy birthday song I have ever heard. The man who was supposedly taking his last breath cuts the cake and eats a piece with his tea which the nurse had carefully steered to his liking and served to him in a china cup.

In a final demonstration of caring, she places a birthday kiss on Bill's forehead, setting an example for the other nurses who follow her lead. As we leave the room and bid Bill a happy evening, I see the sparkle of life that has returned to those eyes. Bill has hope.

Infectious hope

Hope. It cannot be taught, or bought, but can it be caught?

Affirming the value of the nurse

As the patient is affirmed by the nurse's actions, the nurse is also affirmed. From the observations and the comments of the nurses, this seems to happen in two major ways. First, the nurses come to know that they are making a difference in the lives of their patients. Second, like the patients, the nurses also find meaning in their experiences.

Julie wrote this story about feeling like she made a difference in a patient's life with a very small but authentic gesture of caring. There's this time I was "out for coffee" (I don't even drink coffee) with the nurse of a former patient. Meeting again was difficult for her as she represented a very sad time in her life. I had shared the approach to and death of her husband. They had obviously shared a special, loving relationship. She wanted to talk with me again, but it was not without a flood of memories. While we drank our coffee, she described to me a moment that the three of us had shared, to which she had often returned during her bereavement. This is the moment.

One time on my perpetual medication rounds I entered her husband's room. I found her and her husband both asleep. He was lying on his bed. She had her head on his chest and had his fingers interlaced in her hair. It was a peaceful and loving sight. I could not interrupt, so I simply wrote them a note on the first scrap of paper I could find, a little yellow sticky. The note said, "Was here. Please call when you're awake. You looked so peaceful, just couldn't interrupt. Your Med. nurse."

Much to my surprise she had kept the note. She put it in her purse that day as we drank coffee. It was dog-eared and tattered, but she still had it. Her husband had a huge funeral. There were probably hundreds of Hallmark cards. It had been more than a year ago. She had travelled, she was doing well, but she had saved this little seemingly insignificant yellow sticky note. A reminder to me that the big things are so obvious, but it's the little things that really do make a difference. My little thing had made a big difference to her. I felt so good.

The miracle circle

Sometimes, when I think about the vastness and complexity of the world, I am overwhelmed. I feel so unimportant, so insignificant.

Then, I meet you, and with a small gesture, lovingly given, I make you feel valued.

The result is a miracle. When you feel important so do I.

It's so simple. It's so profound.

Joint transcendence

In writing about transcendence, O'Bannon and O'Connell (1970) suggest, "Transcendence changes things, the past, the present, and the future. Once transcendence occurs there is no retreating. It is more than the ordinary" (p.160).

Watson (1989) is more specific in her description of transcendence, placing her discussion within the context of the nurse-patient relationship. She says,

When both the care provider and the care receiver are co-participants in caring, the release can potentiate self-healing and harmony in both. The release can allow the one who is cared for to be the one who cares, through the reflection of the human condition that in turn nourishes the humanness of the care provider. In such connectedness they are both capable of transcending self, time and space. Neither stands above the other. (p.132)

In an earlier work, Watson (1985) writes about "transcendence" as well as "transpersonal caring", a situation in which "both the nurse and the patient are changed by the actual caring event" (p.58). I believe that through these exceptional nurse-patient associations something remarkable occurs for the nurse and also for the patient. This extraordinary happening is what I call joint transcendence. Again, I turn to a story to illustrate the power and the potential of such encounters.

Linda was just 19 years old and she had already lost her arm and shoulder to cancer. I was always amazed at how joyful and positive she was and thought, "This can't be real!" But it was. I learned that Linda had lost her support at home. She was really close to her sister and she had really strong religious convictions. I cared for her often over a period of about two years. Whenever we would have new patients with the same diagnosis as Linda, and she was around, she would offer to come and help me teach them about their disease. Using herself as a model, she would just whip off her shirt and show them her scars.

Towards the end, Linda met me in the hall and told me that the disease had spread and the doctors wanted her to try radiation therapy. I encouraged her to try the treatments; it was all I could do; she was only 19! But for her, taking the radiation was worse and she let me know it was. I was stunned. I just kept shaking my head and saying in disbelief, "You are not even going to try?" I felt upset because she wasn't fighting it. The nurse in me wanted to do something for her. I didn't want to lose her. It would have been easier for me to be more palliative with her if she had been in my age group, but she was only a teenager. When she saw I was falling apart, Linda took me aside, put her arm around me and said, "No Marie, it has just spread too much. I can't do this any longer. I'm O.K. I know I'm going to die, but I'm O.K. with that."

I was shattered.

A few weeks later, we had a call from the nurses in Linda's community. It's a couple of hours drive from here. They wanted to learn how to look after her at home so she could be with her family until the end. I asked to be the one to go to the community and teach the nurses what they needed to know.

Though I was eight months pregnant with my first child, I wanted to be the one to do something for her.
About 15 minutes into the teaching session with the nurses, Linda showed up. She wasn't well. She was thin and pale, but she looked at me and said, "Here I am Marie. I wanted to come today and be your model like I've always been." Then the class was over and she had to go. I wasn't coping very well with the goodbye because I knew it would be our last. Again she nurtured me. I will never forget what she said. She said, "Marie, it's O.K. In fact it's kind of exciting. Here you are off on a new journey of motherhood and I'm off on a journey of my own. We are both going to be just fine." I was so preoccupied driving home. It was true. I was off to become a mom. She was off to... I didn't know for sure to where, or to what, but she was.

Shared journey
Together, nurse and patient rise above the pain, suffering, and despair of cancer, to climb to the top of the mountain that has no summit. They take turns carrying one another. For they know that neither can get there alone. In their time together, they share through touch, silence, and light-heartedness. In their time together, they learn about themselves, their needs, their strengths, their limitations. But most of all they learn about their similarities. They both share a common fate of mortality, an understanding which makes the pleasures of life more intense. They both possess the potential for knowing joy, awe, and wonder. They both understand that though the physical body may be diseased, disfigured, distasteful, the spiritual body can be healthy, beautiful, and whole. Through the intimacy of their relationship they discover they are valued, they are worthwhile, that they can and do, make a difference. Each, in their own way, creates meaning out of their experience. As they reach higher and higher planes, the patient may leave to take up challenges elsewhere, while the nurse, having gathered strength from the journey is able to carry on.

These stories and observations of exemplary nursing practice from my study provide powerful illustrations of the value of nurses and contribute to a definition of nursing. I am certain that many of you recognized your own approaches to patient care in the examples I have given. Relax for just a few moments and think about some of the patients in your life whom you have carried and who have reciprocated by carrying you.

You are my nurse.
You are my nurse.
You ease my pain.
You bath my skin.
You make my bed.
You rub my back.
You meet my needs.
I heal you.

You are my nurse.
You feed me meals.
You give me rest.
You tend my wounds.
You sense my suffering.
You answer my questions.
I teach you.

You are my nurse.
You know my pain.
You know my loneliness.
You know my despair.
You know my joy.
You share my spirit.
I touch your soul.

And sometimes, for just a moment, I am you, and you are me, and we are one.

Together, we go beyond the limits of ordinary experience, to live the extraordinary.

References