

Bearing Witness for Nurses in Practice  
With Persons Living Their Dying

by

Coby Lynne Tschanz  
BN, University of Calgary, 1987

A Thesis Submitted in Partial Fulfillment of the  
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We accept this thesis as conforming  
to the required standard

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**ABSTRACT**

Framed within Parse's theory of human becoming, this descriptive, exploratory study addressed the research question: What is the meaning of the experience of bearing witness for nurses in practice with persons living their dying. Study themes in the language of the participants were *enduring commitment surfaces gifts and burdens*, *telling-not telling mingles with closeness-reserve*, and *fostering continuing competent practice*. Interpreted in the language of the researcher, study findings were written as *tenacious devotion engenders exquisite encumbrances*, *guarded intimacy*, and *fostering cherished confidence*. Study themes were linked primarily with theoretical concepts of valuing, connecting-separating, revealing-concealing, and transforming. Findings were discussed in light of relevant literature, and possibilities for nursing practice, education, policy, and further research were offered.

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## Chapter 1: Introducing and Backgrounding this Thesis

While the phrase *bearing witness* is associated with far-reaching, global events and human actions, it also surfaces for me intimate experiences of everyday nursing practice. Within the discipline of nursing, one theorist states that bearing witness is lived in being truly present with persons (Parse, 1998). Working within the framework of the human becoming school of thought (Parse, 1998), Cody (2001a) emphasizes that bearing witness “is one of the basic processes of human-to-human relating” (p. 97). He proposes:

The contemporary call to bear witness...is a call to listen to people, to be open to the reality of their lives, and to speak of their lives with a devoted fidelity to their experiences as described and experienced by the people themselves. (Cody, 2001b, p. 288)

Practicing as a nurse for over a dozen years in hospice palliative care, and despite my own somewhat hazy understanding of bearing witness, I claim to hear this call and wonder: Of what understandings and experiences related to bearing witness might other nurses tell? How are experiences of bearing witness important to other persons? Do persons bear witness in experiences of joy and celebration as well as in circumstances of suffering and sorrow? Is it possible to *not* bear witness? How might new understandings of experiences of bearing witness contribute to nursing theory and everyday nursing practice? How might nursing policies be influenced by new understandings of experiences of bearing witness? These and other questions are raised and explored throughout this research study.

Guided by a descriptive, exploratory methodology and within the framework of the theory of human becoming (Parse, 1981, 1992, 1998), this study focuses on the meaning of bearing witness for nurses in practice with persons living their dying. The goals of this qualitative study are to (a) offer new understandings of the human health experience of bearing witness; (b) discuss implications of this experience for nursing practice and education; (c) discuss implications of study findings for nursing policy and further research; and (d) contribute to the expansion of the theory of human becoming.

Chapter 1 of this thesis serves to explicate my process in evolving the focus and goals of this study.

*Backgrounding: Evolving a Proposal*

The focus on bearing witness as a phenomenon for study evolved within my interests in attending to accounts and stories of experiences within health care practice; endeavoring to discern and honor persons' preferences related to nursing practice; and exploring the usefulness of the theory of human becoming (Parse, 1981, 1992, 1998) as a guide for my practice. Study and contemplation within all of these areas of interest surfaced the intriguing possibility that nurses in practice can and do offer persons something other than a problem-solving process of assessing, planning, diagnosing, implementing, and evaluating. To illustrate, included below is a personal journal entry highlighting my evolving awareness of such possibility (Tschanz & Northrup, 2004).

JOURNAL ENTRY: It is not a comfortable experience to be with others in times of turmoil, uncertainty, and suffering. It is not easy to know what to 'do', when to leave or stay, how to 'be', or what people want or desire in the moment. Still, you'd think I'd get used to not knowing. After all, this seems to be a familiar experience in nursing practice. It's just that sometimes I also feel burdened and...sort of...distracted by thinking that I must know how (or am expected to know how) to, well, fix things: to make things 'normal' or 'all right'. Yet, I understand that I can't, and even, shouldn't 'fix things'. At some level I know there's something about this work that isn't about seeing problems and carrying out interventions, but is just as valuable to the people we meet.

I remember visiting a woman named Kate in her bedroom at her home. She was experiencing excruciating pain. Her husband and six-year-old daughter were there, too; both, it seemed, desperate to see some ease to suffering.

I didn't know time could pass so slowly. It took way, way too long before Kate claimed some measly relief from the subcutaneous medication I administered. Later on there was further delay when I had to call another nurse to find out how to use that particular continuous analgesic infusion pump, and I felt angry that Kate and her family had left it so late in calling for help. I thought maybe the whole thing could have been avoided or more promptly solved if they'd called earlier. Why all this suffering?

Most of the time I knelt on the carpet by Kate's bed, just hoping that things would ease for her. It was hard to see her body and face shift with pain. It was hard to

listen (and I'm not sure I really listened) to her tell of her anger in learning that she had cancer and that it had been detected too late. And, in the midst of her telling, I watched her direct the comings and goings of her daughter and husband.

I remember wondering: What was her life like for her now?

I remember what Kate said when her daughter pointed out the armoire full of bright and colorful hand knitted sweaters. Her daughter turned to ask, in a matter-of-fact manner, if she could have her mom's sweater collection after Kate died. Kate said, "Absolutely, you can have whichever ones you want." Her daughter skipped out of the room. Kate was pleased; her little girl asked boldly for what she wanted, and Kate had many sweater-gifts to offer.

I remember meeting Kate's eyes from the side of the bed, wondering, again, what was it like for her to be a mother now? What hopes did she have for her daughter, for herself?

Only a few weeks later, Kate's family attended her funeral service. They made a point to offer a thank you to me "for being there on that day when Kate was in so much pain". Yet, I remember feeling more despair than hope, thinking maybe they were being polite.

After all, I didn't do or solve much at all. Surely, it *was* my privilege to be able to respond to her family's call for help; it's just that the struggle with how to serve anyone in such circumstances was still so fresh. After all, Kate was dead, her family still suffering. What did Kate's family remember of our visit? Did anyone else know of Kate's pleasure, her moment of celebration in her daughter's request, or did they hold only memories of pain?

But, come to think of it, her family didn't say "thank you for leaving", they said "thank you for being there". So, what did they mean in saying "thank you for being there"? And how, in similar situations, can and should I 'be there' with others?

I wonder, if Kate was pleased to give her daughter her prized sweaters, what gifts, proffered in the name of nursing practice do people expect, desire, and value from nurses? I wonder, is bearing witness one such gift? (Tschanz & Northrup, 2004)

This story of practice contributes to the process of clarifying and explicating my choice of research topic in several ways. Specifically, it surfaces an awareness that in being present with persons there are times when I choose to attend closely to, as well as remember and recount, something of a particular situation encountered in everyday

practice. For me, those moments serve to expose questions about and possibilities for bearing witness in nursing practice. The story also brings me to ponder the value of attending to what persons have to say about their experiences within the nurse-person process. As such, the story provides a glimpse of some of the challenges in discerning and honoring persons' preferences in similar encounters. Further, the questions within the story illustrate something of the complexity of nursing practice, shedding light on the variety of possible goals and intentions in being present with others. Similar to examples offered by other nurses (Mitchell, 1990; Mitchell, Closson, Coulis, Flint, & Gray, 2000), the narrative also reveals my struggle with a changing practice, eliciting questions about how this change may be nurtured.

As demonstrated in the first part of this chapter, one aspect of the process of *backgrounding*, or making explicit the underpinnings and evolution of this thesis and research project, involves examining experiences of practice. In the next sections of this chapter, the focus and goals of my research are further clarified through an exploration of literature related to persons' preferences and nurses' expectations related to experiences of bearing witness and through tracing my choice of a nursing theoretical framework for this study.

#### *Clarifying Preferences and Expectations*

There was an interesting pattern revealed as I conducted a search of healthcare literature and other resources related to bearing witness. Specifically, there were many references to and illustrations of bearing witness (or perhaps other similar phenomena) in various circumstances, including those of persons living their dying (Albom, 1997; Barnard, Towers, Boston, & Lambrinidou, 2000; Callanan & Kelley, 1992; Childs, 2000; Haswell, 1998; Kuhl, 2002; McMartin, 2002; Owen, 2000; Remen, 2000; Robertson, 2000; Symansky, La Pointe, Osborne, & Curtis, 2003). Indeed, a growing interest in experiences of bearing witness seemed evident by the sheer volume and variety of accounts presented through various media. In addition to narrative, poetic, and visual accounts and illustrations, there were, within a variety of perspectives and disciplines, a number of scholarly sources offering philosophical and theoretical discussions about

bearing witness and related phenomena. However, relatively few of these references and illustrations reflected *research-based* material about bearing witness.

The dearth of formal study about the experience of bearing witness is relevant because it is often implied or explicitly stated that nurses (and most especially those working in areas such as hospice palliative care) routinely encounter or create opportunities to be present with persons and bear witness in pivotal life experiences (Borneman & Brown-Saltzman, 2001; Canadian Nurses Association [CNA], 2000; Charon & Montello, 2002; Cody, 2001a, 2001b; Drought, 2002; Howell, 1998; Krammer, Ring, Martinez, Jacobs, & Williams, 2001; McKinley, 2001; Storch, 2004; Tolle, Tilden, Rowenfield, & Hickman, 2000; White, Coyne, and Patel, 2001). For example, Cody (2001a) writes that bearing witness is “vital to caring for others and perhaps more vital than anything else one can do” (p. 295). Drought (2002) states, “in all of our work we bear witness to the experience of others” (p. 238). She emphasizes, “nurses are witnesses to the most profound and intimate human experiences, to the joys, sorrow, wonders and mysteries of life” (Drought, 2002, p. 238). Storch (2004) says, “among our responsibilities to the dying is the enhancement of their quality of life and the life of the community by bearing witness” (p. 277). If bearing witness is vital to caring and necessary for fulfilling professional responsibilities, then experiences of bearing witness appear to be of tremendous importance in nurse-person processes and thus for persons’ quality of life and health. Hence, I had anticipated that there would be an extensive collection of research material supporting and exploring the assertions of these and other authors.

Despite what might be presumed from the above statements about the importance of bearing witness and in light of a lack of formal research specific to experiences of bearing witness, it seems important to broadly identify what persons desire and value in nurse-person process. Consider, for example, that Barnard, Boston, et al. (2000) claim, “insufficient attention is paid to the voices, perceptions, and judgments of patients and families themselves” (p. 6). Indeed, there is growing awareness that it is quite common for health care workers to presume meaning for and preferences of other persons with

respect to living-dying, suffering, hope, and dignity. Increasingly, this practice of presuming is questioned by many scholars and practitioners (Borneman & Brown-Saltzman, 2001; Cody, 2001a; Enes, 2003; Gregory & English, 1994; Groves & Klausner, 2005; McKinley, 2001; Nekolaichuk & Bruera, 1998; Parse, 1994; Street, 2001; Wang, 2000; Yedidia & MacGregor, 2001). Significantly, in a study inviting persons to tell of their experiences of receiving care in palliative inpatient settings, McKinley emphasizes that “only people who are living with all that it means to be dying...can state what is of value to them” (p. 27).

Valued aspects of persons’ experiences with health caregivers are revealed in several studies undertaken with various populations of health care practitioners and with persons living their dying and with their families. In one such study, Kuhl (2002), a hospice palliative care physician and researcher, conducted a study with persons guided by the question: “What is the lived experience of knowing you have a terminal illness?” Of particular interest to me are Kuhl’s reflections in which he identified that his adult coparticipants:

*longed* [my italics] for others to know about them: the difficulties they experienced in being taken seriously by doctors and other health care providers; the uncomfortable memories that surfaced during the last period of their lives and the truths that had never been spoken; their legacy in terms of children, work, students; and their sense that spiritual strength was increasing as their physical body weakened. (p. xxvii-xxviii)

While this is an especially evocative expression of persons’ preferences (and experiences), other authors, representing various disciplines and perspectives, convey similar wishes from persons and their family members. For example, Rasmussen, Jansson, and Norberg (2000) write that persons valued nurses’ “willingness” to “know the patient as a person” (p. 32). Other research emphasizes the importance of taking into account personal contexts, reporting that family members appreciated professional caregivers who understood the uniqueness of persons’ “lives, values, and preferences” (Steinhauser, Clipp, McNeilly, Christakis, McIntyre, & Tulsky, 2000, p. 828). McKinley (2001) interpreted her findings as showing how the quality of human-to-human processes in *working towards* health goals can be even more important to persons than *achieving*

planned outcomes. Excerpts from McKinley's interviews described how study participants valued being with caregivers who demonstrated recognition for persons as unique beings capable of making personal decisions and continuing to experience various aspects of living including fear, sadness, and humor.

I suggest that the findings of these studies demonstrate how persons are profoundly aware of the actions and intentions of caregivers. Further, although most authors of the studies did not refer specifically to experiences of bearing witness, findings resonate with aspects of Cody's (2001b) explication of this phenomenon. To me, this seems particularly evident with respect to the "call to listen" (Cody, p. 288), to attend without judgment, and to work with respect for and seek to convey to others the unique, complex being and experiencing of persons served in nursing practice. Insights offered within these studies surfaced personal memories of experiences of nursing practice in which persons and families described interactions with nurses as significantly influencing health and quality of life. As such, persons conveyed something of their preferences within the nurse-person process. Specifically, they valued close attention to personal experiences, beliefs, and preferences; recognition of the uniqueness of all persons; and acknowledgment of the import of specific situations for and choices made by persons. Upon reflection, these preferences seem somewhat obvious. Yet, as illustrated in the journal account of the visit with Kate and her family, nurses—myself included—are sometimes uncertain about what is valued by others. Similarly, according to both personal experience and the literature, nurses do not necessarily view themselves as capable of or comfortable in being present and bearing witness with others.

A brief survey of the literature reveals an extensive array of factors influencing the nurse-person process in hospice palliative care and other settings (Barnard, Towers, Boston, & Lambrinidou, 2000; Bernardo, 1998; College of Registered Nurses of British Columbia [CRNBC], 2005a; Drought, 2002; Dunniece & Slevin, 2000, 2002; Eifried, 2003; Haberman, Germino, Maliski, Stafford-Fox, & Rice, 1994; Hewa & Hetherington, 1990; Kristjanson, McPhee, Pickstock, Wilson, Oldham, & Martin, 2001; Meraviglia, McGuire, & Chelsey, 2003; Stanley, 2002; White, Coyne, & Patel, 2001). Factors include, but are not limited to challenges related to the education, preparation, and

support of health care professionals (Dunniece & Slevin, 2000, 2002; Eifried; Meraviglia, McGuire, & Chelsey; White, Coyne, & Patel). Hewa and Hetherington suggest that “members of the nursing profession are trapped between competing paradigms” (p. 183), and require a new paradigm that is more congruent with their values rather than with those underpinning a mechanistic approach. Kristjanson, et al. discuss limitations in interrelationships attributed to accepted methods of disclosure about prognosis and diagnosis. They also explore challenges in the nurse-person process related to discrepancies among persons, family members, and staff with respect to expectations of and for professional health care. Several authors (Bernardo; Dunniece & Slevin, 2000, 2002; Stanley) cite challenges associated with scheduling, physical space, staffing, and technology. A CRNBC (2005a) document cautions that inherent power imbalances exist, and nurses must be diligent in maintaining boundaries and protecting vulnerable clients. These and other aspects of practice, interrelationship, and organizational structure may be seen as potentially or actually diminishing nurses’ opportunities for and abilities in being present with persons in ways that enhance quality of life and health.

Thus, the relevance for bearing witness as a topic for study is demonstrated through personal reflection; in statements linking bearing witness with expectations for nursing practice; in findings about preferences for nurse-person process; in challenges for nurses in being present with others; and in the dearth of formal research about the experience of bearing witness. Further, I suggest that the extensive list that cites challenges associated with nurse-person processes highlights the importance of perseverance and creativity in finding ways of practicing with respect for persons’ preferences and in supporting nurses in this practice.

#### *Shifting Perspective*

Several of the articles mentioned in the preceding section offer a variety of ideas and recommendations for addressing challenges associated with nursing practice. Congruent with conventional and therapeutic aims of practice, many of the articles focus on finding solutions and incorporating *problem-focused*, *interventionist* approaches in and for practice. Yet, additional insights are revealed through a close examination of familiar ways of being present with persons and upon consideration of other possibilities for goals

and intentions in nursing practice. Specifically, if experiences of bearing witness are presented as having to do with being present with persons in ways that view human experiences as unique to the person rather than predictable to others, in knowing people as persons rather than diseases or objects, and in focusing on processes rather than outcomes, then understandings of experiences of bearing witness might be expanded through study within *non-interventionist* theoretical perspectives and frameworks. In other words, further study, theory, policy, and practice related to bearing witness may be enhanced through a shift from viewing human experiences as problematic and predictable and toward viewing human experiences as unique and personal.

Before exploring the implications of this shift with respect to nursing research and policy, and prior to specifying and outlining a theoretical perspective supporting a shift in perspective, I revisit Kuhl's (2002) work. Although his work is not specific to nursing practice or conducted within a nursing theoretical framework, it offers insights into a subtle shift of purpose experienced in and associated with some experiences of bearing witness. In addition, further consideration of Kuhl's work contributes to my process of choosing a theoretical perspective for this study.

Continued exploration of Kuhl's (2002) work revealed for me how his practice in research seemed to evolve to encompass profoundly different ways of and purposes in being present with persons. Specifically, I interpret that through abiding with the desires of persons in his study and attending to accounts of their experiences, Kuhl learned to be present with his coresearchers in a new way. It seems to me that Kuhl chose to transform his way of being present with others when he understood how a traditional, problem-solving perspective shaped his ability to hear about others' personal experiences. A problem-solving approach supported a goal to judge and anticipate the actions and experiences of his coresearchers. In other words, it supported a goal to *intervene* for the purposes of interpreting, predicting, and influencing experiences of living and dying so that those experiences reflected normative models and trajectories of living and dying. By contrast, a change of view supported a new, *non-interventionist* intention, whereby Kuhl sought to listen for the unique account of experiences as offered by each person. Kuhl's

new view and goal brought him to listen in new ways, helping him to shift his perspective as a qualitative researcher so that he came to understand that “it was (his) job to listen, to bear witness” (p. 41).

Although Kuhl (2002) did not explicitly define what he meant by the term *bearing witness*, he wrote, “the set of skills I needed to bear witness was very different from the skill set” (p. xx) used in detecting and diagnosing disease. Considering Kuhl’s statement, it was not clear to me how or, even, if bearing witness encompasses a set of skills, he spoke further of learning to listen “to what people were saying rather than...for the information [he] wanted to hear” (p. xix). He told of “suspending judgment”, of “hearing testimony”, of “taking seriously” what another had to say, of “believing” the story as it was told, and of working “with every ounce of [his] being to understand” (p. 41). Significantly, Kuhl’s coresearchers conveyed their deep appreciation for his new understanding and for a different, non-interventionist intention in being present with them. Further, they expressed the hope that their contributions in research would influence the everyday practices of other health care workers.

Thus, it is exciting for me to consider how, as Kuhl (2002) shows, experiences of conducting research and of bearing witness hold considerable impetus and vision for different ways of being with persons in practice. Interestingly, Parse’s (1981, 1992, 1998) theory of nursing, first published over 20 years ago, emphasizes the value for nurses in being present and bearing witness with persons, rather than focusing primarily on assessing and intervening or completing tasks and procedures. Considering my hope to enhance understanding of experiences of bearing witness and live new ways of being present with others, I anticipate the potential for considerable change in my nursing practice. Still, I wonder, how might such change be further evolved and supported?

#### *Nursing Theory-Guided Practice*

Personal reflections, Kuhl’s (2002) accounts of his experiences in research, and nurse authors’ discussions about options for ways of being in nurse-person interrelationship reveal how beliefs and values significantly influence practice (Borneman & Brown-Saltzman, 2001; Bournes, 2002; Lee & Pilkington, 1999; Mitchell, 1990; Mitchell, Closson, Coulis, Flint, & Gray, 2000; Northrup & Molzahn, 2003; Northrup &

Cody, 2001; Parse, 1981, 1992, 1998; Pilkington, 1999; Stanley & Meghani, 2001). Consider, for example, how Kuhl's statements in the introduction to his research reflect his new understandings about people and life experiences:

"Alice, like others before her and many since, taught me that dying is more than just a physical event. It is a process that includes one's whole being" (p. xvii)

"The most important thing I know now that I didn't know then is this: *People who are dying are still living*" (p. xxiii).

Such statements can be seen to show how evolving beliefs shaped Kuhl's decision to change his way of being present with the participants in the study. In other words, it seems to me that different ways of *seeing* persons reveal and bring about different ways of *being* present with persons. This point is illustrated in another personal journal entry which shows that evolving understandings and values about persons can foster an awareness of different possibilities for nursing practice.

JOURNAL ENTRY: Have been reading Kuhl's (2002) book. Again. It seems that goals and intentions in health care practice (as in research) can indeed focus on meaning and experience rather than things like identification of problems, abnormalities, and risk factors; implementation of interventions; and resolution of issues. I find myself shifting from talking/writing about *goals* and *purposes* to talking/writing about *intentions* in nursing practice. According to the thesaurus, these words can be used interchangeably. Still, for me, the word *intention* speaks to how what I do or focus on is rooted in my assumptions. Goals and purposes seem less focused on human processes and interrelationships and more on interventions and end-points. I want to focus on exploring assumptions and process at the moment.

Frankly, I am feeling a growing sense of dissonance with interventionist approaches, as with Kate where I struggled with living out expectations focused on "fixing things". (I remember once going to a visit where a family member said: "I'm so glad you're here. The other nurse said you'd fix things." Well, I didn't fix things.) Through my experiences with Kate and others, I have more clarity about personal beliefs (and how values and beliefs are important) about humans and my intentions in nursing practice. Specifically, in thinking about remembering and recounting something of that experience, I see that my growing sense of commitment toward and understanding of the value of remembering and recounting experiences isn't dictated by any job description or work-related protocol (although it might be facilitated and constrained by such policies!).

Rather, it seems to have something to do with new or different or clearer personal beliefs about the importance of recognizing Kate's humanity and being; about working with respect for her questions, challenges, and preferences; and about not aiming or intending to change anything about her decisions and experiences in life, death, and dying.

I turn now to one nurse's (Mitchell, 1990) account of a struggle to shift her way of being present with others in practice. She writes that change (and possibilities for change) in practice with persons evolves with and through new understandings, is lived in new values and beliefs, and is supported by particular choices of guiding theory. Similar to my experience, she tells of new understandings about persons and health and a growing discomfort with nursing practice guided by theories and models focusing on problems, not on "lived experiences of human beings" (Mitchell, p. 171). All of these factors contribute to her choice of the theory of human becoming (Parse, 1981, 1992, 1998), a non-interventionist theory congruent with her beliefs, as a guide for nursing practice.

My assumption is that nursing theory does provide guidance for and insights into ways of being in nursing practice. This is indeed a purpose of theories of nursing and a view well documented in the literature (Alligood & Choi, 1998; Cody, 1994; Frederickson, Williams, Mitchell, Bernardo, Bournes, & Smith, 1997; Parker, 2001; Parse, Coyne, & Smith, 1985; Visintainer, 1986; Wills, 2001). Further, in a recent hospice palliative nursing care text, Wills states specifically that theories of nursing "can guide nurses in ways of caring for dying clients and grieving family members" (p. 30). I interpret this to mean that nursing theory provides direction and support for practice in situations where nurses strive to be present with persons who are living their dying and in moments when nurses are called to bear witness in human health experiences. Thus, shifting from a tradition of presuming problems and seeking solutions, and struggling to evolve a different nursing practice, I attend to the insights of Mitchell (1990) and, likewise, choose to consider Parse's (1981, 1992, 1998) theory of human becoming as a guide for nursing practice.

As illustrated in the next journal entry, study and dialogue with professors and students in graduate school foster for me a growing understanding of how the theory of

human becoming offered new perspectives about humans and health, and offered a language through which to explore new possibilities for nursing practice and research.

JOURNAL ENTRY: Barks' (1991) version of Rumi's poem entitled *Love for Certain Work* reads, "Each has been given a strong desire for certain work. A love for those motions, and all motion is love" (p. 17). That "certain work", for me, is nursing practice with people living their dying. And, I think the human becoming school of thought offers a fresh, non-interventionist perspective in which to explore and evolve understanding and practice of this work.

Recently, a professor at the school of nursing asked why, out of all possible theories of nursing, I was particularly interested in the theory of human becoming. Instead of offering my prepared response (ok, my semi-prepared response), I claimed: "The theory sounds, well, it *is* like poetry to me". I think we were both surprised by that answer.

After all, theory is science. As with any science, the language of Parse's theory can seem difficult, and the concepts and principles are not necessarily easy to understand. Again, as with other sciences, it takes a fair deal of study, reflection, and practice (never mind perseverance) to become comfortable with using new language and to understand the implications of unique conceptualizations in theory and practice. For me, the poetry in the human becoming perspective is in the ontological underpinnings of the theory, in Parse's use of language, and in her attention to and appreciation for rhythm, paradox, ambiguity, possibility, and mystery.

Oddly enough, a few days after meeting with the professor, I re-read an article in which a nurse scholar referred to theory as "the poetry of science" (Levine, 1995, p. 14). Sweet! Levine's words surfaced a new awareness of both theory and poetry as modes of representing and inviting innovative understandings of human experiences.

The theory of human becoming serves several purposes related to nursing practice and to the goals of this research study. As suggested above, the theoretical framework introduces new possibilities for nurses envisioning, exploring, articulating, and living non-interventionist intentions in being present and bearing witness with persons in research and practice settings. Since, in the words of Cody (2001a), bearing witness can be considered a "basic process of human-to-human relating" (p. 97), I anticipate that new insights about the experience of bearing witness will enhance possibilities for being present with persons in nursing practice. As introduced later in this chapter, the theory of

human becoming also provides a lens through which to examine and evolve policy related to nursing practice (McLeod & Spee, 2003). In addition, the theory offers a framework in which to conduct research, advancing nursing science about the experience of bearing witness and contributing to the expansion of the theory of human becoming. A discussion about my choice of nursing theoretical framework in research and a summary of the context and substance of the theory is presented next.

### *Nursing Research*

Levine (1995) remarks there is a “rich reservoir” (p. 13) of knowledge about human life offered within the sciences of many different disciplines. Congruent with its existence and evolution as a scientific discipline, nursing makes distinct contributions to this reservoir. Further, it is the responsibility of members of the discipline of nursing to contribute to ongoing discussion and advancement of nursing science (Barrett, 2002; Cody, 1997; Donaldson & Crowley, 1978; Fawcett, 1999; Nagle, 1999; Northrup & Molzahn, 2003; Northrup, Tschanz, Olynyk, Schick Makaroff, Szabo, & Biasio, 2004; Schlotfeldt, 1989; Schoenhofer, 1993; Visintainer, 1986). Indeed, Nagle suggests that a commitment to articulate and expand nursing science is a matter of disciplinary “extinction or distinction” (p. 71). Nagle and the above authors emphasize that the scope of nursing as a discipline is neither distinguished nor sustained if defined exclusively by a list of designated tasks or the application or advancement of the science of other disciplines. Rather, to preserve nursing’s status as a discipline, and as a profession that offers quality health care service, nurse scholars and practitioners must continue to contribute unique knowledge and evolve a flourishing scientific base that supports nurses in practice. In the interest of contributing to nursing’s scientific reservoir, I choose to frame this study within a nursing theoretical perspective, specifically the theory of human becoming (Parse, 1981, 1992, 1998).

All nursing theoretical perspectives articulate specific views with respect to the phenomena of concern to nursing. Such views evolve and direct actions and approaches within nursing practice and research (Cody, 1995a; Donaldson & Crowley, 1978; Northrup & Molzahn, 2003). Within nursing, these views and approaches may be organized and examined in various ways (Fawcett, 1993; Monti & Tingen, 1999;

Newman, 1992; Parse, 1987; Parse, Coyne, & Smith, 1985). Parse (1987) and others (Parse, Coyne, & Smith, 1985) identified and conceptualized two categories including the totality and the simultaneity paradigms. Situated within the simultaneity paradigm, the theory of human becoming (Parse, 1981, 1992, 1998) arises from and evolves within non-empiricist views of humans and health, and guides nurses in non-interventionist nursing practices. The context of this theoretical framework, and hence of this study, is established in the following discussion that specifies each paradigm's philosophical underpinnings and associated assumptions related to practice and research.

Theories of nursing situated within the totality paradigm are congruent with empiricist philosophy underpinning the natural sciences (Northrup & Molzahn, 2003). As such, persons are conceptualized as whole, meaning composite, bio-pyscho-social-spiritual beings subject to the influences of an external environment or system (Barrett, 2002; Cody, 1995a; Fawcett, 1993; Parse, 1987). Health is a "dynamic state and process" (Cody, p. 145) judged against norms and determined by a sense of well being primarily associated with resolution of disease or alleviation of symptoms. These assumptions are articulated through totality paradigm theories such as the Roy adaptation model (Roy & Zhan, 2001) and the self-care deficit nursing theory (Orem, 2001). Nursing goals are specific to each theory, but generally focus on prescriptive and problem-solving activities. Mirroring medical practice, activities of assessing, diagnosing, planning, implementing and evaluating are cited frequently as processes of nursing practice. As such, aspects of a person and his or her life, environment, and health are viewed as measurable and are able to be manipulated by health care workers. Workers are viewed as experts striving to predict, control, or otherwise manage life events and experiences. Consistent with such understandings of humans and health, research within the totality paradigm seeks to identify causal relationships among variables. This focus is congruent with empiricist, natural science approaches (Barrett; Cody; Fawcett; Northrup & Molzahn; Parse).

Within the simultaneity paradigm, understandings about humans and health and approaches in practice and research are distinctly different. Theories within this paradigm are congruent with non-empiricist philosophical assumptions, "influenced heavily by existential phenomenology" (Northrup & Molzahn, 2003, p. 74). Persons are not viewed as particulate, but are irreducible beings in mutual process with universe. As such, the

human-health-universe process is inseparable and embedded in mystery (Giorgi, 1992; Malinski, 2002; Northrup & Molzahn; Parse, 1981, 1987; Parse, Coyne, & Smith, 1985). Persons are conceptualized as intentional and freely choosing, thus knowledgeable about their own health and able to make and bear responsibility for personal health choices (Cody, 2000; Northrup & Molzahn; Parse, 1987; Parse, Coyne, & Smith). Health is for each person, “a process of becoming and evolving; it *cannot* be objectively assessed and is not delineated by norms or...qualifiers” (Cody, 1995a, p. 145). Human health experiences are uniquely cocreated and lived, holding unique meanings for each person. Change is viewed as non-causal, thus it is not possible to generalize or predict meaning and experience from one person to another (Giorgi; Parse, 1998).

Some of the theories situated within the simultaneity paradigm include health as expanding consciousness (Newman, 1997) and the theory of human becoming (Parse, 1981, 1992, 1998). As with theories within the totality paradigm, specific practice goals and methodologies arise within each theory. Generally, goals of nursing practice “are oriented toward quality of life and evolving patterns of living for the person and family” (Cody, 1995a, p. 145). Reflecting the ontology and epistemology of the simultaneity paradigm, research goals and methodologies are congruent with the human science traditions. (Differences between and implications associated with human or non-empirical and natural or empirical science research traditions are discussed further in chapter 3). Briefly, research within the simultaneity world view focuses on enhancing understanding of personal meaning and human lived experience (Giorgi, 1992; Malinski, 2002; Mitchell & Cody, 1992; Parse, 1998). It is within nursing’s simultaneity paradigm, underpinned by non-empiricist views, that my research study is situated and framed.

### *Theoretical Perspective*

Drawing from the works of Rogers, Heidegger, Sartre, and Merleau-Ponty, Parse (1981) offered an original work entitled *Man-Living-Health: A Theory of Nursing*. Throughout the theory, gerund forms of verbs are utilized “to make explicit the process orientation of the theory” (Parse, 1992, p. 37), and Parse continues to evolve the language and content of the theory of human becoming in response to the emergence of new meaning, understanding, and science. Changed in 1992, the title *The Theory of Human*

*Becoming* reflected adjustments in dictionary definitions of the term *man*. Currently encompassing practice and research methodologies, and in light of the existence of a community of scholars committed to further study and evolution of the theory, there now exists the human becoming school of thought (Parse, 1998). These and other changes and aspects of the theory are in keeping with the epistemology of human science in the simultaneity paradigm (Parse, 1997).

Conceptualizations of humans, universe, and health within the human becoming school of thought (Parse, 1998) are congruent with the simultaneity paradigm and non-empirical views. Specifically, re-conceptualization of these phenomena as the human-universe-health process, or *human becoming*, reflects the inseparable nature of this construct (Parse, 1992). Northrup and Molzahn (2003) clarify, “the term human becoming establishes the human, the universe, and health as an irreducible... multidimensional phenomenon that is manifested in ever-changing patterns of value priorities that influence one’s life as lived” (p. 88). In earlier resources, Parse (1981, 1992, 1998) described human beings as unitary and different from the sum of parts. Seeking to clarify the ontology of human becoming, Parse (2004) refined her description of the human-health-universe process as “indivisible, unpredictable, and everchanging” (p. 1). The notion of health within the theory of human becoming is viewed as “a personal commitment” (Parse, 1990, p. 136). As such, health is defined by the person for him or herself and lived through value choices. In this way, personal health experiences cannot be defined, measured, or altered through the judgments, choices, and actions of others. The philosophical underpinnings articulating this view of the human-universe-health process were originally synthesized and articulated by Parse in nine foundational philosophical assumptions (see Appendix A). Congruent with the evolution of this theory of nursing and serving to eliminate repetition, the nine statements were refined into three philosophical assumptions (Parse, 1992) listed in Table 1.

Table 1

*Assumptions About Human Becoming*

- human becoming is freely choosing personal meaning in situations in the intersubjective process of relating value priorities.
- human becoming is cocreating rhythmical patterns of relating in open interchange with the universe.
- human becoming is cotranscending multidimensionally with the unfolding possibilities. (Parse, 1992, p. 38)

Emerging from the philosophical assumptions are three major themes: meaning, rhythmicity, and transcendence. At a theoretical level of discourse, each theme leads to the statement of a principle; the three principles comprise the theory of human becoming. The meaning of each theme and principle is articulated through a combination of three concepts (Parse, 1981). Although the principles of the theory are presented in a linear fashion for ease of discussion and study, they are considered to be neither separate nor sequential. Explanations and illustrations of each principle and associated concepts are offered below.

Arising from the theme of meaning, principle one states: "Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging" (Parse, 1998, p. 35). Meaning "refers to ultimate meaning or purpose in life and the meaning moments of everyday life" (Parse, 1998, p. 29). Cody (1994) emphasizes meaning in this view is not abstract, but intersubjective and inexhaustible, continuously evolving "in the interplay of the familiar and unfamiliar" (p. 48). Thus, in a process of evolving diversity, persons cocreate their realities through choices made in various ways and dimensions (Parse, 1999b). Although cocreated, each person evolves, conveys, and experiences meanings uniquely. Meaning is continuously shaped and reshaped through imaging, valuing, and languaging (Parse, 1999a).

Parse (1992) explains that imaging is akin to picturing and “refers to knowing” (p. 37). Knowing emerges within each person’s unique frame of reference as he or she coconstructs meaning and reality. This is a process of interpretation that is paradoxically tacit-explicit and pre-reflective-reflective (Parse, 1998). Explicit knowing is “articulated logically and reflected on critically” (Parse, 1998, p. 36), whereas tacit knowing is pre-reflective, being somewhat “vague...and hidden” (Parse, 1998, p. 36). New images surface in life experiences and in turn give rise to fresh possibilities and value priorities (Parse, 1981, 1992). In valuing, persons determine for themselves the significance of something, thus confirming-not-confirming various personal, “cherished beliefs” (Parse, 1999b, p. 37). Chosen, valued beliefs form “a matrix of principles and ideas” (Parse, 1998, p. 38) that frame and guide a person’s way of viewing and living the human-universe process. The languaging of whatever or whomever is valued occurs through myriad symbols as well as mutual processes of expression such as speaking-being silent and moving-being still (Parse, 1998).

For example, in considering available options with respect to care when death appears to be imminent, a person may picture possible alternatives and preferences of health care approaches and venues through engaging in meditation, visiting alternative care settings, and researching community resources. In imaging, the person may question and contemplate values and beliefs, cocreating new meanings with respect to experiences such as dignity, safety, and comfort. In languaging choices, a person might engage in discussions with caregivers, develop written directives and plans, submit applications to specific community services, and/or defer exploration and decisions to others or another time. Valuing surfaces as a person chooses and lives what is important to him or her.

Referring to the theme of rhythmicity, principle two states: “Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing, enabling-limiting while connecting-separating” (Parse, 1998, p. 42). Rhythmicity refers to an inherent cadence or “timing and flow” (Parse, 1998, p. 43) of human-universe patterns of relating. Human-universe is inseparable, encompassing the continuous coconstitution of diverse, multidimensional realities through paradoxical, rhythmical

processes of interrelating (Parse, 1998). Paradoxical processes encompass “apparent opposites” (Parse, 1999b, p. 7), but are single, distinguishable, and rhythmical patterns “lived all-at-once” (Parse, 1998, p. 30). Mitchell (1993) states, “living paradox is a manifestation of the human-universe interrelationship and is an inherent aspect of everyday life” (p. 47). In becoming, humans are cocreating paradoxical rhythms encompassing recognizable and seemingly contradictory experiences, ideas, and beliefs (Mitchell; Parse, 1998).

Three paradoxical concepts identified within principle two are revealing-concealing, enabling-limiting, and connecting-separating. Humans are all-at-once revealing and concealing, connecting and separating, and enabling and limiting with other persons and the universe. Parse (1998) explicates that “the human as mystery” (p. 43) is emphasized in the paradoxical rhythm of revealing-concealing, involving “disclosing-not disclosing all-at-once” (Parse, 1998, p. 43). In living choices, humans are living the paradoxical rhythm of enabling-limiting, thereby cocreating both limits and opportunities for themselves and others (Parse, 1998). In choosing to be and not be involved with persons and certain projects, humans are connecting-separating: all-at-once showing and not-showing who they are and moving or attending in some ways and not others (Parse, 1992, 1998).

For example, in choosing to be with a person who is living their dying, a health care worker may focus on being present with that person. While performing tasks and duties associated with the care she or he offers, the worker may choose to both connect and separate in new ways or on different levels with the person. In living the paradoxical rhythm of revealing-concealing, the worker may show the value of service to others while concealing a value for independence. At the same time, she or he may focus on enhancing a sense of togetherness with one person while diminishing possibilities of intimacy with others.

Principle three states: “Cotranscending with the possibles is powering unique ways of originating in the process of transforming” (Parse, 1998, p. 46). Transcending is “reaching beyond the possibles” (Parse, 1998, p. 30) in a multidimensional world.

Tension, struggle, possibility, conflict, surety, and doubt unfold as humans are present in the world, living paradoxical patterns of forging ahead-holding back in the midst of everyday rhythms of conformity-non-conformity and certainty-uncertainty (Parse, 1981, 1992, 1998). In becoming, persons envision and extend beyond new and different possibilities.

Three concepts explicated within this principle are powering, originating, and transforming. *Powering* involves a pushing-resisting rhythm or energizing process (Parse, 1981). It is a process through which being-non-being is continuously affirmed-not affirmed (Parse, 1998). *Originating* “means creating anew” (Parse, 1987, p. 156), whereby persons take action to bring to light and choose unique ways of living. Imagining and envisioning new possibilities, persons live paradoxical rhythms of certainty-uncertainty and conformity-nonconformity (Parse, 1998). Parse (1981) describes *transforming* as the “changing of change” (p. 64), a continuous process of becoming more complex through reaching toward unique possibles with shifting perspectives “as a different light is cast on the familiar” (Parse, 1999b, p. 7). Thus, Parse specifies that new insights and lived choices are transformative (Parse, 1992, 1998). As such, persons do not return to old ways of viewing and being, but “can only move toward other possibles” (Parse, 1981, p. 65).

For example, a family member meeting with a nurse might engage in discussing, researching, and puzzling over implications and reasons for a loved one’s increasing sleepiness. Having been advised that these changes may be related to medications or a serious change in condition, the family member shares this information with a family friend. In discussion, they come to consider how sleep is also seen to contribute to healing. They wonder if healing might occur in both living and dying, thus surfacing new insights and possibilities. Hence, understandings of what might be and is expand and grow more complex. With a new sense of mystery, the family member’s way of being with their loved one changes as they explore and choose possibilities in living-dying.

Incorporating one concept from each principle, theoretical structures or propositions are written at a less abstract level than principles (Parse, 1987). They are

statements of lived experiences and can guide research and practice (Parse, 1981). Some possible theoretical structures or propositions are:

- 1) Powering emerges with the revealing-concealing of imaging
  - 2) Originating emerges with the enabling-limiting of valuing
  - 3) Transforming emerges with the languaging of connecting-separating.
- (Parse, 1998, p. 55)

Here again, rhythmical patterns of relating, such as revealing-concealing, enabling-limiting, and connecting-separating, reflect the belief that “lived experience is...paradoxical” (Mitchell, 1993, p. 44). In keeping with the epistemology of the simultaneity paradigm, Parse’s theoretical structures are non-directional propositions and are non-causal in nature (Parse, 1987, 1992). It is possible that additional propositions may be derived.

#### *Human Becoming Research Methodologies*

Several research methods have been developed within the human becoming school of thought. These include the Parse research method (Parse, 1987), the human becoming hermeneutic method (Cody, 1995b; Parse 1998), and the qualitative descriptive project-process-post project method (Parse, 1996, 1998). The first two methods contribute to the evolution of the human becoming school of thought. The Parse research method is a phenomenological-hermeneutic method developed for the purposes of researching human health experiences. Processes of this method include dialogical engagement, extraction-synthesis, and heuristic interpretation. The human becoming hermeneutic method is utilized to “discover emergent meanings of human experiences through a study of texts and art forms” (Parse, 2001d, p. 172). The third method of inquiry is an applied research method contributing to knowledge about practice guided by the theory of human becoming.

#### *Human Becoming Practice Methodology*

In nursing practice guided by the theory of human becoming, the goal is quality of life from the person’s perspective (Parse, 1987). Health care literature offers different definitions and descriptions of quality of life from various perspectives. According to the ontology underpinning human becoming, quality of life is determined by the person

himself or herself. It is considered unique and changing for each person (Parse, 1994). Quality of life is “not a human lived experience but is the incarnation of one’s lived experience at the moment” (Parse, 1994, p. 19). Nurses in practice contribute in cocreating the goal of quality of life from the person’s perspective by honoring personal values, choices, and health experiences (Daly, Mitchell, & Jonas-Simpson, 1996).

Congruent with the philosophical underpinnings of the theory, the person makes his or her health choices according to personal preferences and values. Thus, in practice with the person, the nurse does not intend or seek to change another’s personal views or quality of life, but “lives true presence” (Parse, 1998, p. 78) in process with the person. In living true presence, the nurse “bears witness to the person’s or group’s own living of value priorities” (Parse, 1998, p. 71). Parse (1999b) describes presence as “a special way of being with another that recognizes the other’s value priorities as paramount” (p. 82). Further exploration of the true presence is conducted in chapter 2 of this thesis.

Parse’s (1987) practice methodology consists of the three dimensions of illuminating meaning, synchronizing rhythms, and mobilizing transcendence. Although the dimensions and associated processes are described and presented sequentially in this document, they transpire in practice all-at-once and not in a linear or step-wise fashion. Synthesized from another source (Tschanz & Northrup, 2004), descriptions of these dimensions and processes are presented in the following paragraphs.

The practice dimension of *illuminating meaning* is “explicating what was, is, and will be” (Parse, 1998, p. 69). It is “shedding light through uncovering the what was, is, and will be, as it is appearing now. It happens in explicating what is. *Explicating* is a process of making clear what is appearing now through languaging” (Parse, 1992, p. 39). In illuminating meaning, the nurse respects the uniqueness of personal meanings and experiences, thus inviting the person to articulate or otherwise convey personal thoughts, feelings, understandings, and beliefs. In doing so, personal meaning may be clarified, enhanced, and transformed (Parse, 1992, 1998). In this perspective, information is not presented as representative of or directing persons toward expected or normative outcomes, trajectories, and/or goals. Rather, the person is viewed as the expert of his or

her own health and as such, able to create and choose his or her own meaning and care options. Thus, the nurse is present with the person as the person determines the significance and relevance of any information and personal experiences for himself or herself (Parse, 1994).

Another dimension of human becoming guided practice is *synchronizing rhythms*. Here again, without intending specifically to change, mitigate, or otherwise alter a person's experience, the nurse "dwell(s) with the pitch, yaw, and roll of the inter-human cadence" (Parse, 1992, p. 39). Parse likens the process of "dwelling with" to "treading water; while one *appears* to remain in the same place, different waves arise to create subtle movement and often gigantic leaps" (p. 40). In a process of *dwelling with*, the nurse may recognize paradoxical expressions of personal meaning and experience, but continues to abide with the uneven, everchanging, and rhythmical flow of connecting-separating (Parse, 1992).

A third dimension of Parse's practice methodology is *mobilizing transcendence*. This involves "moving beyond the meaning moment with what is not-yet" (Parse, 1998, p. 70). The process of *moving beyond* involves propelling with envisioned possibles of transforming. The dimension of mobilizing transcendence is lived as a person describes hopes, dreams, desires, and possibilities. As such, the person is moving "beyond the meaning of the moment to what is not yet" (Parse, 1998, p. 70). Moving beyond is focusing and shifting toward something that may occur or become. Through a continuous process of cocreating meaning, new awareness of other possibilities and values surface and are chosen.

For example, in the course of daily visits and discussions, a nurse abides with a person as he or she clarifies personal meanings and implications of options for medical intervention for symptom control. The nurse is present with the person, working according to the person's wishes, even as choices vary. One day a person may bring to light and choose to live a value of clarity of thought and decline any sedating pain medication, believing this will support a goal to attend an important event. Another day, the person may shift that particular value and goal, hoping to achieve a different degree of

symptom control. With new meaning and experience, values and goals continue to change. Thus the nurse “remains present with the person, honoring changing preferences as new meanings and possibilities are created, new value priorities are chosen, and new plans are made” (Tschanz & Northrup, 2004, p. 110).

Research conducted within a nursing theoretical framework contributes to the expansion and evolution of nursing theory, practice, and policy. New insights about human experiences, such as bearing witness, enhance awareness for possibilities in and implications of chosen ways of being in the nurse-person process. Persons and families benefit from advancements in nursing theory through the provision of enhanced quality practice and services. In addition, research findings influence policy development by contributing to policy that is congruent with personal and communal health care preferences as well as the values and practices of health care providers.

#### *Bearing Witness and Policy*

Nursing policy both expands and limits opportunities for working in ways that are congruent with a person’s wishes, and nurse’s values and goals or intentions related to practice (Cheek & Gibson, 1997; Mitchell, 2001). For example, the final paragraph of the CNA (2000) fact sheet on palliative care states:

Palliative care is about life—the value, the meaning, and the enhancement of the quality of life. Palliative care teams provide pain and symptom management and recognize that patients and cultures bring individual views of suffering to the dying process. They are trained to deal with the dying process and offer support to clients. (n.p.)

While important aspects of hospice palliative nursing practice are represented in the statement about quality of life, the words “management”, “deal”, and “support” reveal interventionist perspectives and intentions as predominant within this policy. At this early point in my thesis, I ponder the question: Is it possible for a nurse to focus on quality of life as described by the person, to work in a non-judgmental way, to bear witness to another’s “living of value priorities” (Parse, 1998, p. 71) and, at the same time, seek to “deal with” a person’s experience of living and dying?

This study is proposed as a means of contributing to the examination and evolution of policy that influences nursing practice. Hence, I suggest that broader understandings of meanings, patterns of relating, and possibilities (Parse, 1981, 1992, 1998) related to bearing witness may well provide insight into nurse-person processes as nurses bear witness with persons living their dying. Further discussion in chapters 5 and 6 explore how new understandings about experiences of bearing witness relate to policy associated with nursing practice.

#### *Summarizing Chapter 1*

Many factors contribute to the choice of phenomenon and theoretical perspective for any research study. Accounts of practice, shifts of intention, and explorations of persons' expectations of nurse-person processes contribute to the choices in this thesis and establish the relevance for further study about the experience of bearing witness. An echo of the "call to bear witness" (Cody, 2001b, p. 288) and further support for this research is evident in the voices of two hospice palliative care nurses (Borneman & Brown-Saltzman, 2001). Borneman and Brown-Saltzman ask their nurse colleagues to consider, "go[ing] beyond assessment, diagnosis, intervention, and evaluation" (p. 415). Indeed, they suggest that "interventions may not be the true representation of what is needed" (Borneman & Brown-Saltzman, p. 421) in nursing practice with persons living their dying and with their families. These authors identify a need for nurses to honor persons' preferences and offer their time and "focused attention" (Borneman & Brown-Saltzman, p. 421) in fostering exploration of personal meaning and hope. Further, Borneman and Brown-Saltzman make a provocative claim in saying, "presence may be our greatest gift to...patients and families" (p. 422). Of course, according to one's perspective, the gift of presence may be understood and offered in many different ways. Accordingly, literature discussing the particular gift of bearing witness in being present with persons is explored in further depth in chapter 2.

## Chapter 2: Exploring the Concept of Bearing Witness and Reviewing the Literature

Chapter 2 encompasses an exploration of the concept of bearing witness and a review of research literature. Available resources from the years 1989-2005 were located through an electronic search utilizing the following data bases and search engines: ATLA Religion Database, CBCA Fulltext Reference, CINAHL, Dissertation Abstracts International, Google, Philosophers Index, and Web of Science. Resources surfaced in several categories of literature including those related to bearing witness, nursing education, nursing presence and relationship, and health caregivers' practice in hospice palliative care. The following search terms were included: being with, bear/ing witness, witnessing, witnessing suffering, testimony, nurse-patient relationship, nursing presence, presence, true presence, and hospice/palliative care. Additional resources were gleaned from article and research study reference lists.

References to bearing witness were found in diverse disciplines and areas of interest including nursing, medicine, psychology, social work, theology, history, philosophy, law, art, media studies, business administration, journalism, and social and environmental action. Resources encompassed a broad variety of accounts of human experiences as well as philosophical and theoretical discussions and critiques. Yet, I located only a few research studies directly related to health care and nursing practice. While an in-depth discussion of philosophical literature is beyond the scope of this project, an exploration of theoretical and narrative resources serves to expand my understanding of the concept of bearing witness. This exploration is followed by a review of available research literature related to experiences of bearing witness in nursing practice.

### *Bearing Witness and Nursing Presence*

In my initial forays into the literature, I noted that references to bearing witness were often linked with nursing presence and interrelationship. Yet, several authors state that aspects of nursing presence and interrelationship present significant challenges for study (Harper, 1991; May, 1990; Smith, 2001). Harper suggests that "the idea of presence is difficult to write about because the experience of presence is itself elusive" (p. 6). In an

overview and analysis of literature from the disciplines of religion, philosophy, and nursing, Smith states that the complexity of meaning and experience related to nursing presence is due to the concept's "roots in religious mysticism and existentialist philosophy, both highly abstract fields whose respective terminologies do not easily lend themselves to concrete definitions and description" (p. 317). Nonetheless, there is significant philosophical, theoretical, and practical interest in this topic. Significantly, in the discipline of nursing, bearing witness in being present with others is strongly associated with quality nursing care and persons' quality of life.

Nurse authors (Aranda & Street, 1999; Doona, Haggerty, & Chase, 1997; Holzemer, 1997; May, 1990; Smith, 2001) trace the discipline's abiding and growing attention to nurse-person processes and the concept of nursing presence to the early 1960's. They emphasize the value in new research and continued examination of existing scholarship related to nurse-person relationships. Significantly, Smith identifies a revived interest in this topic linked with growing attention to related concepts such as intuition, reciprocity, mutuality, commitment, responsibility, caring, empathy, and holism. Smith also associates the greater prevalence of discussion to recent advances and popular foci in nursing theory.

While it is important to attend to current trends, I note that several nurse theorists have long recognized the significance of presence in nursing practice. These theorists include, but are not limited to, Parse (1981, 1992, 1998) and Paterson and Zderad (1988). For example, Paterson and Zderad conceptualized nursing as "an intersubjective transaction" (p. 13) between the nurse and person or a group of persons. As such, nursing is "a lived dialogue" (p. 22) encompassing a "purposeful call and response" (p. 23). According to Paterson and Zderad, the work of nursing requires a valuing of and engaging in active, whole, or genuine presence of the nurse with others. Presence is described as a "gift of one's self" (Paterson & Zderad, p. 16), which "cannot be seized or called forth by demand, it can only be given freely and be invoked or evoked" (Paterson & Zderad, p. 16). In this way, to be present with someone involves a belief in the other as a person and not as an object. Paterson and Zderad state that genuine presence is manifested in qualities of intimacy and reciprocity.

The term *genuine presence* is reminiscent of *true presence*, as articulated by Parse in her nursing theory initially published in 1981. Within the human becoming perspective, Parse (1992, 1998) describes true presence as lived through the processes and dimensions of a specific practice methodology related to the theoretical themes of meaning, rhythmicity, and transcendence. She specifies true presence as an “unconditional loving, non-routinized way of being” (Parse, 1997, p. 34) within which the focus shifts from the nurse’s personal interests to whatever the other chooses to share. According to Melnechenko (2003), the modifier *true* can be seen as reflecting a focused intention and commitment of the nurse in being present with the person. Melnechenko identifies Merleau-Ponty’s work on the concepts of co-constitution and co-existence as particularly influential with respect to conceptualizing true presence within the human becoming perspective. As such, the assumption is that each person discloses only what she or he selects through co-creating, choosing, and illuminating meanings, interrelationships, and possibilities (Liehr, 1989; Melnechenko; Parse, 1994, 1999b). Within this perspective, true presence in practice is a way of being with others, focusing on the person and their experience, rather than on identifying or resolving issues. In Parse’s view, true presence in nursing practice demonstrates respect for the uniqueness of each person.

In preparation for being present with another, the nurse “dwells with the universe at the moment, considering the attentive presence about to be” (Parse, 1996, p. 71). Parse (1992) describes this experience as “an all-at-once gentling down and lifting up” (p. 35) bringing about “an unencumbered soft foothold” (p. 35). Attentiveness in being present requires the nurse to “focus on the moment at hand for immersion” (Parse, 1994, p. 18), being “gracefully present from one’s center” (Parse, 1996, p. 71).

Living true presence, the nurse enters into face-to-face discussion, silent immersion, and lingering presence, attending to whatever meaning is revealed by the person (Parse, 1997). Dialogue in the nurse-person or group process is led by the person or group and occurs through any medium whereby thoughts and experiences are conveyed, including “artful presencing through the music of flute playing” (Jonas, 1994). In silent immersion, wordless messages are offered and acknowledged. Lingering presence refers to the way in which a moment or time of engagement is “inextricably

woven into the fabric of one's life" (Parse, 1998, p. 73). Liehr (1989) emphasizes that there is no specific time frame or span required for living true presence.

In living true presence, explicit-tacit glimpses and recollections of a moment, person, or situation surface at any time and hold a variety of meanings. The nurse "is not a guide or a beacon, but an inspiring attentive presence that calls others to shed light on the meaning moments of life, bearing witness to the choices in changing health patterns" (Parse, 1998, p. 75). The nurse works with the intention "to bear witness to the other's becoming" (Parse, 1998, p. 73). Parse (1992) writes that "true presence is a special way of 'being with' in which the nurse bears witness to the person's or family's own living of value priorities" (p. 40).

Thus, nurses may serve others by bearing witness to a person's unique, everchanging health and quality of life. Seeking to expand my understanding of how other authors refer to and conceptualize bearing witness, I attend to additional resources within and beyond the discipline of nursing.

#### *Bearing Witness: A Focus on Witness*

Within much of the available resource material, the terms *witnessing*, *testimony*, and *bearing witness* are considered to be closely related and sometimes used interchangeably. For example, one of fifteen entries under the term *witness* in the Oxford English Dictionary refers directly to bearing witness. It states:

10. to bear witness: (said properly of a person, book, etc.) to give oral or written testimony or evidence; hence fig. to furnish or constitute evidence or proof; to testify, witness to (occas. of). To bear (one) witness: to corroborate one's statement to be a witness of one's action.

Referring to bearing witness as a human activity, this definition focuses on bearing witness as an action undertaken in a focused, purposeful way.

According to the above definition, not only persons, but items, events, or existing circumstances may be considered to bear witness to the existence of other phenomena or experiences. This is illustrated in the following excerpts:

"the emergence of a variety of conceptual systems of nursing bears witness to the coming of age of nursing as a discipline" (Parse, 1998, p. 3).

“this poem says something about bearing witness. It bears witness to it.” (Derrida, 2000, p. 184).

“the call itself bears witness to the pervasive neglect of bearing witness to one another’s joys and sorrows in contemporary life” (Cody, 2001b, p. 289).

“the purpose of this essay...is to bear witness to cultural differences” (Diprose, 2001, p. 25).

Thus, something that a person creates or an aspect of a situation that is highlighted, serves to affirm or testify to the occurrence or likelihood of something else. Expressed these ways, bearing witness is primarily associated with the purposes of witnessing or attesting to the existence of something.

Purposes of bearing witness are commonly associated with providing proof and serving judgment related to events or actions and experiences of others. These goals are particularly evident in references to witnessing or bearing witness in law courts, during public ceremonies and testimonies, and for journalistic and activist purposes. For example, to bear witness or act as legal witness in a court of law means to present evidence or testifying in order to establish or clarify the details of an event or action. As such, it is important that a witness is judged to be a competent, reliable, objective-as-possible observer or expert (Paciocco & Stuesser, 1996). Presuming and seeking to discover fact or truth within an objective reality seems of particular importance in legal traditions and is congruent with natural science and empirical perspectives. In these circumstances, it seems that the focus of bearing witness is on the witness and the specific event or circumstance.

At least one aboriginal tradition involves calling persons from distant villages to witness important events and ceremonies in the life of a community. In such instances, witnesses accept the responsibility to be in the present, closely observe events, and report back to their own community (Thompson, 2002). I understand that if necessary, as in situations of dispute or in making pivotal decisions influencing the life of the community, such witnesses may be asked to return to the visited community in order to recount or verify what was witnessed previously. Bearing witness from this perspective is described

as a sacred tradition. This is a communal process and, as in the previous paragraph, the description as presented focuses on attending to the details of the event taking place and the responsibility of serving as witness.

Within several religious traditions, bearing witness encompasses a vital, and some would say necessary, aspect of living in community and sharing ideas and experiences related to spirituality and faith. For example, writing from Christian perspectives, several authors (Gaventa, 2002; Peace, 2002) discuss how witnessing can be considered a matter of conversion and conversation: a way of exploring faith as well as fostering relationship, dialogue, and spiritual conversion. In this view and in contrast to bearing *faithful* witness, bearing *false* witness can be described as propagating “erroneous ideas” (Evans, 2004) about other persons and communities or, more bluntly stated, telling lies (Long, 1991). A brief survey of theological literature suggests that bearing witness is interpreted in a variety of ways, yet similar to legal and aboriginal traditions, it is often undertaken in the company of others. In addition, I read an emphasis on what the witness has to say about his or her ‘reality’ and what might come about in the telling.

Tatman (1997), in an article entitled “Telling Life Together: A Feminist Theological Reflection on Bearing Witness”, provides another perspective on bearing witness. She states that bearing witness is about hearing testimony, arguing that in bearing witness, persons seek to account for the actions of others. Further, she emphasizes, bearing witness is about believing and acting on the words of others in order to rectify, mitigate, or avoid doing harm. To illustrate, she tells a story of how one person’s (Sally) multigenerational family—all of whom who once lived together—are dispersed to reside in various locales and institutions when their rental property and long-time home is sold to a property developer. Tatman suggests that as Sally recounts for her children (just as Tatman recounts for her audience) the family’s pain and sorrow related to the developer’s actions, Sally is both telling of a family’s destruction and bearing witness to the power of love and remembrance. Through this process, she says the family is recreated as whole.

Tatman (1997) claims that from her perspective, to bear witness is to “listen lives together” (p. 99). Central to this restoration, she emphasizes that if “bearin’ witness is mostly ‘bout makin’ sense outta what’s been happening,...bearin’ witness is [also] about judgin’ ” (Tatman, p. 88). Specifically, while Sally’s (and Tatman’s) audience is clarifying and attesting to the sequence, meaning, and relevance of events, they are also evaluating whether or not the participants of the story acted appropriately, fairly, and faithfully. I understand that from Tatman’s perspective, making judgments about the behavior of others is central to bearing witness. Further, by judging the actions of others and calling them to account for their actions, those who listen to the story (or read the narrative) are cautioned to examine their own lives. Listeners (and readers) are challenged to avoid acting in similar ways to those persons bringing harm.

These above references to bearing witness invite readers to ponder the complexities of notions of truth, reality, knowledge, and understanding related to human experience. From an empirical perspective, bearing witness is associated with supplying proof and evidence so that judgments may be made. Yet, from other perspectives and as Behar (1996) points out in her book *The Vulnerable Observer*, notions of truth can be considered “slippery” (p. 193). Indeed, several authors (Cody, 2001b; Derrida 2000) suggest that bearing witness is not necessarily about providing proof or undertaking judgment. As Cody points out, Derrida plainly questions to what degree, if any, bearing witness can be associated with certainty or proof. Although Derrida describes bearing witness as closely associated with offering testimony, he distinguishes between offering testimony and providing proof. He suggests that “whoever bears witness does not bring proof; he...comes to attest...that some ‘thing’ has been present to him” (Derrida, p. 190) in the past. Derrida views experiences of bearing witness as “appeal[ing] to the act of faith” (p. 188), meaning that if I claim to bear witness, “I swear that I have seen, I have heard, I have touched, I have felt, I have been present” (p. 188-189). Here again, the emphasis is on the witness and what he or she has observed or experienced.

Considering notions of truth and reality from non-empirical perspectives, and specifically within the human becoming framework, assist me to further expand

understandings of bearing witness. Within a non-empirical perspective, there is no objective reality; reality is a matter of perspective or interpretation. Yet, working within a human becoming perspective, Cody (2001b) indicates that the notion of *veracity* is central to bearing witness. He explains that bearing witness can be considered to encompass “the direct, personal apprehending of something in the moment, and the attesting...to the veracity or authenticity of what was witnessed” (Cody, p. 289). The difference in this perspective is that bearing witness does not involve seeking to establish reality as *what really happened*, but to attend to whatever is significant to or experienced by a person however he or she chooses to tell of it (Cody). From a human becoming perspective, it is not possible to know all (or on some level even understand what) another’s experience is. Thus, rather than seeking to judge an action or experience as right or wrong or an account as accurate or inaccurate, the nurse guided by the theory of human becoming attends closely as a person conveys whatever he or she chooses to share.

Within all of the above perspectives there are hints, promises, and outright exhortations related to a witness’s ongoing responsibility and commitment in bearing witness. As Bodnar (2000), writes: “Remember me. It goes without saying for those who bear witness” (n.p.). According to Derrida (2000), bearing witness involves an explicit or implicit commitment in some way. In other words, “the witness promises to say something to another” (Derrida, p. 194) about what he or she witnesses. Carrying forward or conveying something of what was witnessed can be considered as distinguishing witnessing from bearing witness. The importance of taking action is echoed by many other authors, and along with injunctions for action comes responsibility. For example, Laub (1992) writes, “to a certain extent, the interviewer-listener takes on the responsibility for bearing witness that previously the narrator felt he bore alone, and therefore could not carry out” (p. 85). Indeed, depending on purpose and perspective, expectations for the witness include activating, advocating, attending, intervening, affirming, healing, helping, listening, judging, protecting, recording, remembering, reporting, accounting, recounting, calling to account, etc., etc. (Blackwell, 1997; Bodnar;

Cody, 2001b; Derrida; Diprose, 2001; Drought, 2002; Felman, 1992; Glassman, 1998; Heurman & Olson, 2000; Laub; Nelson, 1996; Peters, 2001; Price, 1989; Raffensperger, 2002; Tatman, 1997; Thompson, 2002). Considering such expectations in the words of Tatman, bearing witness is “a serious matter” (p. 88) with widespread implications for persons, families, and communities.

Bearing witness and witnessing is highlighted as a matter of significant concern for persons and groups for several reasons. Overall, Peters (2001) remarks that actions of witnessing are immensely influential in society because such actions commonly relate to “law, theology, and atrocity” (p. 7-8). Indeed, many resources cite examples of and recommendations for witnessing or bearing witness for persons threatened or harmed through genocide and war (Schindler, Spiegel, Malachi, 1992), torture (Blackwell, 1997) and other experiences of violence, trauma, injustice, and suffering (Bunkers, 2001; Cody, 2001a, 2001b, 2001c; Diprose, 2001; Drought, 2002; Felman & Laub, 1992; Glassman, 1998; Heurman & Olson, 2000; Peters; Raffensperger, 2002; Tatman, 1997).

JOURNAL ENTRY: I think about how bearing witness is often associated with war and disaster, but also reconciliation and hope. Consider, for example, accounts by survivors of and witnesses to the Holocaust and the Truth and Reconciliation Commission in South Africa. I think about efforts in Canada to understand the devastation to families and communities wrought by enforcing residential schools. I think about Romeo Dallaire’s (Dallaire & Beardsley, 2003) account of war and genocide in Rwanda. I think about attending many Remembrance day celebrations at the cenotaph down by the neighborhood recreation centre. Notions of remembrance, judgment, reconciliation, and justice are strongly associated with bearing witness. Raising awareness and healing also seem central to bearing witness. I remember stories told by people living with HIV/AIDS or cancer or ALS or..... And the voices on Canadian Broadcasting Corporation [CBC] radio of deliberate-desperate-hopeful voices of people surviving the aftermath of tsunamis, earthquakes, and hurricanes. (Do you have to be close to something-see something, smell something-to bear witness?) Bearing witness somehow pivots on the decision to face (face up to?) or turn away (about face?) from aspects of human experience: an everyday, but possibly monumental choice. I wonder, is bearing witness always a matter of sort of “facing up to” something, ie. bearing witness *to* something, or *for* something?

Underpinning discussions of bearing witness, is the assumption that meaning, purpose, justice, and healing, and transformation at personal and communal levels can be

facilitated in and through experiences of bearing witness (Bar-Tur & Levy-Shiff, 1994; Cody, 2001b; Frankl, 1984; Glassman, 1998; Kahn & Steeves, 1994; Radley, 2002; Tatman, 1997). Bar-Tur and Levy-Shiff refer to bearing witness as “a coping mechanism” in their presentation of a case study focusing on the experiences of a survivor of the Holocaust. In his article, *Portrayals of suffering: On looking away, looking at, and the comprehension of the illness experience*, Radley explores the work of several persons who painted self-portraits after surgery. He refers to a woman whose chest is scarred after an operation, saying that “in order to look beyond the scar, the woman had first to look at it” (Radley, p. 10). I read an inference that the woman’s healing is dependent upon bearing witness for herself. Focusing on community and social issues, Glassman refers to bearing witness related to his experiences at Letten, an area in Switzerland where persons were permitted to gather to sell, purchase, and use street drugs. He states that healing for persons who are suffering *cannot* come about unless other persons bear witness to that suffering. Looking to the discipline of nursing, Kahn and Steeves cite the importance of bearing witness in transforming the discipline by creating a new vision of nursing. Specifically, Kahn and Steeves suggest this comes through “speaking out about the suffering we encounter, about how it is best responded to and relieved, and about a future in which no one’s suffering is ignored” (p. 264). In these ways, there are significant implications for bearing witness with respect to personal and social health, as well as the future of nursing and health care.

Bearing witness is most often associated with situations of suffering or, in the words of Tatman (1997), when “things [go] from being OK to being bad wrong” (p. 88). Yet, authors also remark that bearing witness is important in times of celebration and beauty (Bodnar, 2000; Cody, 2001b; Drought, 2002; Pilkington & Jonas-Simpson, 1996; Raffensperger, 2002). This is well emphasized by nurse scholars Pilkington & Jonas-Simpson working within the human becoming tradition. They write, “in loving true presence the nurse bears witness to the struggles, the joys and sorrows of the person’s life” (Pilkington & Jonas-Simpson, p. 37). In a nursing editorial, Drought refers to bearing witness as a privilege, saying it is “at the heart of the [nursing] profession and is

profoundly linked to our ethical traditions and challenges as a profession: a source of the greatest joys in practice as well as profound anguish” (p. 238). She notes that nurses bear witness to the “wear of disease, the environment and time....[as well as] the love that binds humankind” (Drought, p. 238). Described these ways, bearing witness may be viewed as a paradoxical experience, which is congruent with Parse’s (1981) view of human lived experience.

Attending to aspects of joy and suffering in human life, several authors point out risks and opportunities associated with experiences of bearing witness (Childs, 2000; Drought, 2002; Holton, 1994; Laub, 1992; Peters, 2001; Tatman, 1997). Laub writes, “the listener to trauma comes to be a participant and a co-owner of the traumatic event: through his very listening, he comes to partially experience trauma in himself” (p. 52). Similarly, Holton states, “bearing witness can be a dangerous activity when the political stakes are high” (p. 80). For example, choosing to speak out or demonstrate against perceived injustices or truths may lead to shunning or isolation, loss of job or funding or respect, or physical harm. Perceptions of truth hold a variety of ramifications, no matter whether a person is in a court of law or hospital bed. Yet, along with the possibility of suffering harm, several authors note the potential for personal growth and change. Drought refers to the possibility of experiencing great joy and deep anguish in bearing witness with others, saying, “we are forever changed by what we see” (p. 238). Peters describes both “burden...[and] treasure” (p. 708), saying that “to bear witness is to put one’s body on the line”, but also “potentially to have your life changed” (p. 714). According to these authors, there are deep implications for persons in experiences of bearing witness.

Throughout the above discussion, the focus is on bearing witness to something: an event or truth. The focus is on bearing witness for something: for justice or healing. Yet, in some ways and in the words of Glassman (1998), “when you go to bear witness, it means that you go with no preconceived notions about what you’ll see and what will happen” (p. 88). Similarly, Stanley (2002) writes that being present with an other “requires a willingness to participate in a story that has not been written” (p. 937). These

statements hint at different experiences and perspectives of bearing witness: ones that do not seek to discern truth, convey judgment, or establish surety. This difference surfaces more clearly for me in literature discussed below.

*Bearing Witness: A Focus on With-ness*

Refining my focus on the literature and most particularly within the human becoming perspective, the emphasis on bearing witness shifts to something other than witnessing, observing, testifying, or attesting to or about something else. While still hinging on the attentive presence of another, bearing witness can hold intentions other than those related to providing proof. Here, I consider again several quotes from Parse (1992) and Cody (2001b):

True presence is a special way of 'being with' in which the nurse bears witness to the person's or family's own living of value priorities. (Parse, p. 40)

The contemporary call to bear witness...is a call to listen to people, to be open to the reality of their lives, and to speak of their lives with a devoted fidelity to their experiences as described and experienced by the people themselves. (Cody, 2001b, p. 288)

As discussed further in the section about research related to bearing witness, Melnechenko (2002) similarly refers to bearing witness as, "the willing act of authentically being with an other, in his or her living and telling of his or her situation, with the intention of attending, listening, and journeying with the other" (p. 8). In Laub's (1992) words,

For the testimonial process to take place, there needs to be a bonding, the intimate and total presence of an other in the position of one who hears. Testimonies are not monologues; they cannot take place in solitude. The witnesses are talking to somebody: to somebody they have been waiting for for a long time" (p. 70)

Glassman (1998) states quite simply that "bearing witness means to have a relationship" (p. 88). Referring to Derrida's (2000) comments cited earlier and circling back to my earlier discussion of nursing presence, an important aspect of bearing witness involves entering into interrelationship with others (Cody, 2001a, 2001b, 2001c; Glassman; Laub; Parse) rather than focusing on seeking to provide evidence or judgment.

This emphasis on interrelationship surfaced for me in the work of several physicians including Kuhl (2002) and Haswell (1998). In a brief anecdote entitled “Bearing Witness” Haswell, a physician, tells of her experiences during office and home visits with Walter, a man living with cirrhosis. After meeting Walter several times, Haswell describes having an awareness of many things left unsaid or unclear about Walter’s life, bringing her to wonder what, exactly, Walter expects of her as his physician. When after a time the burden of disease progresses so that Walter could not easily travel to the physician’s office, Haswell arranges to visit at Walter’s home. Haswell’s description of one such meeting is especially poignant. She recalls, “He [Walter] reached out and I took his hand. [Walter asked,] ‘Can I tell you?’ Something settled between us. Then the story came out, in short sentences, with long pauses between” (Haswell, p. 980). In this way, Walter tells Haswell of a dreadful, long-ago day when he accidentally drove over and killed his young child.

In this and other accounts and descriptions of bearing witness, I read an appeal issued to and heard by a witness. Walter’s painful plea seems particularly stark and far-reaching. “Can I tell you?” (Haswell, 1998, p. 980). Walter’s “call to listen” (Cody, 2001b, p. 288), to use Cody’s words, is clearly voiced and, perhaps, asked of himself and his physician. His request constitutes choices about whether and how to tell, as well as whether and how to listen. In Haswell’s story, the physician makes her choice and remains present with Walter. It seems that in this invitation and choice for bearing witness, as in Kuhl’s interactions with research participants, the willingness to engage or not highlights the potential for a new depth of interrelationship and understanding.

JOURNAL ENTRY: I wonder, how did Haswell (1998) come to name her narrative “Bearing Witness”? Somehow, in reading her title, I am warned that the story will be sort of...delicate, on some level perhaps tender and awful, or awe-ful. I wonder, too, what changes were heralded as Haswell (bravely, I think) chose to attend to Walter’s plea? What might have come about if denied? I am reminded of Vanier’s (1970) poem: “an encounter is a strange and wonderful thing/presence/ one person to another/present/one to another/life flowing/one to another” (p. 76). What strange, ugly, and wonderful possibilities exist in bearing witness or not in being present with another person? Indeed, what thoughts, memories, and meanings might surface for those who hear, read, or tell about any experience? What new ways of being with others might the person and the witness uncover,

risk, choose, live? If choices in bearing witness bring about some opportunities and not others (Is that enabling-limiting according to the human becoming perspective?), surely such decisions deeply influence our work as nurses, our ways and experiences of living and being together.

For me, the above sources (Cody, 2001b; Derrida, 2000; Haswell, 1998; Kuhl, 2002; Melnechenko, 2002; Parse, 1992) further highlight bearing witness as involving something in addition to serving as witness. Along with the notion of *witness* comes an intimate, human *with-ness*, an active and engaged attending, being, experiencing, and bearing with another. Interestingly, the online Cambridge Advanced Learner's Dictionary states that to bear with a person means "to be patient and wait while someone [else] does something". Although authors often specify or imply that it is necessary to be present-in-body in bearing witness, none of these cited references refer to bearing witness *with* someone. Rather, the phrase is written most often as: *to bear witness to* or *for*. Nonetheless, *bearing witness with* someone can be distinguished from a focus of serving as an external, expert, passive, or objective witness charged to present his or her observation or testimony. Bearing witness with an other can be seen as a uniquely intimate, interactive human-with-human process.

Thus, experiences of bearing witness within nursing and other health care literature are variously associated with being present with others. In my early preparation for this research, Kuhl's (2002) point about learning to attend to others with "every ounce of [his] being" (p. 41) evoked for me the popular topics in nursing literature of nursing presence and nurse-person process, explored throughout resources pertaining to nursing theory, research, education, policy, and practice. Circling back to Parse's 1981 work in nursing theory, bearing witness is closely associated with the notion of presence. Also working within the human becoming tradition, Bunkers (2001) states that "attentive presence is the essence of bearing witness" (p. 201) and Cody (1999b) refers to true presence as "a way of bearing witness" (p. 119). Cody (2001a) remarks further that bearing witness is "uniquely constituent with presence" (p. 97). As such, bearing witness is closely linked with but not the same as living true presence, perhaps distinguished in

some situations by the choice to speak out or otherwise convey something about the experience of the person.

Exploring bearing witness within the human becoming perspective (see Parse, 1981, 1992, 1998), Cody (2001a) makes explicit the paradox of bearing witness-not bearing witness. Conceptualized this way, Cody remarks that even as a potential witness focuses his or her attention on one event, there are other unspoken, missed, or negated appeals to which the person bears witness in other, more muted ways to an experience at hand. He specifies that in choosing to bear witness in one moment, one “is simultaneously not bearing witness to that phenomenon in other ways or to other phenomena” (Cody, p. 97). In other words, a person cannot bear witness in the same way to all events and moments with all other persons, but cocreates both limitations and opportunities with whomever or whatever he or she is present or attending. Cody emphasizes that in this way, bearing witness-not bearing witness is an integral pattern of human interrelationship: “a paradoxical rhythm of human becoming” (p. 97).

If bearing witness-not bearing witness is integral to human interrelationship, it seems important to consider again several points made in the previous section related to the implications of choices made in bearing witness. Indeed, if bearing witness is seen as vital to bringing about healing, it seems possible that injustice or harm may be done or perpetuated when no one hears and/or acts on another’s words of experience. In a research study related to bearing witness, Cody (2001c) states,

“the refusal to bear witness surfaces when we believe we cannot bear witness to our own reality with those around us. It surfaces when we demur from bearing witness to the reality of others around us.” (p. 216)

Considering Haswell’s (1998) narrative of her visits with Walter, perhaps there are occasions when, for some reason, something does not “settle” between persons; there is no “silent immersion” as described by Parse (1997). Thus, certain information or preferences are not related, particular experiences are not recounted. Similarly, Felman (1992) describes times when persons “do not quite look, they avoid looking directly, and thus they overlook at once their responsibility and their complicity as witnesses” (p. 208). Potential implications of refusing to bear witness are articulated further by Cody (2001b)

in an article discussing several commonly espoused bio-ethical principles. He argues, “ethical behavior in human affairs turns largely on bearing witness” (Cody, 2001b, p. 289), thus challenging professional caregivers to consider the significance of everyday patterns and processes of human interrelating. Cody (2001b) asks if it is at all possible to avoid doing harm, to do good, to live and serve others with respect for personal dignity, and to understand and recount something of a person’s health experiences and desires *without* bearing witness to the reality of the person’s life as he or she describes or expresses it. Further, an attempt at understanding what is and has been of importance to a person assists the caregiver to serve another in a way that has some relevance to that person (Cody, 2001a, 2001b; Coles, 1989; Howell, 1998; Kuhl, 2002; Parse, 1992). Seen this way, it seems quite possible to act in ways that are experienced as harmful if one does not willingly seek to learn of, and somehow honor, the unique and everchanging reality and priorities of each person’s life.

Exploration of theoretical and narrative literature related to bearing witness expands understandings of various aspects of bearing witness and reveals the potential significance of this experience in nursing practice and for persons’ quality of life and experiences of health. I turn now to focus my attention to research literature. For the purposes of this thesis, I limit this review to research within health care. All of the studies located are within the discipline of nursing.

#### *Bearing Witness: Nursing Research*

Among all of the resources retrieved through my literature search, there were relatively few formal inquiries related to bearing witness. Within the discipline of nursing, nine studies related to the phenomenon of bearing witness were available to me. One study focused on mendacity as a refusal to bear witness (Cody, 2001c). Two studies (Cody, Bunkers, & Mitchell, 2001; Melnechenko, 2002) focused specifically on bearing witness to suffering as a phenomenon for inquiry. In six studies (Cody, 1992; Eifried, 1998; Kahn & Steeves, 1994; Kruse, 2004; Pellico, 2004; Riley-Giomariso, 1998), bearing witness surfaced in some way in the research findings. Study populations varied, including the experiences of families (Cody, 1992; Cody, Bunkers, & Mitchell; Kruse),

paid and occupational caregivers (Cody, Bunkers, and Mitchell), nurses (Kahn & Steeves; Melnechenko) and nursing students (Eifried; Pellico; Riley-Giomariso). Four of nine studies were conducted within the human becoming school of thought (Cody, 1992; Cody, 2001c; Cody, Bunkers, & Mitchell; Kruse). Attending to Cody's (2001c) research and Radley's (2002) article cited earlier in this chapter, a search using the key words *mendacity* and *looking away* revealed several studies in the areas of political science, history, literature, developmental psychology, and theology, but none within the discipline of nursing.

In a study adhering to the processes of the human becoming hermeneutic method (Cody, 1995b), Cody (2001c) shed light on the complexity and implications of what it means to bear witness and to reveal or hide versions of the truth. Specifically, he chose Tennessee William's play *Cat on a Hot Tin Roof* through which he explored "the conceptualization of mendacity as the refusal to bear witness" (p. 209). Cody (2001c) wrote,

bearing witness is an intersubjective process that says, at a minimum, "What is real for you *matters* to me." Bearing witness in many forms (testimony, publication, and so forth) is an expression of commitment to stand for the truth as one understands it. It also can be seen as the most respectful response to existential aloneness....The refusal to bear witness...emerges as an abandonment of the other, a negation of his or her value, and an assertion of some greater priority than acknowledging or standing for the truth of the other's experience. (Cody, 2001c, p. 213-214)

Cody (2001c) referred to bearing witness as "life-affirming" (p. 215) and as foundational in relationships. In contrast, he conceptualized the refusal to bear witness as mendacity, "a turning-away-from" or "*not-being-with* that devalues the other by devaluing that which is dismissed as not real or not important" (p. 215). Cody (2001c) cautions that not bearing witness may well be at times "necessary, honorable, or inevitable" (p. 216). In addition, Cody (2001c) remarks that bearing witness with others

does not require an element of objective truth, nor does it necessarily require a precise understanding of the details of the person's experience. What it requires is respect and attention, a nonjudgmental regard and unconditional love rooted in a profound respect for human dignity. (p. 215)

One significance of this study relates to how Cody (2001c) identifies the experience of mendacity as the refusal to bear witness. In his words, close attention to what we choose to bear witness to or not is immensely relevant in “enhancement of the quality of life for people [that professional health care workers] serve” (Cody, 2001c, p. 219) and calls for an examination for public policies reflecting the refusal to bear witness to human reality. Further, Cody (2001c) emphasizes that this phenomenon remains significantly “understudied” (p. 209).

In an earlier study and dissertation, Cody (1992) addressed the question: What is the structure of grieving for families living with AIDS? This study was also presented in an edited version in the text *Illuminations: The Human Becoming Theory in Practice and Research* (Parse, 1999b). Utilizing Parse’s (1987) research method, Cody participated in dialogical engagements with ten different families. Essences extracted from the narratives of lived experiences of grieving in living with AIDS contributed to the formation of a proposition for each family. Common to all ten propositions were four concepts including: *easing-intensifying with the flux of change*, *bearing witness to aloneness with togetherness*, *possibilities emerging with ambiguity*, and *confirming realms of endearment*. Thus, the structure of grieving for the ten families was written as: “easing-intensifying with the flux of change through bearing witness to aloneness with togetherness as possibilities emerge with ambiguity confirming realms of endearment” (Cody, p. 113). Interpreted in light of the theory of human becoming, the theoretical structure of grieving was “powering the connecting-separating in originating valuing” (Cody, p. 131).

While the experience of bearing witness was not the focus of Cody’s (1992) study, *bearing witness to aloneness with togetherness* surfaced as a concept common to all ten participant families as they related the meaning of grieving for them. These findings are consistent with Parse’s theory, in that they suggest that persons bear witness to a person’s becoming in being truly present with that person (Cody, 1992, 2001c). Cody (1992) related bearing witness to aloneness with togetherness to the theoretical concept of connection-separating. His discussion of this concept focused on the aspect of aloneness

with togetherness in the experience of grieving and not on bearing witness per se. Recommendations arising out of this study included a suggestion for study of the lived experience of bearing witness to suffering.

Citing a previously unpublished study guided by Parse's (1987) phenomenological research methodology, Cody, Bunkers, and Mitchell (2001) presented research findings describing the "universal human health experience....bearing witness to suffering" (p. 247). The population of this study encompassed 25 caregivers (both family and occupational) of persons living with AIDS. For persons in this study, the structure of the lived experience of bearing witness to suffering for persons living with AIDS was articulated as *bearing witness to suffering is expressing a commitment sparked by veneration through attentive presence with one in anguish, expanding the now in light of beliefs and doubts yielding a hard-won serenity amidst ongoing joy-sorrow*. In the language of the researcher, bearing witness to suffering was written as *incarnating devotion through communion in misery, amplifying possibilities in light of certainty-uncertainty, yielding a bittersweet calm*. Through a process of conceptual integration, bearing witness to suffering was interpreted as *linguaging the paradoxical unity of connecting-separating in originating-transforming*.

These findings hold implications for other caregivers in bearing witness to suffering. As Cody, Bunkers, and Mitchell (2001) remarked, "Clearly, the value of loving presence cannot be overestimated" (p. 251), most particularly in health care settings. Participants in this study shared the possibility of experiencing great tranquility in knowing that they were present with their loved ones and had offered all they could to them, in times of joy and sorrow (Cody, Bunkers, & Mitchell). I am left with a curiosity about what persons might convey when asked to relate the meaning of experiences of *bearing witness*, and not necessarily *bearing witness to suffering*.

In her master's thesis, Melnechenko (2002) focused on the phenomenon of bearing witness to suffering. Following her interests, she searched for but identified no other studies regarding pediatric nurses experiences of bearing witness to suffering. Thus, she designed and conducted a hermeneutic phenomenological study exploring the lived

experience of pediatric nurses who bear witness to suffering as they care for dying children and their parents. This study is especially interesting to me with reference to the researcher's choices regarding study design.

Melnechenko (2002)'s assumption is that a theoretical "pre-understanding of a phenomenon" (p. 11) hinders "the freedom to construct meaning and interpret findings...in light of simultaneous theories....which is antithetical to the phenomenological approach" (Melnechenko, p. 11). In addition, Melnechenko states that a guiding "theoretical perspective could have created the possibility of reporting data that were tainted with theoretical bias and reflected the theoretical perspective, not the participant's perspective" (p. 11). According to these beliefs and in contrast to my approach outlined in chapter 3 of this thesis, Melnechenko did not claim a specific theoretical framework guiding her data collection.

Explicating her philosophy as guiding her study and as congruent with a phenomenological tradition, Melnechenko (2002) chose van Manen's (1990) technique of analysis. Study themes were viewed in light of van Manen's perspective. Subsequently, Melnechenko also chose to interpret findings through the lens of the theory of human becoming in order to expand "the scientific base of the discipline of nursing" (p. 40). It seemed incongruent to me that the author proposed an atheoretical stance in data collection yet undertook theoretical interpretation for her analysis. This led me to query how Melnechenko sought to establish rigor within the study. In this case, she stated credibility was established as she returned to participants to validate findings. She included descriptions of her processes and included participants' quotes as a way of illustrating themes and demonstrating auditability. While Melnechenko's findings offer much of interest related to her topic of study, as I understand it, an atheoretical approach is incongruent with a human becoming perspective (Parse, 2001b).

In her study, Melnechenko (2002) offered an operational definition of bearing witness as "the willing act of authentically being with an other, in his or her living and telling of his or her situation, with the intention of attending, listening, and journeying with the other" (p. 8). She interviewed six nurses addressing the following questions:

What is the meaning of bearing witness to suffering? How is the experience of bearing witness to suffering lived by nurses who care for dying children and their parents? In this study, the meaning of bearing witness to suffering was described as *the loss of familiar sense of self, prompting intentional involvement to aid in comforting the discomforts while seeking meaning*. For study participants, the experience of bearing witness to suffering as lived was *a loss of physical and personal integrity, a need to protect and to be comforted, a call to other to relate and be close, and a reengaging with the world in which they lived*.

Melnechenko (2002) related her findings in general to human becoming themes of meaning, rhythmicity, and transcendence. Of particular note, Melnechenko found that in contrast to much of the existing literature, although persons interviewed described personal losses, they did not focus on moral distress or grief, but stated that through seeking meaning bearing witness to suffering provided opportunities for personal and professional growth and fulfillment. Change and possibilities for growth are echoed in the work of Cody, Bunkers, and Mitchell (2001) who solidly link bearing witness to suffering with human becoming concepts of originating and transforming. In addition, the nurses interviewed in Melnechenko's study stated that they recognized a need to establish boundaries and distance themselves, while at the same time evolving close relationships with the children and their parents. Participants also reported feelings of guilt and anger, and found comfort in sharing what they had witnessed and satisfaction in believing they were enhancing others' experiences of quality of life (Melnechenko). I interpret this as illustrating the paradoxical quality of human experience, as described by Parse (1981).

In discussing implications of her study, Melnechenko (2002), emphasized the importance of nurses being willing to "witness, accept, and encourage whatever expressions" of experiences might be conveyed, thus creating a safe environment in which children and families may find "value and meaning in the life that remains" (p. 95). She advocated for honest and open communication in practice. Of particular import, Melnechenko recommended that nursing education "extend beyond the bio-psycho-social-spiritual teachings to include existential elements of caring" (p. 96), supporting

nurses in practice where they “do not feel obliged to withdraw or distance themselves from the other to be with them therapeutically” (p. 96). In addition, she suggested further research be undertaken to identify any commonalities with experiences of male participants and persons in other countries and clinical settings, and to determine how nurses can be supported in their experiences.

Kahn and Steeves (1994) conducted a descriptive study whereby 26 nurses in graduate studies participated in interviews about what “suffering, caring, and coping meant to them” (p. 261). Analyzing narratives encompassing very complex and personal aspects of suffering, they identified nurses as witnesses and moral agents. According to Kahn and Steeves, “a witness is a special kind of moral agent, one with an obligation to speak out” (p. 261). They conceptualize four ways in which a person may serve as witness, including firsthand observation, ceremonial witness, expert witness, and bearing witness. In this conceptualization, firsthand observation includes observing and speaking out about an situation or circumstance. The ceremonial role involves watching and validating an event. An expert witness offers a public testimony or presentation of his or her specialized knowledge or area of expertise. The fourth category of witnessing is bearing witness. They emphasized that to bear witness or “to testify to one’s faith in a collective vision of the future” (Kahn & Steeves, p. 264) is important in the way that it fosters the development of nursing’s voice and vision with respect to responses to suffering. Interestingly, as Cody (2001c) points out, these authors take for granted the quality of nursing presence as “genuinely beneficent” (p. 217).

For her dissertation, Eifried (1998) designed a study aiming to contribute to a pedagogy attending to suffering as witnessed and experienced by nursing students. She conducted a hermeneutic phenomenological study in the tradition of van Manen (1990) and addressed the question: What is it like for a student in nursing to be with patients who are suffering? Study participants included 13 students who agreed to be observed in clinical settings, contribute journal entries, and participate in one-on-one and group dialogue sessions. In an article summarizing her research, Eifried (2003) relates how she began each interview by asking participants to “tell a story about a time they could not

forget when they cared for a patient who was suffering” (p. 60). Attending to this interview question, I wonder how would participants have responded if asked to convey their experience of caring for patients who are suffering? The invitation to focus on what stands out or is remembered is interesting since remembering and recalling are commonly associated with bearing witness. Indeed, Eifried’s (1998) analysis surfaced the metatheme of bearing witness to suffering, including the following subthemes: *grappling with suffering*, *struggling with the ineffable*, *getting through*, *being with suffering patients*, *embodying the experience of suffering*, and *seeing possibilities in suffering*. In *grappling with suffering*, study participants described an awareness of feelings such as apprehension, helplessness, powerlessness, aloneness, sadness, and suffering. In *struggling with the ineffable*, participants lived with questions for which they did not necessarily have answers. *Getting through* involved various activities such as turning to others for understanding, finding private spaces at work, feeling needed, feeling capable, praying, and needing to discern with whom students could share their thoughts and experiences. *Being with patients who are suffering* surfaced through students’ responses in touch and speech, including words, laughter, silence, and song. *Embodying the experience of suffering* meant that “patients express their suffering through their bodies. The students sensed their patients’ suffering through their own bodies. The students physically experience their own hurt and learn through their embodiment of suffering” (Eifried, 1998, p. 64). *Seeing possibilities* was expressed in experiences of suffering and vulnerability, in exploring meaning in students’ lives and in patients’ lives, and in the learning that took place. Eifried (1998) wrote,

bearing witness, providing testimony, telling the story to others, can be ways of understanding and learning about suffering. For the students, bearing witness to suffering opened their hearts to their own suffering and called them to seek compassionate ways of being present to suffering patients. (p. 89)

She interpreted that for the students, bearing witness to suffering encompassed the “telling of...stories” (Eifried, 1998, p. 82) about personal experiences of suffering or, in other words, telling “about the truth as they know it” (Eifried, 1998, p. 82). In addition to providing personal testimony (in being present with patients who are experiencing

suffering), the students and patients together became aware of the many dimensions of suffering and possibilities for meaning in life (Eifried, 1998, 2003).

Discussing her findings, Eifried (2003) explored “learning amid suffering” (p. 65), revealing how in bearing witness to suffering, nursing students “struggle [and learn] to be authentically present to patients” (p. 80). In light of her findings, and reflecting the tremendous depth and complexity of experiences in learning, Eifried (1998) stated that nursing education must involve the creation of “a caring community” (p. 93). She suggested this should involve

welcoming students into an inviting atmosphere, knowing and connecting to others, presencing by being open and attending, creating a sacred space that sustains the primacy of caring, safeguarding the practices of reading, thinking, writing and dialogue, and engendering community. (Eifried, 1998, p. 193)

Surfacing the metatheme of bearing witness to suffering as an aspect of beginning nursing education demonstrates how pivotal this experience is for nurses in their processes with others. Eifried’s recommendations for education would seem to serve long-time practitioners and new nurses as well as students.

The concept of bearing witness surfaced in another study focused on nursing education. In her dissertation, Pellico (2004) sought to better understand “the nature of teaching and learning best suited to accelerated learning of nursing knowledge and skills” (p. 12-13). In one section of her study, Pellico utilized a “unique blending of narrative analysis and aesthetic criticism” (p. 117) to analyze 132 journals of non-nurse college graduates participating in an accelerated program of education in nursing. She identified six themes: *forgive and remember*, *intimacy and intensity*, *silence and voice*, *routines and rituals*, *bravery and bearing witness*, and *masquerading and identifying*. The theme of *bravery and bearing witness* was described as “pervasive” (p. 139). Interestingly, several students entitled their stories “Witness” or “Bearing Witness”, wherein Pellico stated that they told of

connecting with patients, hearing their stories, and bearing witness to patients’ lives. Bearing witness took two forms; one was in the moment, standing and being one in the experience, that of witnessing; the other aspect related to retaining and in some stories treasuring the memory for a lifetime. (p. 139)

Within students' journals, it was revealed that patients contributed greatly to student learning, affirming for students "that their greatest strengths were compassion, empathy, ability to listen, and bear witness to the patients' reflections and experiences" (p. 181).

Related to her analysis, Pellico (2004) identified "ten critical elements when learning to become a nurse" (p. 191). These elements included

learning to understand the language of medicine; learning to provide physical care; learning technical knowledge; learning communication skills; learning to become a keen observer; learning that nursing is hard work in general and specifically difficult in an accelerated program; learning to become vulnerable in the educational process; learning to deal with sadness, suffering and inequities; learning to deal with power disparities; and learning to advocate for themselves and patients. (Pellico, p. 191)

Pellico noted that "nursing is hard work and nursing education is equally challenging" (p. 207). She stated that there is only a very limited and inadequate focus in curricula supporting nursing students in learning related to their own vulnerability and learning about dealing with suffering. Pellico interpreted that her study reveals that "opening up, to bear witness to another is a critical element of nursing, one that perhaps mutates into empathy but at year one is raw and painful" (p. 192). In her summary, Pellico suggested that "increased emphasis" (p. 192) be placed on supporting students, especially related to experiencing vulnerability in witnessing trauma and living with other challenges arising within a program of nursing education. Similar to Eifried's (1998) recommendations, Pellico's suggestions hold relevance for nurses throughout their careers.

In light of Pellico's (2004) findings, it would be interesting to explore in another project perceptions of similarities and differences between empathy and bearing witness. In the above quote it appears as if Pellico is suggesting that empathy and bearing witness comprise a continuum, yet I suggest that empathy and bearing witness may be viewed as quite distinct. Further, within empirical perspectives, the ability to have empathy presumes the ability to deeply understand something of another's experience. From a human becoming perspective, the degree or even ability to which persons understand another's experience is questioned.

Kruse (2004) highlights this point in her research within the human becoming perspective, pointing out that bearing witness to the experience of another “does not require objectivity or understanding of the experience by the observer” (p. 220). She conducted a study guided by Parse’s phenomenologic hermeneutic research method (1987) focusing on the phenomenon of *letting go*. This research arose from an earlier study on the meaning of serenity. Eight participants chose a photograph representing *letting go* and engaged in dialogue with the researcher. Study concepts were *persevering in presence despite hardships*, *bearing witness to wavering decline*, and *life unfolds with a new view*. Structural transposition of *bearing witness to wavering decline* was interpreted as *envisioning the suffering of another* and linked with the theoretical concept of imaging. Kruse stated that *bearing witness to wavering decline* “called for a nonjudgmental regard and respect for the dignity” (p. 221) of the person’s living and dying. Kruse recommended further study of each concept comprising the findings of her study.

In her dissertation research, Riley-Giomariso (1998) conducted an interpretive phenomenological inquiry addressing the question: What is it like for senior level baccalaureate students to experience the clinical setting of critical care nursing as they are accompanied by their teacher? The participants for this study were 12 nursing students in their last year of a baccalaureate program placed with the researcher in an adult acute care clinical setting. Data for the study consisted of participants’ art drawings; written stories, reflections, and drawings; and texts of open-ended discussions and videotaped groups sessions. The researcher also contributed her reflections and poems.

Riley-Giomariso (1998) conducted her analysis according to van Manen’s (1990) processes of analysis. The theme of *suffering* arose, including *bearing witness to suffering*. Her personal reflection hinted at the rhythm of bearing witness-not bearing witness. She wrote poignantly, “sometimes bearing witness to the suffering of others is all that you can do. And for some, even bearing witness to suffering is asking too much. Some will choose to never see, hear, or smell suffering” (p. 175). Viewing Riley-Giomariso’s text within a human becoming perspective, I am struck by the complexity of

interrelationships and the paradox illustrated within her experiences and in students' experiences and drawings. They portrayed both despair and satisfaction in being with and learning to provide nursing care for others. So, too, was the "interconnectedness" of human experience highlighted, bringing to mind Parse's (1981) assertion of a mutually cocreated reality.

Similar to Eifried's (1998) and Pellico's (2004) studies, Riley-Giomariso (1998) was primarily interested in implications for nursing education. She wrote,

when we bear witness to suffering, we need to tell the story so the experience of suffering comes to light. It is only then that we can help students to continue to bear witness....Teaching others to bear witness to suffering is not easy, and that is the quandary in which I find myself. (p. 175)

The author stated that "students and teachers need to enter critical care [settings] mindfully aware of the intensity of the human experience in this setting" (p. 32). The intensity of experiences pertained to all involved: patients, families, students, and teachers. As Riley-Giomariso conducted her study, she states that a narrative pedagogy supported her in being with students in ways that helped them to "find meaning in their clinical experiences and...possibilities for sacred interconnectedness with their patients" (p. 218). The recognition of the importance for nurses in being willing to engage in intimate interrelationships is strikingly highlighted in all the above studies.

### *Summarizing Chapter 2*

Chapter 2 explored theoretical and reviewed research literature related to bearing witness. As revealed within these resources, experiences of bearing witness hold relevance for caregivers and others, revealing significant implications for nursing practice and education. However, the phenomenon is significantly understudied within the discipline of nursing. Study of the experience of bearing witness is well suited to the human becoming perspective, which views the human as mystery and human experience as paradoxical and uniquely personal. Chapter 3 specifies this study's methodology.

### Chapter 3: Specifying Methodology

Chapter 3 details choices in and processes of study design and methodology for this qualitative descriptive exploratory study within the human becoming perspective. As specified by Parse (2001c), processes of descriptive exploratory studies include the following:

1. Planning a coherent design to ensure scientific merit.
2. Specifying the participant group.
3. Planning for the protection of participants' rights.
4. Gathering data....
5. Analyzing-synthesizing data....
6. Discussing findings in light of the disciplinary perspective guiding the study.
7. Recommending further research. (p. 58-59)

This chapter outlines choices of study design including philosophical assumptions; participant selection and protection; study question, purposes, and objectives; and processes of data gathering and analysis. All choices reflect my interests and establish the ontological and epistemological frame of reference of this study (Denzin & Lincoln, 2000; Guba, 1990; Parse, Coyne, & Smith, 1985; Parse, 2001b, 2001d). In addition, Parse's (2001e) criteria for appraising the quality of a qualitative research study are presented as adhered to in study design, conduct, and presentation (see Appendix B).

#### *Planning a Coherent Design*

In contrast to the traditional, empiricist view of science as a product delineating prescriptive formulas and apparent truths or facts, White (1938) challenges scholars to "view science as a way of behaving, as a way of interpreting reality" (p. 372). In this way, science is viewed as a process rather than a product (Northrup, 2005). Conceptualized as *sciencing*, scientific inquiry is a continuous creative process, which surfaces ever changing understandings of phenomena through rigorous and systematic processes and methodologies (Parse, 2001a; White). Parse lists the assumptions underpinning sciencing as follows:

1. To question is to reach beyond what is with what is possible.
2. A question in itself incarnates the questioner's attitudes, beliefs, and style and points to personal projects.

3. Both questions and answers are set with the boundaries of the questioner's understanding of the phenomenon.
4. The questioning process and the answers are intersubjective. (p. 2)

Parse (2001a) contends that the concept of sciencing is particularly relevant to and congruent with the study of human experiences in which "absolute truths are not sought" (p. xxv). A process of sciencing is congruent with non-empiricist philosophical assumptions that underpin this study framed within the human becoming theoretical perspective (Parse, Coyne, & Smith, 1985). Within this particular ontological and epistemological view of scientific inquiry, I seek to make explicit my assumptions and perspective. Specifically, this study is designed and conducted in the light of personal philosophical assumptions as I engage in a process of questioning, interpreting, and conceptualizing within a chosen theoretical perspective. Thus, it is my understanding that study participants and I together cocreate data related to the phenomenon of inquiry.

As detailed in chapter 1 of this thesis, the phenomenon for inquiry was bearing witness and the chosen theoretical perspective for this study was human becoming (Parse, 1992). In asking the research question of what is the meaning of the experience of bearing witness, I was directed to a qualitative research approach (Guba, 1990; Parse, 2001b, c; Parse, Coyne, & Smith, 1985). This approach originated within the social sciences as suitable for formal inquiry into the meaning of life events and/or human experiences (Denzin & Lincoln, 2000; Guba; Parse, Coyne, & Smith; Parse, 1996, 2001c; Phillips, 1989).

The specific method chosen to support investigation of the research question was descriptive and the approach was exploratory. Descriptive inquiry "focuses on social connections, interrelationships, life events, and other matters concerned with the social sciences" (Parse, 2001c, p. 58). An exploratory approach was appropriate here since the aim was to conduct an in-depth study of a phenomenon about which little was articulated (Brink, 1998; Parse; Parse, Coyne, & Smith, 1985). Explicating assumptions underlying descriptive exploratory research, Parse writes, "humans create social networks, humans can describe retrospective and prospective life events, and patterns and themes surface through intense study of phenomenon" (p. 57). Congruent with the qualitative approach

and the human becoming perspective, this research study focused on describing and exploring a human lived experience.

Smith (1989) states that for the purposes of research, “it is important that the phenomenon be named at a level of abstraction experienced by the subject” (p. 3). Thus, I make explicit that, in my experience, bearing witness is a term utilized and an experience lived in a variety of ways by many health care workers. It is of significant interest to the discipline and practice of nursing. As illustrated in chapters 1 and 2, bearing witness in being present with persons is considered to be an important aspect of nursing practice and crucial to fulfilling professional responsibilities (Cody, 2001a; Drought, 2002; Storch, 2004). Within the human becoming perspective, bearing witness is posited as integral to the process of cocreating human interrelationship (Cody). Cody explicates bearing witness-not bearing witness as “a paradoxical rhythm of human becoming” (p. 97). Nurse scholars Cody, Bunkers, and Mitchell (2001) refer to bearing witness as a human health experience. Thus, further exploration of the experience of bearing witness is relevant to human-universe-health and nurse-person processes, and to the discipline of nursing.

#### *Specifying the Participant Group*

The population of this study was registered nurses who self-identified as currently in practice with persons living their dying. While nursing practice takes place in a variety of settings including homes, hospices, and hospitals, this study sought to identify understandings of the experience of bearing witness common to all study participants, regardless of practice setting. For the purposes of this study, nurses who volunteered to participate in the proposed study were solicited from within the Victoria Hospice Society (VHS), which offers a variety of hospice palliative care services in hospital and home.

While some authors employ terms such as *palliative care* or *hospice and palliative care*, the membership of the Canadian Hospice Palliative Care Association [CHPCA] (2003-2005) has coined and adopted the phrase *hospice palliative care* to reflect an understanding that the terms hospice and palliative are neither interchangeable nor independent entities. Together, these terms continue to evolve in meaning from their Latin derivations denoting respectively, “hospitality” and “to cloak”. The CHPCA (2003) document, *A Model to Guide Hospice Palliative Care: Based on National Principles and*

*Norms of Practice*, states that rather than focusing on curative goals in health care, hospice palliative care “aim[s] to relieve suffering and improve the quality of living and dying” (p. 17). Generally, nurses and other practitioners understand this to mean that persons accessing services within this area of the health care delivery system are living with a medical diagnosis for which, from a medical perspective, cure is perceived to be unlikely and prognosis is considered limited or death is viewed as imminent. In this study, the term *hospice palliative care* was used to denote this particular focus and categorization of health care and nursing practice.

The phrase *persons living their dying* refers to the general population of persons with whom the nurses were in practice. In contrast to *clients*, *patients*, or other designations, the term *persons* aims to challenge habits of labeling (Deegan, 1993). This choice of language demonstrates a preference for viewing people as unique human beings rather than consumers, symptoms, diagnoses, or problems. Jonas (1994) first coined the phrase *persons living their dying* within the human becoming school of thought (Parse, 1998). Distinct from describing and labeling persons as *palliative*, *terminal*, *dying*, or *at end of life*, the phrase *living their dying* refers to a human experience. Following the lead of several other authors and researchers (Hutchings, 2003; Lee & Pilkington, 1999), this term was selected for use in this study because it reflects my belief that persons, including those who are accessing hospice palliative care services, are living and dying simultaneously and are continuously, uniquely evolving and experiencing their living-dying. The terminology chosen is congruent with the theoretical framework of this study.

Eligible participants for this study were English-speaking adults (19 years or older) who self-identified as registered nurses currently in practice. Participants who volunteered for this study included nurses who fulfilled managerial, administrative, education, research, and clinical duties and responsibilities within VHS. They were willing and able to convey personal meanings and experiences of bearing witness in their nursing practice with persons living their dying. According to Parse (2001c), “there is no set number of participants required by this [exploratory] method” (p. 59). Seven persons participated in interviews. Several other nurses offered to participate if the study was

extended or required additional participants. In addition, several members of other disciplines indicated they would be interested in telling of their experiences of bearing witness and hoped for future opportunities to do so.

All seven participants in this study were women, each of whom is introduced in chapter 4 of this study. In a manner consistent with this study's perspective, I did not specifically seek to collect demographic data. From this perspective, findings surface as concepts and themes common to all study participants. These are not considered generalizable to others. Findings are not correlated with or attributed to particular qualities or characteristics of participants, populations, or organizations.

#### *Protecting Participants*

Protection of participants was achieved through several strategies and requirements of research commonly accepted as necessary for conducting studies with human participants. These involved scrutinizing the research proposal for ethical soundness, obtaining formal ethical consent, ensuring persons freely and voluntarily agreed to participate in the study, and adhering to measures addressing participant comfort, anonymity, and confidentiality.

Ethics approval for this study was granted by the University of Victoria and the Vancouver Island Health Authority Joint Research Ethics Subcommittee. Throughout the process of gaining ethical approval and conducting the study, I adhered to guidelines presented by the Human Research Ethics Board [HREB] (University of Victoria, 2004) and consulted when necessary with staff members in the University of Victoria Office of Research Services. I examined other research studies conducted within the human becoming perspective (Bauman, 1994; Bournes, 1997; Cody, 1992; Daly, 1994; Hutchings, 2003; Jonas, 1992, 1999; Nellett, 1998; Northrup, 1995; Schick Makaroff, 2005; Whiteman, 2004) and engaged in a process of teaching-learning with my thesis supervisor, supervisory committee, participants, and peers.

Notification of this study took place by letter of invitation (see Appendix C) and word of mouth. Thus, persons were free to consider whether or not to contact me and to participate in the study. In addition, I introduced my project during an information session

at a staff educational meeting. Persons who choose to ask questions about the project or wished to view the consent form were free to contact me in person or via phone or email.

Each participant was required to sign a consent form (see Appendix D) indicating that he or she understood the conditions of participating in the study and was given an opportunity to have any questions answered to their satisfaction by the researcher and/or a member of the supervisory committee. The consent specified the nature of the study, avenues to confirm ethics approval, measures to protect anonymity and confidentiality, and any potential benefits and risks associated with the study. In addition, the consent clarified that persons were under no obligation to participate in the study and were free to discontinue or reschedule the study without explanation or consequence. Participants were free to contact me or my supervisor at any time.

Working with each participant, I endeavored to minimize the possibility of interruptions and enhance experiences of contributing to the research study. Interviews took place at a time and in a private, comfortable location convenient to each participant. Meeting places ranged from participants' homes to office spaces within the agency, and times ranged from early morning to late afternoon. Interviews began when the participant indicated it was appropriate and ended when the participant said the interview felt complete. Interviews lasted anywhere from 55 to 90 minutes and were scheduled over a period of several months. Participants and I had the option to request a second interview to enhance depth or clarity of descriptions. As detailed later in this chapter, I requested and was granted a second interview with one participant.

Aspects of protecting anonymity and confidentiality of each participant were addressed by utilizing several measures pertaining to the consent to participate and data management and in accordance with the HREB (University of Victoria, 2004) requirements. Specifically, I did not reveal the identity of any participant and I assigned a pseudonym for each person to be utilized in textual descriptions of participants. Identifying details in participant introductions, descriptions, and quotes were altered or removed in presentations or publications of findings. Consents for participation in this study were kept separate from data. These will be shredded and recycled after a period of

five years. A single list of participants' names, contact information, and codes was kept by the researcher, separate from the audiotapes, transcriptions, and consents. The list will be shredded and recycled once the study is complete. Audiotapes were numerically coded and stored in a locked metal box and placed in a locked cabinet available only to the researcher and, upon request, members of the supervisory committee. Tapes were transcribed and tracked via a numerical code. These were erased once data analysis was complete. The transcriptionist was required to sign and uphold a confidentiality agreement (see Appendix E) and place transcribed data onto a clean computer flash drive provided by the researcher. The flash drive was stored in a locked cabinet. The flash drive will be erased once the study is completed. Printed copies of the transcriptions were made for the researcher and committee supervisor, and stored in locked cabinets. Transcriptions will be kept for a period of five years, permitting potential further study of the phenomenon by the researcher and inclusion of data in research studies with other persons. At the end of the five-year period, consents and printed copies of transcriptions will be shredded and recycled.

Potential benefits of engagement in this study were identified as similar to those that might be experienced in sharing everyday experiences of nursing practice with persons living their dying. Specifically, participants agreed that nurses commonly discuss, debrief, and critique practice situations as an aspect of reflective practice, and the opportunity to explore and discuss experiences of bearing witness was perceived as meaningful and beneficial to participants. In a time when it remains important to define and articulate the science and scope of nursing practice, participants agreed it was necessary to expand descriptions of the many intangible but immensely valuable contributions of nurses in practice. Further, nurses relate many challenges in practice with persons living their dying and value opportunities to ponder where and how to glean support and guidance in being present with persons. Framed within the human becoming theory of nursing, one aim of this study was presented as contributing to nursing science and descriptions of bearing witness. Participants indicated that they valued contributing to the disciplinary knowledge base in this way, hence shedding light onto nursing

practices and policies. There was no monetary remuneration associated with participation in this study; however, I gave each participant a thank-you card and note (at a small cost incurred by myself) upon completion of data gathering.

This study was designated as minimal risk in accordance with the guidelines of the University of Victoria Office of Research Studies (2004). Each participant decided for him or herself whether they could contribute the time necessary for the interview, and there was no indication of hierarchical or authoritative dynamics of interrelationship. Indeed, persons in both staff nurse and managerial positions indicated their interest in participating in the study. Although it was not possible to make predictions about experiences of participating in research interviews, it was conceivable that participants experienced challenges in relating experiences of bearing witness. Similar to potential benefits, possible challenges were associated with activities of reviewing personal practices. I checked with each participant to inquire about their experience of participating in the interview. Several participants commented that they felt somewhat fatigued after the interview. None of the participants indicated that they utilized the contact information for professional support services and resources available to them (see Appendix F).

### *Gathering Data*

Data was gathered via face-to-face interviews and included notes taken prior to, during, and after interviews. In this section of the thesis, I would like to share some of my experiences of participating in interviews. This is an important aspect of this thesis since interviewing for research is a complex process and quite different from my nursing practice in hospice palliative care. While both are interactive processes, I am surprised at just how interactive interviewing for research purposes is.

I was reminded of Heinlein's (1961) novel, *Stranger In a Strange Land*, and his characters referred to as Fair Witnesses. Fair Witnesses are described as people called upon to observe events, negotiations, and the conversations of others, perhaps in a fashion similar to formal witnesses in aboriginal communities of past and present. In Heinlein's story, a Fair Witness is trained and educated to observe, report, and "testify

before the High Court” (p. 100) or in public, subsequently describing in detail what he or she saw. The way I understand it, a Fair Witness is hired to be fully present for an event or discussion, entirely focused on what happened in a particular situation. Unlike me, a Fair Witness is never distracted by other events, personal thoughts, uncertainty, or the urge to engage in analysis in that moment. While I recognized that the work of a researcher was not that of Heinlein’s Fair Witness, I was struck by how easy it was for me to be distracted and I was somewhat dismayed at how difficult it was for me to be truly present with the participant of each interview. Following conversations with various colleagues, I realized that while I did know how to be present with others in my own particular way in my everyday nursing practice, I was not yet familiar with the way of being present that I was aiming for in interviews.

In interviewing, I aimed for practicing true presence as described by Parse (1992): “a special way of ‘being with’ in which the nurse bears witness to the person’s...own living of value priorities” (p. 40). In other words, Parse (1994) describes true presence as “a powerful interhuman connection experienced at all realms of the universe” (p. 18). In this way, I hoped to facilitate the participants’ exploration and expression of their experiences of bearing witness. Analyzing each interview and reflecting upon my experience however, I noted it was very difficult and tiring for me to stay focused with the participant and what she had to say about her experiences. As several other researchers indicated (Hutchings, 2003; Schick Makaroff, 2005), practicing true presence took significant preparation and practice. In my situation, I discovered a challenge related to how I conceived of my phenomenon of study. Specifically, when I thought about bearing witness as a *concept* with some sort of accurate definition, I found I was looking for certain attributes of the definition within the participant’s descriptions. When I was reminded that the focus of the research was the *experience* of bearing witness, then I began to see that it was important to let go of a definitive conceptualization in order to be able to attend with appreciation and respect to the uniqueness of each participant’s experience. As Dass and Gorman (1990) write, “to view the world only in terms of concepts strips it of its mysterious beauty, its power to refresh” (p. 130). The necessity of

remaining focused on the participant's experience, and not my experience or a dictionary definition or conceptualization, seemed obvious, but was crucial in seeking to be truly present with each participant.

In light of the small number of study participants within a small organization, one of my concerns was preserving anonymity and confidentiality within participant introductions and extracted descriptions. Sometimes it seemed to me that stories, words, and phrases within the interviews were particularly distinctive, complex, and with many references to specific individuals and situations. Thus, I was unsure how to preserve participant anonymity and confidentiality, yet maintain a rigorous process of analysis-synthesis and provide illustrative quotes from participants. This was particularly the situation with respect to my interviews with one participant in this study.

On initial review and analysis of one participant's interview transcript and tape, I was struck by the complexity and diversity of information and ideas presented. She rapidly presented many ideas, examples, and experiences for consideration. In initially drafting the extracted description of bearing witness for this participant, I struggled with language and detail of data to the degree that I wondered if I was 'putting a spin' on the data rather than engaging in analysis-synthesis. Persisting with reading and listening and writing, I came to understand that much of the interview revealed the participant's beliefs and philosophy of nursing practice and personal interrelationship. Unfortunately, what was initially less clear to me was how this related to the meaning of the experience of bearing witness for her. In this way, I was not sure whether or how this data could be included in my analysis. Thus, I reviewed the transcript and tape with my supervisor, and we agreed that I should request a second interview, to which the participant generously agreed. My thesis committee supervisor offered suggestions for better facilitating and focusing discussion on the person's experience of bearing witness. Hence, during the second interview, I continued to strive in my endeavors to be present with my participant, and asked her at various points to make more explicit links to the phenomenon of study. In this way, her description of the meaning of her experience of bearing witness became more apparent to me. Still, significant challenges remained in identifying research

themes, synthesizing illustrative examples of research themes, and maintaining anonymity, calling into question whether and how I could include the data in the study.

The process of continuing to abide with the taped and transcribed data took on a new degree of intensity in which I made the decision with my supervisor to include the data from all interviews conducted for this study. The process of making this decision enhanced in several ways my understanding of issues related to interviewing, analyzing-synthesizing, and presenting findings. First, attending to my challenges provided further opportunities for in-depth analysis of the process of being truly present in research interviews. This, as noted earlier, was vital for my continued learning as a beginning researcher. Indeed, I found myself wishing that I could conduct more interviews with the study participants and with others. There was so much to learn, and each encounter brought new insight and understanding. At the same time, some aspect of interviewing that seemed clear on one occasion could be quite obscure to me in the next interview or session of writing.

Second, I learned that there was an interplay among data from all interviews in the process of analyzing-synthesizing. Specifically, the data from one transcript helped shed light on the study themes that were or were not common to all participants. I learned that transcripts were not viewed in isolation from each other. Rather, the words, phrases, concepts, themes, and examples from one highlighted what was and was not apparent in the others. Here, I came to understand that persistence and perseverance in engaging with the data through reading and re-reading, listening and re-listening, and writing and re-writing, *was* the process of analyzing-synthesizing. This helped me to see how each participant described her experience of bearing witness and facilitated my process of extracting illustrative examples. As such, I came to view analyzing-synthesizing as an interpretive process. Even so, the choice of whether or not and how to include a particular interview as data was a complex, careful process of critique and decision-making.

The theoretical themes of human becoming determined the objectives and interview questions of the research study (Parse, 1996, 2001b, 2001c). The three theoretical themes emerging from the philosophical assumptions of human becoming are

meaning, rhythmicity, and cotranscendence (Parse, 1998). Interview questions derived from the objectives are presented in Table 2.

Table 2

*Study Objectives and Interview Questions*

1. To describe the meaning of the experience of bearing witness for nurses in practice with persons living their dying.
 

Interview Questions:

  - a. What, for you, is the meaning of bearing witness?
  - b. What is the experience of bearing witness like for you in practice with persons living their dying?
  - c. How would you describe the experience of bearing witness?
  - d. Would you give some examples of what it is like for you to bear witness with others in your nursing practice?
  - e. What, for you, contributes or not to the experience of bearing witness?
  - f. What would be important for me to know about your experience of bearing witness?
2. To describe patterns of relating in bearing witness for nurses in practice with persons living their dying.
 

Interview Questions:

  - a. How has the experience of bearing witness influenced the way you are with others? What changes have taken place?
  - b. How has the experience of bearing witness influenced relationships with others? What changes have taken place in your relationships?
  - c. How has the experience of bearing witness influenced your nursing practice with others?
3. To describe possibilities, hopes, and concerns surfacing in experiences of bearing witness for nurses in practice with persons living their dying.
 

Interview Questions:

  - a. What possibilities/dreams/visions/hopes/concerns do you hold with respect to bearing witness in nursing practice?
  - b. What hopes/concerns do you have related to bearing witness with others as you continue your nursing practice?
  - c. How does/has the experience of bearing witness influence/d how you would like to be with others in your nursing practice?

Most often, open-ended questions of a general nature were asked, such as:

1. Could you tell me (more) about that?
2. Can you give me an example of that?

3. What was it/that like for you?
4. What changes have taken place...?
5. Would you tell me how that relates to bearing witness for you?

In asking general questions, the goal was to encourage the participant to focus on whatever she chose with respect to the phenomenon for inquiry and avoid redirecting the dialogue onto some aspect of the description specified by the researcher.

*Analyzing-Synthesizing Data*

JOURNAL ENTRY: A well-known translator of the poetry of Rumi (a thirteenth century Sufi poet), Barks (1999) writes: "I wait beside these poems with a kind of heart-listening" (p. xvii). Reading this, I think of Barks as a sort of...distiller. Someone who creates a rich, poetic liqueur as he abides with the words and rhythms of Rumi's work. In this abiding, I guess that Barks has to trust that the meaning of what has been written or recited may yet appear in new ways. And so, he lives the mysterious, (perhaps) tedious processes of waiting and translating. And, in a while, new words and word-patterns surface. It seems that there is a change from one language to another, yet something of meaning and intention remains in common within the old and new poems. In the midst of cocreating, something both persists and is transformed. Thus, the new poem is *of* both Barks and Rumi. Although it is not clear to me that research actually involves translating, I imagine that similar to this process, and resonating with Parse's (2001c) descriptions, the processes of interviewing and analyzing-synthesizing also involve a sort of waiting and "heart-listening".

As outlined by Parse (2001c), processes of analyzing-synthesizing data within descriptive exploratory studies involve:

- a. Identifying major themes according to the objectives in the language of the participant(s).
- b. Reading the transcribed text of the interview while listening to the audiotape and viewing the videotape.
- c. Identifying and separating major ideas contained in the data about the phenomenon of concern.
- d. Identifying and separating major ideas common to all participants.
- e. Naming representative themes of the major ideas common to all participants.
- f. Stating major themes according to the objectives in the language of the researcher.
- g. Constructing a description of the phenomenon from a synthesis of the themes in the language of the researcher. (p. 59)

Within the human becoming tradition, Parse, Coyne, and Smith (1985) describe analysis-synthesis as:

A process of separating the themes according to the major elements in the objectives, examining these elements, and constructing a unified description of the phenomenon as lived by subjects. The major themes are transformed to a higher level of discourse in the move from the subjects' language to the language of the researcher. (p. 94)

Adhering to these processes and participating in research synthesis-analysis was an interesting, intense experience. It involved listening to tapes; reading and adjusting the accuracy and detail of transcriptions; reading interview notes and reflections; tracing on large pieces of paper the path of each interview (including illustrative stories and phrases shared by the participant); drafting many versions of each person's description; summarizing how each participant decided to participate in and prepare for interviews; summarizing what it was like for participants to participate in the interview; writing a general introduction to participants; writing out and sorting aspects of the experience that each participant emphasized; identifying theoretical concepts and themes as well as study themes. This was not a linear process. Whenever I experienced a lack of momentum in course and process, I would seek inspiration and clarity through consulting with my supervisor, committee members, and peers; reading other theses, articles, or novels; creating poems using participant's words and phrases; writing in my journal; praying or meditating; and retreating to the outdoors. The intensity and variety of this process contributed greatly to my learning as a beginning researcher.

JOURNAL ENTRY: On Being in Analysis: No doubt Deborah and I are not the first supervisor-student pair to joke about how being enmeshed in this complex research process of analysis-synthesis could be interpreted as similar to engaging in a deeply personal process of analysis. You know, as in some sort of psychoanalysis—but I guess that's incongruent with this perspective. Still, I suggest the similarity is in the intensity of the process and how I so easily make sure 'it's all about me and my process'. The whole thing is quite fascinating, yet incredibly arduous. So, when people ask me how I am doing, and I tell them: "I'm in analysis." And then I mutter: "In more ways than one." Even as I am (ostensibly) writing about other persons' experiences of bearing witness,

somehow I am also examining (in excruciating detail) the murky minutiae of my own life.

These days, whatever comes to my attention is construed and considered in light of my research. For example, I read an email, the source of which I can't recall, from a friend that included quotes of what little children (apparently) have to say on the topic of love. One quote says, "When someone loves you, the way they say your name is different. You just know that your name is safe in their mouth." I think how utterly delightful is this observation and lose track of the rest of the email, meandering off to contemplate the significance of re-naming study participants. What *about* pseudonyms, anyway. Are they, and the attached stories and memories, safe in my mouth, and within the pages of my thesis? Names and words contribute to significant changes in our world, so what does a change of name and a rearrangement of words do here? Perhaps, for one thing, this line of thought simply emphasizes how whatever a researcher calls data (including whatever he or she does and does not hear, note, see, read, and write) is to some degree a very personal matter, having to do with values, lens, and interpretation. See? It's all about me.

Sometimes I feel overwhelmed by the amount of data and the idea of producing a thesis or product. Often I feel irritated by 'interruptions' requiring me to attend to other commitments in various jobs or at home. When engaged with the data, I experience a sort of 'being in the moment', as if in analysis I have to 'be present' with the data. I have a sense of the data sort of...steeping or percolating. Somehow, this process takes time and space. Hence, I decide that I need to find ways to persist in this work, reminding myself to trust the processes of writing and learning and analyzing-synthesizing. I need to remember again how in my grad school classes I learned that writing-reading-thinking-journalling-dreaming-etc. *works*. When I am writing a paper, I don't know *what* will happen, but in that process, something *does* happen, and, then, a product is created.

One of my greatest challenges in analyzing-synthesizing involves reading transcripts and moving my process from one of criticism to critique. Indeed, I confess that my first readings and hearings of transcripts were punctuated by my occasional (mild) curse or groan in light of what I see as my clumsy style. (It is not easy to learn the techniques of interviewing within this perspective.) Nonetheless, a change from self-criticism to scholarly critique seems necessary so that I shift the focus from me and my so-called analysis to the participants and what they have to tell about their experiences. I wonder, even though our interviews are 'done', perhaps, somehow, my participants and I are still cocreating...Early in my studies I came across Barks' (1999) phrase "heart-listening" (p. xvii) describing an aspect of his process of translating poetry from one language to another. As Deborah points out, Barks' "heart-listening" seems

akin to Parse's (1994) conceptualization of lingering presence. An aspect of living true presence in practice, lingering presence refers to "a reflective-prereflective 'abiding with' attended to through glimpses of the other person, idea, object, or situation" (p. 19). In this way, I persist in abiding with our data in a process of analysizing-synthesizing.

### *Appraising Qualitative Research*

A set of criteria for assessing the quality of a qualitative study was introduced by Parse, Coyne, and Smith (1985) and further refined by Parse (2001e). I gave consideration to these criteria in developing and conducting this research study. As listed in Appendix B, appraisal from the perspective of these authors encompasses conceptual, ethical, methodological, and interpretive dimensions. Within each dimension, the study's logical flow and correspondence with its philosophical framework are enhanced through addressing the standards of substance and clarity (Parse). As Parse explains, "*substance* refers to the soundness and comprehensiveness of presentation of the phenomenon under study, accuracy of the supporting evidence, and semantic consistency in levels of discourse" (p. 243). "*Clarity* refers to the logical flow of ideas, appropriate grammatical expressions, and technical precision" (Parse, p. 243). Criteria for fulfilling the demands of substance and clarity in four dimensions are summarized below.

Substance and clarity within the conceptual dimension of a qualitative study are established as the phenomenon for inquiry, research question, and theoretical framework of the study are accurately, clearly, and comprehensively presented (Parse, 2001e). This provides a framework for achieving congruence within ontological and epistemological aspects of a study, and requires that the researcher explicate philosophical assumptions as well as choices and lines of inquiry and reasoning. Thus, I presented the frame of reference, including philosophical and theoretical perspective of this study, in detail. In addition, the study question was shown to be consistent with this frame of reference.

Substance and clarity within the ethical dimension addresses scientific merit, protection of participants, and integrity of the study (Parse, 2001e). Scientific merit is established by ensuring and demonstrating congruence throughout the research process. Throughout this thesis, I strived to present the process of research in a comprehensive fashion and with semantic consistency and logical coherence. I specified how the study

contributed to the unique knowledge base of the discipline. I ensured that formal ethics approval for the study was granted. Confidentiality, safety, privacy, and anonymity of participants were preserved through commonly accepted measures for research with human participants. Protective strategies and measures are well documented and illustrated within the text and appendices of this study. The prospective participants freely and voluntarily chose whether or not they would be involved in the study. In addition, the integrity of the study was reflected in the accuracy and authenticity with which data were addressed and reported. I strived to accurately and appropriately credit the work of other scholars.

As described by Parse (2001e), the methodological dimension of a study encompasses the processes of gathering and analyzing-synthesizing data. The choice about how data were gathered was dictated by the research question and detailed in the text of this thesis. Substance and clarity of this dimension were also addressed through establishing the coherence of the study and adhering to the processes of analyzing-synthesizing outlined in the specified method of research.

I sought to address requirements for substance and clarity within the interpretive dimension through ensuring that implications pertinent to theory development, practice, and further research were clearly identified and disseminated (Parse, 2001e). Following Parse's criteria, it is my belief that study findings are accurately represented, resonating with other persons as making "a valuable contribution to the literature" (p. 246). The final determination as to how requirements for substance and clarity are met within interpretive, conceptual, ethical, and methodological dimensions rests with the members of my thesis committee.

### *Summarizing Chapter 3*

Chapter 3 of this thesis provided information and reflections regarding study design. Adhering to Parse's (2001b, 2001c, 2001e) guidelines for design and critique of research studies, assumptions and perspectives of the study were presented in detail. Constructed with the framework of human becoming (Parse, 1981, 1992, 1998), the study phenomenon, question, participants, and method were specified. Study findings are presented in chapter 4.

## Chapter 4: Presenting Study Themes

The purpose of this chapter is to present and discuss research findings from this study. Each of seven study participants is introduced and a description of bearing witness extracted from each interview is presented. Congruent with the chosen methodology, study themes common to all participants are presented in the language of participants and in the language of the researcher. Study themes are illustrated with quotes extracted from participant-researcher interviews. It is important to note that on some level the assumptions and principles of the theoretical framework of this study are inseparable. Thus, although participant quotes are chosen to clearly illustrate study themes, it may be that an extracted quote may well illuminate a variety of theoretical themes and concepts.

### *Introducing Participants and Presenting Extracted Descriptions*

Writing participant introductions and descriptions was a particularly intense process that required close supervision and the creation of many drafts. This was a process within analysis-synthesis that served to explicate words, phrases, and descriptions unique to each participant. In order to enhance the flow and tone of the narrative, I used quotation marks in the descriptions to encompass only quoted sentences and long phrases and to better facilitate understanding through emphasis. Despite using the words of participants, it was important to do so without inadvertently revealing the identity of study participants or persons within stories. Considering challenges related to preserving anonymity and confidentiality within a small community, I provided only a general introduction to each study participant, including descriptions of how the person chose to participate in the study and what the interview process was like for her. I note that, despite my concerns regarding anonymity and confidentiality, several participants were pleased to announce in public their support for this project and willingness to participate.

### *Introducing Participant One: Anne*

Anne was the first person to volunteer as a participant for this study. She worked for several decades as a nurse, contributing to the evolution of hospice palliative care nursing on many levels. Anne and I met in the comfort of her kitchen overlooking her garden, and we engaged in additional conversation before and afterward, as she recounted

stories of bearing witness in both professional and personal aspects of life. Anne was articulate and thoughtful, describing her experience of participating in interviewing as similar to “walking a labyrinth”. This process brought many memories and some new insights for her. She gave consideration to several perspectives, including her experiences of serving as witness and as a person who, at times, wanted someone to bear witness to her experiences. For Anne, interviewing itself involved a process of bearing witness.

*Extracted Descriptions of Bearing Witness for Anne*

In Anne’s experience, bearing witness meant following through with “what we say we [can] do” for a person, such as managing pain and symptoms, and at the same time acknowledging we have no control over how things will be for a person. Exploring what she could provide for others in practice, Anne realized that the only thing in her control was how she was with a person. Hence, she considered bearing witness for others to represent a covenant and near obligation: her promise to never abandon someone even in the most difficult of circumstances. As such, Anne strived to honor a person for being whomever he or she was, instead of working to make sure a person’s life and death happened a certain way. Although sometimes she saw and experienced immense sadness and suffering, bearing witness also brought to her an awareness of “the indomitable human spirit...[and even held] glimpses...of...humour”. Experiences of bearing witness crystallized for her an ultimate commitment to live with an awareness of a deep and spiritual relationship with others and her world. Everyday she sought to enjoy and bear witness to the many parts of life, including all that was burdensome, mundane, and precious.

In bearing witness, Anne experienced a deep, moving intimacy with others. While she spoke of bearing witness as something one does for another, experiences of bearing witness came “at a place of not [focusing on] doing” things for others, but in being present, being still, and attending to others. The depth of intimacy with others was such that her very soul was touched; she felt as if she had “taken something on”; something was lodged in her memory or, even, seared in the cells of her body. Her experience in bearing witness was evidence that something significant had happened for someone. In

this way, she felt connected and was more than a sounding board for others, but without becoming enmeshed in their lives. She saw herself as serving as a sort of vessel so that people were free to be themselves. Sometimes Anne experienced a resistance in getting to know a person, yet she knew she was bearing witness when she could say, "I know you". She noticed that others often acknowledged that she bore witness to what they were going through. When the opportunity arose, Anne told other caregivers what she had "seen...acknowledged...felt, [and how she had] been moved" in the presence of a person, so other caregivers might know something about the experience of that person and perhaps see the person in a different way.

Considering possibilities for teaching others about bearing witness, Anne indicated nurses should be encouraged to develop close connections, but be sure to maintain appropriate boundaries. She spoke of "bringing that [experience of bearing witness] to the fore". Hence, new nurses and other employees would be supported in learning about how bearing witness was important for nursing practice. As a process, she thought it could be nurtured and developed through sharing story telling and experiences, supporting mentorship and study, engaging in reflective and meditative exercises, building team, and providing an encouraging ethos within the organization.

*Introducing Participant Two: Leah*

Leah was an experienced nurse, having worked in diverse practice settings and medical specialties. She described several very difficult experiences in life, including the deaths of several friends and members of her family, that led her to explore the hospice movement and hospice palliative care nursing. At the time of our interview, she was contemplating the possibility of furthering her formal nursing education. Education and participation in research studies represented something she thought was particularly valuable for all nurses, that is, taking time to "touch base", to reminisce, share, and learn from relationships and experiences in practice.

Leah and I met early one morning at her home. Once Leah saw her family off for the day, and except for a phone call or two recorded by the messaging machine, the relaxed and quiet atmosphere was enlivened with her energy. To begin, we shared

something of our mutual interests related to family and work and then addressed Leah's questions about the study. The stories about bearing witness that came to mind, she said, "are mostly ones about spirit and things about the heart of the care...provided: things about understanding something."

*Extracted Description of Bearing Witness for Leah*

The many gifts of sacred and sweet times of bearing witness with friends, students, patients, families, and peers comprised for Leah a rich and dynamic tapestry. Woven with dark threads representing suffering and grief, bearing witness was for her also "about the miracle of life", including experiences of joy and humour. Leah valued her work for allowing her to do practical things for others as well as "touch on spiritual and psycho-social" aspects of life. Leah said that through bearing witness the "very fibre" of who we are is changed, and she wondered if such changes in her served to bear witness to the lives of others.

Although Leah didn't always feel connected or have the energy to be with others, Leah said that the experience of bearing witness was a time of loving relationship, of being "heart to heart" and when "spirit touches spirit". She felt a commitment to respond to calls and an intense desire to bring about comfort, safety, personal growth, and healing for others, yet also thought it was important to accept and trust the flow of events, and honor the preferences and experiences of others. These days, Leah trusted more and worried less, believing that if she truly was needed and the time was right, somehow she would be able to be with and do something helpful for whomever asked for her help.

Leah said that bearing witness was "about attending to and being with [others] in a full sense,...[and included] a promise...of action". "You know", Leah emphasized, "if we bear witness to something and...don't use it [ie. share, advocate, follow through], we waste...an opportunity" to foster trust and contribute meaningfully to another's experience. Within experiences of bearing witness, Leah emphasized the importance of understanding what each person wanted as well as knowing what he or she was going through. Sometimes needs were clearly stated, other times she could only guess at what a person wanted or was experiencing, as when patients were not able or did not choose to

tell about themselves, or caregivers did not chart or tell what was important to people for fear of seeming inappropriately involved. Even when she didn't know what would be helpful, Leah often experienced a wondrous and mysterious synchronicity of timing in her actions. For example, once she was inspired to read out loud for someone several passages spontaneously chosen from a bible and, to everyone's surprise, found treasured, pressed flowers between the pages of those particular passages. If a person didn't want to be fussed over or had questions that were too big for answers, she would watch and wait with a person, perhaps sitting close, reminiscing, and holding hands. In her experience, people often expressed recognition and thanks for how she was with them and what she had done for them.

For Leah, it was important to continue to remember others, tell stories of celebration and suffering, and share what she witnessed and learned with others. Expressing her hope that experiences of bearing witness be recognized as the "substance and foundation of nursing" practice and not "just whipped cream", Leah looked for opportunities to share and invite others to share stories of their experiences. In this way, she thought other caregivers could learn what was important and feel supported in nursing practice, and patients would subsequently benefit. Leah suggested that increased appreciation of and opportunities for bearing witness would come about if caregivers felt heard by work partners, held an attitude of openness, had reasonable workloads, were skilled in working within the system, were part of a supportive team, and focused on the goal of advocating for patients and families.

#### *Introducing Participant Three: Maria*

Maria was the third participant in this study. We met in her home for about an hour, just before her nap in preparation for a night shift. Maria practiced as a nurse for several years in both hospital and community. Maria said that her workplace seemed overly busy and noisy; she thought that sometimes nurses were more focused on tasks than on listening and caring. Participating in a research study offered a welcome, "almost therapeutic" opportunity for her to tell something of her experiences of bearing witness. She shared memories from very recent shifts and the early days of nurses' training, all

related to caring for people near death. Maria related her interest in hospice palliative care nursing to a difficult time of feeling helpless in bearing witness to the profound grief of a family member. Exploring her experience of bearing witness, Maria asked: Why are professionals sometimes so fearful of speaking with patients and families about death? Why do we judge people for being anything other than who they are or expect them to be something other than they are?

*Extracted Description of Bearing Witness for Maria*

Maria spoke of bearing witness as entering a very special place. Sometimes this meant walking into environments of chaos and distress and seeking to bring about peace and calm, even when it seemed impossible or when others were unwilling or unable to do so. Sometimes she didn't immediately know what to say and do, yet she said it was important to honor that people wanted her care for a reason and to trust that she could be helpful, never abandoning them and never giving up in finding answers. Hence, she persisted through difficult situations and personal fatigue and vulnerability. Within experiences of bearing witness, Maria was committed to honoring people's choices and expectations, striving to avoid making judgments and assumptions. At the same time, she made sure people heard from a caregiver's perspective what seemed to be happening without "couching" or making excuses about the news. Even so, one time she felt as if she was betraying her dear friend by insisting that her friend accept Maria's information that her partner was nearing death.

While her work could be perceived as glamorous and Maria experienced joy in her work, bearing witness did not happen magically, but involved the hard work of giving from her heart. This she called a deep, "agonizing soul part" of herself. Initially experiences were "awesome, ...exciting, ...heady," and satisfying, yet lately she felt a deep weariness, and this profoundly affected her life. She had vivid memories from early in her career, saying, "there is a growth that occurs". For example, she learned to be more professional in her work relationships, have a deeper understanding of what was difficult about her job, and become even more committed to looking for answers to control

symptoms. As such, there was a fine balance for her between maintaining professional standards and honoring and taking care of herself.

For Maria, bearing witness involved a process of sitting with, listening to, and watching others: like “peeling the layers of the onion off to try and get to what’s actually going on”. Maria said that in bearing witness, “you must listen with every fibre of your being”. Maria described times of “outside witnessing”, where she was less involved, and other times when she had a sense of closeness and intimacy in bearing witness with others: of “going right up to the bar...and saying, ok, we’re looking at life, and how you want that to be”.

Although Maria might have to relay bad news, she also helped others to clarify information and choices. It was important to be comfortable with silence and avoid getting distracted with tasks, taking “time to go into [the person’s] place”. She described how people were thankful for opportunities to talk about what was happening for them, but it could be painful. Sometimes Maria felt vulnerable and struggled with boundaries related to roles and relationships. For example, she described a personal relationship in which it felt like her heart was breaking and when she struggled to find words and ways of communicating with a dear friend who could no longer speak. This was a time when Maria was not comfortable with silence, when she felt tremendous sadness and distress at choices for care made by a family member for her friend.

Referring to what supported her to continue her practice related to bearing witness and what she hoped could change, Maria spoke of wanting to work without being criticized for being too close or involved. She strived to find ways of living out her personal standard and philosophy, and ways of practicing within the expectations of the organization and health care team. While Maria spoke emphatically about never wanting to give up seeking to bring comfort for others, she also identified a risk of being over-committed. She cautioned that caregivers must be gentle with and find ways of taking care of themselves. Considering her experiences of and learning through bearing witness, Maria reflected, “We need somebody...coming in and saying [to staff]: ‘Tell me how you are really doing. Tell me your story’ ”. Hence, she saw a need for increasing budgets for

staff support and education. She envisioned the value of having more clinical case reviews and debriefings, making sure to take time for ritual and spiritual aspects of life and work, and finding ways to honor the essential work of “helping people live until they die”.

*Introducing Participant Four: Jo*

Jo was the fourth person who agreed to participate in this research study. She worked as a nurse in homes and on various hospital units for many years, with approximately half of her career focused in hospice palliative care. Throughout her career, Jo undertook a variety of formal and informal clinical, administrative, and educational responsibilities. When she decided that she needed to know better how to serve dying persons, she engaged in a program of study and practice focusing on hospice palliative care. Working in a deliberate fashion, Jo gave considerable thought before choosing to participate in this study, eventually deciding that while others likely understood bearing witness in ways that were quite different from her own, she had many experiences of bearing witness to share in an interview. We decided to meet in an office room at her work after a full shift. Jo said that she enjoyed participating in this research as an opportunity to debrief and gain new insights, and that I served to bear witness to her experiences.

*Extracted Description of Bearing Witness for Jo*

Jo valued experiences of bearing witness for opening her to mystery, giving her the “confidence to be in the moment with people and to see where it’s going to take you rather than have...[a] need to control”. While she acknowledged that there were some things over which she had no control, she worked with a goal and expectation of bringing about “the best possible experience” for others. Sometimes she had no ability to bring about change, but hoped her presence was helpful. Jo emphasized that for her bearing witness was more than just watching or observing; it was primarily an active, intentional process. To begin, she needed “to be still,...to ruminate,...to listen” as she focused on making sense of things. Her way of honoring others was to introduce or offer her insights to others. For Jo, experiences of bearing witness were necessary for her to do her work.

They gave her the ability to continue in work and touched her soul. Such experiences held deep interest for her, they were the high points of her practice, yet it could be hard and exhausting, requiring her to take risks. Jo explained that due to work pressures and stresses she had fewer opportunities to bear witness in the way she would like. However, if she didn't bear witness, her practice could become stale, burnt out, or overly clinical- or task-oriented, causing her to "work in tighter boxes". Hence, she was determined to maintain a balance in her life by taking "time and space" to regain energy.

For Jo, bearing witness was an interactive process that she likened to companioning, coaching, or journeying with others. While there were times when Jo chose to rest or "climb into...[her]self", other times she opened herself up to what was happening, getting to know about others. Even when she worked by phone, she spoke of creating "a sacred space...you just climb into with the person on the other end of the line", but emphasized that she was not living what her patients were. She came to know others quite well through experiences of bearing witness, yet sometimes she could only guess what others were experiencing and she was surprised by what she noticed and learned.

In bearing witness, Jo risked sharing her insights about others, hoping to help people to understand or reframe their own experiences. For example, she recalled talking with several family members regarding their loved one who seemed to be near death. Sometimes the person seemed unresponsive and other times present with them. Jo suggested that the person might be "trying to decide if he wants to stay here or if he wants to go". Just then, the person awoke to say that what Jo said was not true, and that he had been visiting with another family member who had predeceased him. Sharing additional stories, Jo said that others came to know her through experiences of bearing witness, "keeping [her] honest" and letting her know when she's "out of line." These experiences helped her to be less judgmental and sometimes she felt humbled, bringing her to "reevaluate all those things...held dear."

Jo hoped that she, as well as others with whom she worked, would make more opportunities and take responsibility for learning about bearing witness as an important

aspect of practice. For example, she thought that experiences such as bearing witness, among others, could be discussed in learning circles and explored in planned study breaks, such as sabbaticals. Jo also suggested that increased supervision might be beneficial, wherein staff members could be expected to explore their experiences within nursing practice with others on a regular basis.

*Introducing Participant Five: Jen*

At the time of this research, Jen had been practicing in health care for nearly 20 years, with at least half of those years as a hospice palliative care nurse. She decided to focus her practice in hospice palliative care when she saw how surprisingly wonderful the experience of dying could be for persons and their families when supported by palliative care workers. Jen believed that it was very important to conduct research about experiences of bearing witness in nursing practice. She prepared carefully for participating in this research by reviewing the consent form and interview questions and noting down her thoughts and memories of various experiences. We met in a hospital meeting room. Speaking with a degree of intensity and purposefulness, Jen said that while everyone probably had different ideas about bearing witness, preparation for and participation in the interview helped her to “give a name to” an important aspect of her practice and “come to terms with what [her] sense of bearing witness and being is”. Similar to several other participants, Jen said the interview itself involved a process of bearing witness.

*Extracted Description of Bearing Witness for Jen*

In bearing witness, Jen said, “you have to take everything at face value”, honoring and advocating for peoples’ choices without coercing or judging. Within experiences of bearing witness, she struggled with wanting to contribute to the comfort and security of the people she met, but saw this could not always be achieved. She said, “you need to be “supportive of the situation, regardless of how you feel”. Jen indicated that bearing witness was an integral aspect of her practice, one that was both amazing and very, very difficult, sometimes bringing deep hurt. She saw bearing witness as part of her responsibility in her work: “I don’t think I could ever...[carry out my nursing practice]

without bearing witness". Jen believed that you never knew what to expect in life. Thus, she strived "to live for today" and "stop and smell the roses" along the way. Through experiences of bearing witness, Jen learned that things are neither fair nor unfair; they just are. She gained clarity about how she could help others by allowing them to make their own choices.

For Jen, bearing witness focused on "being" rather than doing for others. For this, she needed to be physically and mentally present: involved and caring, watching and listening, gaining understanding about whatever is happening, and offering information. Jen said, "bearing witness [was] all part of relationship building": a continuously evolving, interactive process that happened only when both she and the other person were willing and not distracted. She emphasized that within the experience of bearing witness, she was both with and for the patient and family. She suggested that bearing witness created a safe environment for sharing different perspectives, bringing up philosophical or spiritual issues, and making new suggestions for care. In bearing witness with a patient or family, Jen could find out about, advocate for, and support decisions of patients and families. Since bearing witness to the experiences of others allowed her to know what was happening, she made sure the rest of the caregiving team received important information in case a person didn't want to tell his or her story over and over again. In these ways, Jen was deeply involved with others: working closely with others as a team, striving to avoid closing doors in relationships, and showing some kind of sign that she supported them. Still, it was difficult to bear witness in circumstances where she felt people did not really want her with them, did not know what she was going into, or when she sensed confrontational or challenging dynamics. Sometimes Jen felt vulnerable or had to protect herself; otherwise she could be hurt or risk becoming overly "focussed on what [she] should and shouldn't say or should or shouldn't do." Yet she believed that by recognizing how important bearing witness was and by being "honest and open and available", an interactive, reciprocal process would evolve through which she and others had opportunities to share and learn.

Illustrating her experience of bearing witness, Jen recalled a very difficult and poignant meeting. A woman's family felt very frustrated with the healthcare system and personnel, and feared that her mother would not be treated with respect. At that time Jen had many other duties pulling at her attention, and she said that her expectations did not match what the family wanted for their loved one. At some point, one daughter challenged Jen, asking, "Why do you need to do these things? Are you just doing them [tasks and asking assessment questions] so that you can write them down?" As difficult as it was, Jen had to answer, "Yes". From then on she began to listen carefully to what the family had to say. Even so, Jen worried that very little of her original agenda had been accomplished and nothing had been resolved. She feared she would not be welcomed back by the family. However, the next time she met them, she was given a big hug of thanks. She learned that despite the difficulty of the previous visit and the pressure she felt to fulfill a predetermined agenda, what the family found most important was Jen's willingness to bear witness to their experiences. In this way, Jen saw that others sometimes bore witness to her practice by challenging her way of being.

Jen envisioned continuing to further evolve her process of bearing witness in personal and professional aspects of life. Jen hoped that everyone could learn to bear witness, and to gain greater awareness of this influential and beneficial experience. She believed that through experiences of bearing witness, people could learn to make the best of things and gain personal insights. She believed that if people could be comfortable with themselves and present a positive persona, there would be fewer distractions or things weighing them down and they could interact at a deeper level. Hence, she saw the possibility that in bearing witness, work and relationships could go easier for nurses and others.

*Introducing Participant Six: Margot*

At the time of this research, Margot had been a nurse for over 10 years, and had worked in hospice palliative care approximately half of that time. We met in Margot's home during which she took opportunities to describe her experiences of bearing witness, relate her philosophical beliefs, and share experiences related to personal relationships

and nursing practice. Margot's style was lively and she covered a wide range of topics. She shared written poetry, detailed accounts of her life and practice, and a variety of ideas she encountered as an avid reader. Many of the stories she shared reflected her belief that people had great power when asleep, awake, alive, and dead, and hence influenced the lives of others.

*Extracted Description of Bearing Witness for Margot*

Margot described bearing witness as hard work, an aspect of her practice that was more than a job and almost a vocation. Speaking with conviction, she said that this is "the right work for me now". For her, bearing witness meant being in the moment, being aware, and seeing whatever issue was there. She described the experience of bearing witness as being nonjudgmental: "watching what's going on and later on reflecting on it, and taking what's of value." For Margot, bearing witness was also a way to honor a person's unique struggle or journey, and to do what she could for a person's comfort and ease, for example, by attending to physical symptoms, making sure that other caregivers knew they were doing a good job, and easing patients' distress with bodily changes. Her way of bearing witness included encouraging people to use their remaining time on earth for "soul work" leading to enhanced awareness of the spiritual dimension. Although it was difficult to avoid making judgments and predictions about others, Margot believed that judging others brought negativity and "altered the structure of their journey." Yet, she knew that people chose their own time to die, and so trusted that things would somehow work out all right.

For Margot, experiences of bearing witness were both weird and wonderful. She felt anger and satisfaction, and experienced personal success and failure. Margot said that experiences of bearing witness contributed to both her personal growth and the growth and development of others. For example, because of her experiences, she learned to "trust...that things would work out all right" and to be less fearful in speaking her truth, gaining her certainty in the existence of a spiritual dimension.

While each person and family were unique, in bearing witness Margot saw broader human connections and commonalities within a collective consciousness of the

spiritual dimension. For her, a sense of connection was evident because what she bore witness to in others was often reflected in her own life. For example, a patient's experience might offer insights into her own family dynamics. Other times she did not see the connections to her own life or feel connected with others, and she found it difficult to bear witness for others. This could happen if she felt threatened or found it difficult to relate to a person's perspective. In bearing witness, Margot initiated and took opportunities to share her ideas, observations, and stories, but without wanting to force anyone to come to her beliefs. There was a balance for Margot in knowing when to offer her information, because often she was reminded through experiences of bearing witness to step back from being over involved.

By taking opportunities to speak out and bear witness to nurses' experiences in practice, Margot hoped that others would become more aware of and learn about issues such as those related to work load, morale, and support. In addition, she looked for ways in which she could pass on to patients, families, and colleagues her knowledge and experience of the spiritual dimension and connections. As such, she "[kept] up her sleeve" and shared stories illustrating her experiences and beliefs. Looking to the future, Margot thought about the possibility of compiling stories that might help others become aware of the spiritual dimension of life.

#### *Introducing Participant Seven: Sophia*

Sophia had been a nurse for about thirty years, working in hospice palliative care for over a dozen of those years. She described her work as a hospice palliative care nurse as immensely important to her, saying she would volunteer there even if it were not her paying job. For Sophia, work was not *work*, but a choice and vocation: something that was sacred and through which she is "fed spiritually and deeply and on every level". She loved the rich process of participating in interviews for bringing nurses "back to what's important", back to aspects of care that can get lost in clinical foci of practice. Preparing for our interview, Sophia made a few notes about her experiences and found in her dictionary what she called a "stark...and unhelpful" definition of bearing witness. Sophia said that to her, bearing witness encompassed much more than the definition: "to state

one's belief in" something. During our interview in the living room of her home, she posed and explored several questions, asking, "Can one bear witness to one's self?" and "Does one have to speak one's truth....or is [bearing witness] just being there?"

*Extracted Description of Bearing Witness for Sophia*

For Sophia, bearing witness was a significant aspect of her practice. It was something she tried to do all the time, and she considered it necessary for ensuring there was heart and soul in her practice. Her experiences encompassed times of rejoicing and great angst. Relating experiences of bearing witness within friendship, faith, and nursing practice, Sophia told of the importance of not having an agenda. Yet, sometimes she felt it did not seem good enough to "just be there" and "take everything in". Sharing personal memories of the illness and death of a very dear friend, Sophia wept as she recalled how difficult it was to bear witness to her friend's pain, and told how at that time she shed tears of relief once she knew that her friend's symptoms would be better controlled. In addition, Sophia believed that it was important to honor the reality of others. For example, she acknowledged that nurses often experienced insufficient time and support to undertake their work in their desire to bear witness. Yet, in her view, "our whole lives are bearing witness, every single time we step out the door", when we engage with people and "take the time to be there in the moment with someone".

Within experiences of bearing witness, Sophia gained new understanding about herself and her practice, and the significance of experiences of bearing witness. For example, while publicly speaking her truth was not her practice, she saw how others valued and benefited from bearing witness to their faith in energetic, emotive, and vocal ways. It was wonderful for her to see so vividly the strength of people's faith, allowing them to move forward despite experiencing personal losses. She described this experience as a cleansing whirlwind, which gave her a feeling of being privileged to be part of and which gave new meaning to bearing witness for her. Sophia described having an epiphany when she participated in the memorial service of a friend and noticed that the physician and nurse who cared for her friend chose to attend the service. In her own bereavement, Sophia experienced their presence as serving to bear witness to all that had

happened for her and her friend, thereby affirming her friend's "uniqueness and who she was". In this way, she says she, "got it": seeing the nurse and physician there at her friend's service, she understood in a new way what others had told her time and again about how they valued the attendance of professional caregivers at a loved one's funeral. Pondering these powerful moments, she thought that through sharing her stories with others and coming to new understanding, she was bearing witness to her own experience.

While Sophia knew others were direct in asking about a patient's experience, she waited for a cue that the person wished to tell about his or her experience. Within experiences of bearing witness, Sophia did not often relay what others chose to share. It was private, having to do only with the two of them in the moment. Often, she found out through touch what she needed to know about someone, as when she bathed a person. Similarly, she said that persons "get from me what they get from me" through her touch. Although she set a clear timeline to let people know how long she was available to them, whenever she was with them she was 100 percent there and not distracted with issues such as organizational politics and staff relationships. Sophia described her experience of bearing witness as a mutual, mostly effortless process wherein she and the person both gave and took. Yet, sometimes she was not always aware of the ethereal, back and forth flow and mutual connection she looked forward to. For example, she told of a painful time when her friend had terrible pain and was unable to rest, and Sophia's care of her felt strictly clinical. Still, she recalled another time when her friend had awakened one morning to tell another caregiver that Sophia had been there with her all night long, even though Sophia was far away. She cherished this memory as a treasured "nugget" that, in spite of times of feeling or being apart, bore witness to the close connection between her friend and herself.

Speaking about her hopes and concerns for bearing witness in practice, Sophia said, "I just know you have to have it...If you don't, it just eats away at what it's all about", resulting in too great a focus in practice on clinical and business concerns. Sophia said that within a changing organization, "it's within each one of us to...hold tight to what's important to us" and to offer support to every person we meet. Specifically, Sophia

thought it was important through bearing witness to be aware of strife and make sure that people felt heard and honored. Hence, just as others had done for her, she took opportunities to continue to bear witness for the people she worked with and to what happened around her. She was involved in projects with colleagues as a way of “trying to help, trying to be there”. Her plea was for people to “be gentle with each other”, understand that “everyone’s doing...the best they can”, and she looked forward to figuring out ways to work constructively for change.

### *Study Themes*

Although it was evident that experiences of bearing witness were integrally woven with and vitally important to nursing practice, participants offered detailed accounts of their experiences pertaining to both personal and professional aspects of life. They explored and described their experiences by posing questions and recounting an extensive array of memories and stories. In Sophia’s words, “bearing witness...seems so much more than” simply telling the truth or stating one’s beliefs. Leah remarked that bearing witness meant “a whole bunch of things” to her. The experience of bearing witness was both unique and broad in scope for each participant. Yet, identifiable themes common to all participants surfaced within the data.

Conducted within the perspective of the theory of human becoming (Parse, 1981, 1992, 1998), the objectives of this study were linked with the theoretical themes of meaning, rhythmicity, and cotranscendence. In this study, three themes surfaced as presented below.

#### *Study Theme One: Enduring Commitment Surfaces Gifts and Burdens*

Study theme one addresses research objective one, derived from the theoretical theme of meaning within the theory of human becoming (Parse, 1981, 1992, 1998). This objective was to describe the meaning of the experience of bearing witness for nurses in practice with persons living their dying. Synthesized from all participants’ descriptions of the experience of bearing witness and in the language of the participants, study theme one was *enduring commitment surfaces gifts and burdens*. In the language of the researcher, study theme one was written as *tenacious devotion engenders exquisite encumbrances*.

*Participant quotes illustrating study theme one.*

The following quotes illustrating theme one were taken directly from participant interviews:

Participant one: Anne's description expressing study theme one

Well, I think [bearing witness] is really important because I think it speaks to an essence of how we are with people, over and above our scientific skills and...that sort of thing. Yes, we need to know about pharmacology, and we need to know about disease process and stuff like that but it really doesn't...matter unless you're someone that wants to be cared for by a robot, you know, or a machine....Bearing witness...is...service to another human being... And generally...[there] is extreme sadness or...suffering or when symptoms seem to be intractable, but in fact, as we learn in the work we do, there is actually much more in a balance to that....It's never all bad..It may be a burden at times to see and witness,...but then, you know, everything is...balanced. I believe in a balanced life and therefore there've been incredible joys....I believe that I have a place on this wonderful earth as a privilege and that my ultimate commitment...to that gift is to bear witness to what's around me, even if it's walking to work on a beautiful sunny day....[That] has crystallized...for me because those people have taught me the preciousness in moments.

I remember a really meaningful kind of 'aha' moment for me...[about] the idea of being able to do what we say we do, be it pain control or symptom management, or ease[ing]...suffering....I realized that the one thing I could be confident about in all things was that I would not abandon you, you the patient....The only thing I have ultimate control about is how I am with that person....I think of a situation that we had last week with a woman, in her 50s, dying from a bowel obstruction secondary to ovarian cancer. And...she had been doing all sorts of alternative treatments....Her main hope was to cure it, but it was pretty obvious it wasn't [going to happen]....Well it was a struggle, you know, it really was...Because the naturopath was coming in and doing things to her unbeknownst to us, but eventually we discovered it. But you know in the everyday moment, what she was doing was living as long as possible because life for her was so precious even if she was nauseated or bloated....I think we get hung up by putting ourselves in [her place and saying], "Oh, but I wouldn't live like that, or I wouldn't want that to happen or that's against the rules, etc."....But you could bear witness to her...incredible connection to life, that she was hanging on so strongly, you know, if you got beyond the other stuff and just bear witness to that.

Participant Two: Leah's description expressing study theme one

My mind just goes from one story to the next of these sacred moments and sacred privileges with these people....[Then, Leah tells about a time when a man's family called her to visit them as a friend when they thought the man was near death. She says,] "and I'd just gone to bed...and I thought, "He's OK, he's fine." And then I thought, "Shut up,....The kids need you. So I said, "I'll be right there."

[But], if we were just to simply witness pain and suffering but not have any tools or any place...to take action, then there's no promise...[or] commitment....If we just mess around and go off and forget and don't chart and don't look forward and don't follow through and don't connect with whatever, then the trust isn't going to come....I feel to me that it's much more than...just a kind of a being there and being there at the time and witnessing what's happening....It's the promise of follow through, too.

You know...I just feel incredibly fortunate to have these experiences where you see these families....One of the hard things...is that we bear witness at a time of fairly intense suffering or change, transition, grief, whatever. But death doesn't usually happen without a bit of loss in the picture and a bit of angst. And a bit of, I mean...people can turn it into a celebratory experience, but it's usually a bit of work to get it there, right?...And I think bearing witness to me, is about the miracle of life. And people say to me stuff about, "How do you work [at Hospice], or isn't it hard or whatever?" And I say,... "We all get asked that and people often will say, I've never cried so much, but I've never laughed so much either."

Bearing witness...means...allowing things to unfold....[I remember a woman and] some of the incredible, sweet experiences [with her].... You know, she was a woman who didn't like to be touched a lot...And the last day she really didn't want to be touched very much and she didn't want to have her depends or attends or whatever...changed because she was weak and just didn't want to be fussed over. And so I said, "OK".... You know, because you [have to be there for a patient] and as much as you might have some ideas, really until you know the whole set up, you don't, you don't know.... And...you know,...trying to figure out....how can we make this, how can we help assist this so that this is something that is OK and is acceptable or as OK as possible for this particular person.

#### Participant Three: Maria's description expressing study theme one

Things keep coming up in my mind about incidents, I mean there are so many...and our mandate is to bring people comfort, so to try whatever we can within the realms of safety.... We don't abandon the patient....The beauty of [bearing witness] is sitting, making sure that the person has, is understanding fully what's happening....The joy...is being truly able to enter into that place, even though it's very draining, but is also very satisfying to go...and really be there...even if it's uncomfortable.

It takes a huge toll....The initial few years are very heady, very, very heady, very exciting....Then the deep weariness comes in....The burden of work can be so huge that it feels [like] that's one more thing that I cannot do.

I mean we do come up against these incredibly difficult cases sometimes and the pain is simply totally, totally out of control.... We could say,... "Well,...I think you're the sort of person who's going to have a horrible death so we'll just let you suffer"....To me I think that's an easy way out, isn't it? It's a nice way we can forgive ourselves or excuse ourselves....I mean the truth is...[some people die]...a horrible death. And we [are] powerless to stop it....I wouldn't want to give up and think that. I mean we do come up against these incredibly difficult cases sometimes and the pain is simply totally, totally out of control. But I don't ever want to stop searching for the answer of how to control it.

A few weeks ago....I walked in and the young woman was gushing blood...and her mother was in hysterics.... We got things settled, she settled down.....When I eventually calmed down....One of the comments [from someone] afterwards [was],... "I'm sorry, I just *really* dislike [the mother]. I wish she'd leave the unit and leave us to look after her [daughter]." And it just brought me back and I just thought,...how cruel we are to each other as human beings. That we judge [the mother] for doing anything other than being a mother who at that particular moment was terrified that this was the moment she had been dreading. She's known her daughter was dying. In fact her daughter died very peacefully a few days later and everything was fine.... We are sad when we get like that. That we judge other people's grief: where they should be or how they should behave. There's no right or wrong way to behave. If you want to go crazy, go crazy.

#### Participant Four: Jo's description expressing study theme one

In our interview, Jo's voice held notes of delight and deep satisfaction as she described experiences of bearing witness; they engaged her interest and she learned something everyday, which was valuable to her. She described one experience as "one of the most amazing things that happened to me". Jo said:

You learn sort of the sorts of gems....And in so doing you become changed by that because it touches your soul in some place....Sometimes it's humbling to be changed [laughs]....Because you have to re-evaluate all those things you hold dear....Those high points become less frequent....Like the adrenaline wears you out....I believe I have to do it [bear witness] to do the best kind of job....[It] can be really hard, so it feels like work and it's exhausting and all the rest of it.... You burn out.

Sometimes you might bear witness to something you have no control over or you have no ability to change...There may be somebody who's in pain who wants to remain in pain....[but], you journey with that family, you support them through it....Bearing witness...helps you see, you know, that nothing is the right answer, that there are as many ways as there are people.... You have to be

comfortable with the mystery, not having the right answers....You may go in with a preconceived idea about how things should be, must be, could be, whatever, and you know you're proven wrong so many times that you learn to enter into a place where you're comfortable with the mystery of it. Because if you don't, you'll go crazy because it's not...controllable....For me bearing witness is just not passive because if it was only passive, you would be worn out by it. And you need...that ability to affect. It's not that you're affecting *change* but to offer support which can just be your presence, or else it could even...be coaching....Your role would be to make it the best experience that it can be for them.

Bearing witness is what makes the work, is what gives you the ability to keep coming back....[Otherwise], it just becomes a job and you do it the best you can but in tighter boxes because you can't go over there. It's too hard.

Participant Five: Jen's description expressing study theme one

If there is a time when I'm present but not bearing witness, then that's unfortunate. I don't think that that would work for me. I think that I have to bear witness because I don't know what's happening and I need to be able to participate with [patients and families]....I mean it is so important, especially in the job that I do....I do think it's an integral part of what we do.

When I was coming in [to the interview] I noticed that all three of the [examples] that I had [thought of] were not negative, but they weren't those wonderful experiences where we bear witness and things are just the most beautiful experience ever. And there are so many more of those than there are of these frustrating situations....I find that many times I've gone in and bearing witness to these people who are in this wonderful, amazing comfort zone....You can feel in the air that they're just so comfortable....It's wonderful to bear witness to the positives....And I think it makes a real difference. It doesn't mean that it's easy, doesn't mean it's easy.

I think some of the big things that I find...when you're bearing witness is you need to be caring and non-judgmental. Those are very important factors....It may be something that you find very difficult. You have to allow [patients and families] to make their own choices, even if it means that somebody is at risk....[For example], there was this young girl that I looked after and she had numerous allergies and so you know it was very hard to get a narcotic that would help with her dyspnea....I found it very difficult to watch her, this young girl, dying....It just, it blew me away. And she was very clear, when she was able to communicate with us, that she did not want anything that would interrupt her experience of her death....She's been wanting to experience it every step of the way. She's had total control of what she does and doesn't take, what she will and won't do. And so you need to honor that regardless of everything else that happens....I wanted to make it easier because I was struggling with it. And that's

where the bearing witness is really hard....And who are we to go and change [a person's experience or choice] because it's more comfortable for us?

Participant Six: Margot's description expressing study theme one

Bearing witness for the patient...or the family....that's not just our job but that's our...vocation maybe [that] is a bit strong....It's not...judgment,...that's not it at all, but... to honor their struggle or their journey....[For example], by my speaking to [patients], saying that death doesn't hurt, checking what their beliefs are, of course, but saying that they're safe, that they're in control, that dying doesn't hurt, [then I am helping them]....I could have done things mechanically and never [bothered to say things like that to people]....If I've done my best,...if I've done reasonably well....that's a huge success....[Before], if things went wrong, it was always a tragedy,...[I'd think], "Oh god, how can I fix this?" And most of the time it doesn't need to be fixed. It's doing just fine all by itself....When I caught on to *that*, that everything is unfolding just the way it should....that's OK. That's really OK.

You know, it's the right work for me now....Definitely....[I remember] a lady who was dying....And [after she died, her brother] came in to collect her and her [belongings. Different arrangements had been made by a social worker]....[The brother] felt he hadn't been informed in time...And we didn't feel free to release the body [and belongings to the brother]....And we had no way of checking out [if arrangements could be changed]. So we didn't release the body to him. And, course...when he came back on the Monday he was angry. I felt extremely intimidated by it. [Another staff member] went and defused it really very quickly, [saying to him], "You sound like you're really angry"....For me the feeling was failure. And it was failure in that I felt he was debasing the really good care we'd given, you know, we gave her excellent care, she was well supported....You know, we were really pleased that she died so well. And then to have this blow up in our face....So the image that came to me, of him, was an injured animal, you know just cornered and lashing out. And how did I feel? Well, it was like lead in the stomach, very black, very, very defensive....I mean I get all tearful and that, but it's OK, you know.

Participant Seven: Sophia's description expressing study theme one.

For me, my idea about [bearing witness] was just being present and whatever comes. Like you don't have to go in there with an agenda and speak it....[A friend who was dying] was in big trouble and I needed to go and see her....I arrived and she was in screaming pain....So it was awful; it was awful,...seeing her. I couldn't bear it. So I called in the palliative response team and got that sort of organized. And they walked through the front door and I knew what I wanted to happen and the doctor and the nurse just said, this is what should be happening.

And it was exactly what I wanted to happen....I started to weep, just with the relief of knowing that she was now [going to have comfort].

I try to bear witness always....And you know we have our stuff, our things on the unit where people talk about, you know, how the heart and soul's been taken out of it [practice] and the unhappiness that everyone is feeling and the angst...I know that other people are feeling it. I don't feel it. I don't feel it for me....I mean, there's days that are hairy....But I know...[their concerns are] important. I don't want to negate it for everybody else.

[When I was visiting some people], I went to church every Sunday....And I'm telling you,...the bearing witness that was going on there is they would call the people down, "Come on down!" There was singing and dancing in the aisles. But there [were] people on their knees, and bearing witness was such a huge thing for them....It was unbelievable....It was absolutely unbelievable....That brought new meaning to bearing witness to me,...and that...has not been my practice,...but it was fabulous....It was all in song and in worship and in praise and in rejoicing for this day, this moment in time. And [they were] happy to be alive. It was awesome....I mean, it didn't appeal to me, but I felt completely comfortable....It was just, it was wonderful for me to see people in their, in the strength of their faith, in the face of everything that they faced on a daily basis...They just gave up themselves completely for that moment and then just moved on. It was like this gigantic whirlwind [she gestures], shewwww, cleansing, I guess. And it was very cleansing for them,...and for me,...I felt privileged to be part of it and it...was very moving.

#### *Discussion of study theme one.*

Research theme one addressed the question related to the meaning of experiences of bearing witness for nurses in practice with persons living their dying. One of the most striking features in common for all participants was *enduring commitment* within their experiences of bearing witness. For me, this was conveyed in participants' tones of voice and the intensity of engagement within interviews. In addition, participants' words illuminated the notion of enduring commitment. For example, they referred with deep conviction to a sense of "sacred", "service", "vocation", "need", "commitment", "obligation", "responsibility", "covenant", and/or "promise" within experiences of bearing witness.

Participants' commitment arose out of what they believed was important in their nursing practice. Specifically, participants spoke of a promise to never abandon others, to follow through with promises or actions, to do what they could, to do their best, and to

always look for answers that would help others be more comfortable or safe. Every participant, each in her own way, showed a particular commitment to honor others, yet also bring about such things as comfort, trust, peace, and new understanding. For Anne, this meant going “beyond the sickness and...treat[ing] that person as a human being: who they were, who they are and will always be”. Leah honored others by following through with her promise to find ways of making sure things were as “acceptable...as possible” for others. One way in which Maria, Jo, and Margot worked with respect for others was by providing information so that others might gain insight into their circumstances and situations. Leah, Maria, and Jo demonstrated their commitment to others as they sat with patients and families who were pondering unanswerable questions or making very difficult decisions. Maria, Jen, and Sophia indicated that honoring others meant, in part, being willing to listen to the truth of how things really were for others.

An enduring quality of commitment to others was revealed in participants’ messages emphasizing the necessity of doing whatever they could for persons even in the midst of situations that seemed urgent or chaotic, when choices seemed to put persons at risk, or when conditions at work were challenging. While participants described experiencing a sense of relief when symptoms and other aspects of a another’s situation or experience were settled or more ordered, they expressed recognition that not everything about a person or circumstance could or should be controlled. As Jen commented, “Who are we to go and change it because it’s more comfortable for us?” Thus, participants spoke of the need to work without an “agenda”. Although they indicated that they were not always successful in their endeavors, they frequently mentioned the importance of going “with the flow”, allowing “things to unfold, not making judgments, and accepting whatever comes. Within experiences of bearing witness for these participants, enduring commitment surfaced both gifts and burdens.

The notion of *gifts and burdens* arose as participants reflected upon the meaning of their experiences of bearing witness throughout years of service. Anne acknowledged that for her there was “extreme sadness or...suffering.” She philosophized, “it’s never all bad....and some good comes out of it”. For her, bearing witness meant carrying a weight.

Somehow, over the years, difficult experiences became “bearable” burdens, encouraging her to enjoy the gift of each day. Leah depicted her life as a tapestry encompassing both the dark “underside” of life and wonderful, “choice” memories of times with others. She spoke of her opportunities in life as blessings. Sometimes people referred to her, herself as a gift to them, and she described others as gifts to her. Leah depended on being able to do something for others and, in this way, inaction or a broken promise to follow through with her commitments could be burdensome to her. Maria experienced both tremendous excitement and great, heart-breaking weariness in experiences of bearing witness. While she took professional satisfaction in serving others, her commitment to doing so took a very significant “toll” over the years. In addition, her gift for skillfully offering bad news was sometimes a burden to her. Jo took delight in “gems” of new understanding within experiences of bearing witness, but also felt the weight of the intensity of her work. She described experiences that were wearing and exhausting, yet immensely engaging, prompting her to appreciate the mystery in life. For Jen, the experience of bearing witness encompassed both the positive and negative in life. The difficulties of her experiences and an awareness of her clients’ suffering led her to be grateful for the gift of today. Describing her experiences, Margot told of her pleasure at the success of offering good nursing care, and how, at other times, a sense of failure weighed her down like lead. As an aspect of her experience of bearing witness, she sought to think of others with joy so that when they died, they could “go on in peace”. Exploring her experience of bearing witness, Sophia recalled occasions that held immense suffering and tremendous joy. While she felt blessed through her experiences, she was committed to recognizing and attending to the suffering and disappointments of others. Thus, in myriad ways, the experience of bearing witness was rich and paradoxical for participants, encompassing both gifts and burdens. In the language of the participants, study theme one was *enduring commitment surfaces gifts and burdens*.

*Study Theme Two: Telling-not telling Mingles with Closeness-Reserve*

Study theme two relates to the theoretical theme of rhythmicity within the theory of human becoming (Parse, 1981, 1992, 1998). The research objective was to describe

patterns of relating in experiences of bearing witness for nurses in practice with persons living their dying. In the language of the participants, study theme two was *telling-not telling mingles with closeness-reserve*. Study theme two, in the language of the researcher, was written as *guarded intimacy*.

*Participant quotes illustrating study theme two.*

Presented below are quotes extracted from participant transcripts illustrating concepts within study theme two.

Participant one: Anne's description expressing study theme two

Bearing witness is much more than just the communication. At some points it happens when there's absolutely no communication, no verbal communication, anyways....The point I want to make...is it's interactive actually; it's not just one-sided....It has to be respectful and...by invitation....There's some [people] that you kind of connect with, and I think that this invitation [is] for you to come to a place of deeper connection with them....[If we are] able to do that with them, and keep our own reservations and resistances low....To bear witness, I need to be touched, I need to acknowledge what's going on with that other person. What I see, what I hear, what I feel, how I'm moved.... And it's not, it's not by being a witness; it's *bearing* witness. It's like you're bearing something....It's logged in my cells;...seared in there;...giving evidence of what's going on;...to bear witness that you exist and that your death is occurring....It's a moment that they need to be acknowledged,...and then, in that sense, I'm connected [with them]....as opposed to just being a sounding board,..."I know you. I didn't know you, but I know you in this moment"....It's my feeling, it's not theirs. I don't suffer like they [do]....You've got to be separate to bear witness....[Without] loss of boundaries, and enmeshment.

Bearing witness is also...the retelling of the story....The purpose of [retelling] the story is in the bearing witness of what you've seen, what you've acknowledged and felt, [how you've] been moved, in order to have that communicated to others...[because it] might be significant in the care and the way they approach this person as well....I think [what] bearing witness does is [that even] in the midst of...decline [those who bear witness see that] you [ie. the person who is dying] are essentially who you are and have always been.

[One time I was with a woman and] the thing that I got from bearing witness to her was the innate person she was....She was an accountant, so everything is planned for, predicted, organized; and dying was messy....and her way of coping was being told [the facts]. And, you know, she could then prepare....I had had conversations with her and offered to the team that she was really quite strong; she was coping well. But her style is her need to know. [So, I said to the other members of the team, "Tell her] if you've got any kind of insight

into what's going on or what's happening.... You can tell her anything, even if death is imminent"....So, [bearing witness meant] bringing that to the rounds one morning....[Although], you may not always be called upon, or have the opportunity to tell a narrative.

Participant two: Leah's description expressing study theme two

I think...about times when spirit touches spirit and....things about understanding something....One day [with some other caregivers] I shared kind of a personal piece that I hadn't usually shared...and it opened the door for other people to talk about nursing measures that they had used....And we went from there to learning that most incredible stories of different people and different things they had done...they were stories that had been basically kept to themselves because they were concerned that they were inappropriate....[Another time], this lady had said to me,...it's not the dying that bothers me, or it's not being dead that bothers me, it's the dying....I said, "Would you like me to tell you a little bit about what dying might be like?" And she said, "Yes." So I talked with her about what dying might look like, and the different things the body might go through and different things that the mind might go through, but that I really didn't know a lot about that....So,...I went in to wash her and put a catheter in and get her morning care done....And so as I did her gown up behind her neck she sat up. So I sat down and I looked at her and I said,..."I've bathed you and you can rest now." And she took my face in her hands and she kissed one cheek and she kissed the other cheek, and...she said, "Thank you. Thank you for the beautiful music." There was no music playing that I could hear in the room....and then I said [to her], "Do you remember you asked me what it was like to die?" And she said, "Yes" and I said, "Do you think that's what's happening now?" And she smiled and she said, "Thank you" again and kissed me and [she] lay down....I wanted to...[say to her], "Tell me what it is really like!" [Leah laughs and says with gentle sarcasm:] But it was inappropriate to shake her, and say, "Tell me, come on, wake up! Tell me what's it really like!"

Participant three: Maria's description expressing study theme two

I guess another thing of bearing witness is learning to...end the relationship with families after the person had died....[There were problems for me with] wanting to go to the funeral afterward and wanting to keep up with them afterwards....I eventually learned that we are health professionals and we go and we give from a deep place within us but we have to understand that it is still a professional relationship, with professional interaction....We're very vulnerable....We've entered into this incredibly intimate arena, but we have to remember our role,...[not] overstep the mark and boundaries....That's how you take care of yourself, by remaining the professional.

It's just being prepared to sit...with somebody and talk something...through...and say [to them], "What did you hear, what do you think, what did you deduce from that, where do you think that leaves you?" So that they actually are the ones that are working it out and coming to their [conclusions]....[It's] making sure that the person...is understanding fully what's happening and coming along with you....You could walk in and make a very quick assumption [instead of]...trying to get underneath the layers....actually peeling the layers of the onion off to try and get to what's actually going on here....[Sometimes,] no matter what I wrote down on the paper it wasn't enough, and [in] the charting I couldn't really explain my sense of what's going on...because it's so [complex]....Bearing witness: one of the most unbelievably dreadful things that I ever did was...[tell someone that her family member] was dying....And [she], "Don't do that to me....Denial is my defense. Don't say that to me." And I said, "You have to listen to me because you need to let [others] know."

Participant four: Jo's description expressing study theme two

I think bearing witness is soulful work in that you, you open yourself up to what's happening....In the strictest sense, bearing witness to me would be like being in the field with a pair of field glasses watching a bird build a nest. That would be bearing witness, but that's not what I do. What I actually do is find sticks for the bird to build their nest....You sort of are interacting with the person in that process...I do...believe that...by watching you're also doing some critical thinking....You're watching people be very intimate,...[These are] very intimate processes and journeys that you're bearing witness to....Bearing witness....touches on your humanity because, for me, bearing witness is a quiet thing and in it being a quiet thing...you then look to the reactions of people and you see what makes people human....It does, then, help you in your own situation, in your practice, because then you might be able to say to people, "Gee, some people when they're experiencing this feel sad, or some people get angry or whatever."

[There are other times] when I [deliberately] go inside myself and become very insular...I can do that like, truly. I can just climb into myself and the world can just go by and I ain't reacting....because that's how I rest: by not bearing witness, by crawling into myself.

I have another bearing witness story....It was when...a young man...was dying....but his family wanted...us to pull him back from the brink....so that...he could have a longer time, so that he could get it right, so he would die right...How do you answer that?...One of the things we did...was we...sat with the family and the patient, and just sat there....[I noticed that] the patient was sometimes present and sometimes not, and so I said to the family..., "You notice now how a little while ago he was focusing and trying to focus and be here with us, and now he's gone somewhere. I don't know where he's gone, but he's gone somewhere." And I said, "I think that that going somewhere is him getting ready to go....He is

spending some time looking at where he's going and trying to decide if he wants to stay here or if he wants to go." And the patient looked at me and said, "You're lying to my family. Stop lying to them." And I said, "OK,...I'm *really sorry*...I didn't mean to lie to your family, but I can't get rid of this feeling that you actually are...going over to the other side and looking and getting ready." And he said, "No, I'm not. I'm going to visit...Baba and we're having a visit and I'm spending time with her.'...The family [was amazed] because [Baba had] died, you know. And so for them, when it was all done, when we went through that process and everything, they said, ... "He's ready, we're not"....and that gave them a great deal of comfort, a lot of comfort.

Participant five: Jen's description expressing study theme two

Bearing witness is all part of relationship building, you know. If you're honest and open and available for them they're going to reciprocate that and they're going to be able to have this relationship and tell you things and bear witness with you.... I mean even if...a person...was...[very near death]...and so I couldn't get any of that personal information, you can still bear witness by seeing body language, seeing what's going [on], you know, looking at medication records...I think it ends up being a little more 'tasky' than if there [were] other family members there or...if the person was able to communicate with you.

That's the difference between doing and being. When you *do*, you focus more on the physical, the things that you can see, the tangible things. Whereas when you're being, just being there has a tendency to bring things up very philosophical. People are more willing to be spiritual with you if you allow them that opportunity....I think it makes a real difference....You need to be involved....I'll just speak for myself. I know that I wear my heart on my sleeve....I think that's what makes me good at what I do, because, you know, I am what you see....I will cry if it's a very traumatic thing, but that's OK because I can also be professional in amongst those tears [Jen chuckles].... And so, we...work *with*. We make them [patients and families] part of our *team*. So in bearing witness they become part of our team....So they're bearing witness with us, they're right there beside us being a part of everything that we do, every decision that we make....So bearing witness,...it's being with them....They really rely on what you can offer, even if it's just words....I find [that when there is] confrontation [it] is very difficult for me to bear witness because then I do shut down because then I feel vulnerable. And so when I'm not as open, I'm not as able to bear witness. I'm too busy trying to think of what's the political thing to say, and the political thing to do to try and keep things calm.... You just bear witness, you allow them [patients and families] to express themselves in whatever way they need to express themselves, and eventually you hope that this relationship will foster.

Participant six: Margot's descriptions expressing study theme two

The more I observe and bear witness of their dance [Margot refers here to patient and family interrelationships and dynamics], the more I'm off the dance floor.... You know, I'm not good at it. I mean, I'm still learning to step back.... And to allow the words to come that might offer comfort. Like we had somebody who's mother died.... She was the main caregiver for her mother,... and I said, "You know, you did a fabulous job." I wanted her to, I felt like it was necessary for her to know that she could have no regrets, that she did a really good job... just to offer that comfort that somebody outside their [family] said that she did a good job. Because my bearing witness in that case was [to] her total anxiety, her total loss of her mother whom she lived with... I can't presume to get into her head, but somewhere... [I had] a sensation that she had to bear this.... I do believe in a greater collective consciousness so I mean whatever it is, *however* I connect with her,... she needed that in that particular case.

Last week I met a man.... He was a little fellow. He was climbing out of bed and he fell and everything, but in the morning he said, "Don't tell [anyone]!".... He grabbed my hand and he kissed it all over. "Don't tell, don't tell!" [Margot laughs heartily].

Participant seven: Sophia's description expressing study theme two

[There was] a young woman... in complete and utter angst... [who] had a terrible relationship with her husband... There were many, many people who had a very difficult time working with her, and I found that what worked best for me is I just went in there, [and said], "I've got half an hour. Whatever you want me to do in this half hour I will do for you." If you want me to bathe you, great. If you want me to hang some pictures, great. If you want me to go and make you some toast, you want me to just sit, you want to tell me about what a shit your husband is, I'm here. I've got half an hour. I will give you, that's what you have from me. And there would not be a bell [rung for the nurse] for the rest of the day.... If you could just give her your undivided attention for that period of time,... all she wanted was just a hunk of time to know that you would be there with her... I remember that; and that, to me, was bearing witness to her, where she was, at the time. It didn't necessarily mean... that I had to say anything. If she just felt like spewing, and she did, then I just sat there and let her spew, and it didn't get written in the chart, you know.... Does one have to speak one's truth to bear witness?... That is not, has not been my practice.... None of that, that was all just her.... If it was me... *doing*, then I would *do*; but it was... to me... giving her a timeline, and saying this is what you've got of me.... [At] the end of that half hour I've gotta go. I've got four other patients, but in the meantime I am all yours. For that however long, you've got me. And that's been huge. I don't think it's quantity; it's quality.... You don't get that with everybody—I don't. I mean, there's some patients that there's just that sort of peace around your interaction no matter what it is.... There [are] some

patients [with whom] it's a natural fit. Just for me, I just kind of clunk in and I...have a feeling. We both have a feeling about each other....It's back and forth,...it always has to be, you know, the reciprocity. You know each other. It's...not a one-way street. It's not just me giving;...it just seems there's a place that we get to as a couple, as we're working with each other, for and with each other, that is just sacred.

*Discussion of study theme two.*

The theoretical theme of rhythmicity is richly represented within participants' experiences of bearing witness in this research study. Patterns of relating are illustrated through participants' intimate interactions with patients and families, colleagues, and significant others, as well as in their engagement with nursing practice and their organization. In my interpretation, the notions of *closeness-reserve* and *telling-not telling* were common to all participants.

*Closeness-reserve* surfaced in a variety of ways in patterns of relating within experiences of bearing witness. Most notably, within each interview participants commented on the depth of connections with others, expressed variously as "intimate", "sacred", "heart to heart", "touching", "spirit to spirit", and "loving". Several participants spoke of bearing witness *with* others. While participants most commonly referred to bearing witness *to* or *for* someone or something, every participant said that experience was in some way mutual, referring to it as interactive, reciprocal, or including an acknowledgment from the person to the participant for their part in bearing witness. Within experiences of bearing witness, participants referred to a focus of being with others and being involved with others rather than only doing things for others. Although there were times when participants were distracted by tasks or challenged by the demands related to the work environment and organizational structure, participants identified that doing things for others brought them into closer proximity with patients and families, creating more opportunities for bearing witness.

Despite feeling close to others, participants also experienced a degree of reserve and separateness from others. Reserve was conveyed as participants emphasized that they were ultimately separate from others. In addition, there were times they or others deliberately chose to remain apart or distant. Jo, for example, described how sometimes

she chose to create an intimate space with others, and other times she chose to “climb into” herself so that she was not as aware of or open to what was happening with persons around her. All study participants indicated in some way that it was important to keep a balance of reserve and closeness with others. Maintaining balance or boundaries within experiences of bearing witness was expressed in several ways. For example, some participants spoke of knowing how to end relationships or being vigilant about over involvement. Other participants worked to be very clear about when and how they could or could not attend to others. Participants also expressed and affirmed that their experiences were not the same as or were separate from the experiences of patients and significant others.

Within experiences of bearing witness, participants described closeness-reserve in various circumstances. This included when they were right next to and far away from an other, and even with persons who had already died. This is illustrated in the following quote:

I was there at [a]...funeral....[and] I just got this sense that she was wandering the aisles....I'm not a visionary person; I don't see spirit, but I just got this sense that she was wandering, so I crossed my legs and I put my hand out kind of in an open cup shape and I whispered,...“Come and touch me....Come and touch me”. And then the thing ended. And the woman behind me leaned forward and touched me and she said, “She was here, and she came right to you”.

It seemed that for participants there were significant challenges in the experience of closeness-reserve. At the same time that participants wanted to maintain clear boundaries according to personal and professional codes, they longed or strived for greater closeness with others. For example, Anne cautioned against becoming enmeshed or over involved as she described a situation when a nurse quit her work to attend to a patient she became deeply devoted to. Yet, she spoke of the importance of encouraging nurses to engage in closer relationships with patients. In another example, Maria described how early in her career she often chose to attend the funerals and meet persons for coffee. Over the years, she learned it was better to make sure she ended relationships; yet she also wanted to bear witness for others without being criticized for being too close or involved.

The notion of *telling-not telling* also surfaced within experiences of bearing witness. Within patterns of relating, participants and others shared experiences and information, telling-not telling what they knew, questioned, and experienced. Within limits, participants and others shared of themselves, each coming to see, know, and/or understand some things about the other. Disclosing some experiences and information, study participants told of engaging with others in recounting and hearing stories, reminiscing, pondering philosophical questions, giving personal care, quietly observing and watching, sorting through choices and making decisions with others, and actively seeking and sharing medical information.

In telling-not telling, not everything about a person or situation was shared or known, accepted, and understood. Time, circumstance, and personal choice did not always present opportunities for telling others about experiences. In experiences of bearing witness, participants described encountering and experiencing confusion, vulnerability, misunderstanding, and the unknown. Sometimes, there was risk involved in disclosing information or experiences. For example, Maria, Jo, and Jen experienced vulnerability in sharing their ideas with others, suggesting it was not possible to know how people (patients, family members, colleagues) were going to react to whatever was told. Participants referred to mistakes made in drawing conclusions and criticisms given for sharing various thoughts. Similarly, Anne, Leah, and Maria told of how relationships and ways of being could be judged by others as inappropriate.

In telling-not telling within experiences of bearing witness, all participants were intentional in conveying to others what they had seen, heard, and experienced. Anne recounted her experiences in caring for others so that caregivers were better informed about the people they were caring for. Leah shared stories to commemorate others and support the education of other caregivers. Maria found it helpful in her practice to debrief with colleagues. Jo told persons what she observed so that they could gain new insights about their situation. Jen spoke of communicating a person's story with the rest of the team so that the person didn't need to repeat it to other caregivers. Margot willingly shared her own experiences so that persons and caregivers could gain new understanding.

While Sophia said that most often what she learned about another person remained private, she acknowledged how she and others sometimes benefited from further bearing witness or speaking “one’s truth” out loud to others.

*Study Theme Three: Fostering Continuing Competent Practice*

Study theme three within this study relates to objective three derived from the theoretical theme of cotranscending within the theory of human becoming (Parse, 1981, 1992, 1998). Objective three of the research study was to describe possibilities, hopes, and concerns related to bearing witness for nurses in practice with persons living their dying. In the language of the participants, study theme three was *fostering continuing competent practice*. In the language of the researcher, study theme three was written as *honoring cherished confidence*.

*Participant quotes illustrating theme three.*

The following quotes illustrating theme three were taken from participant interviews:

Participant 1: Anne’s description expressing study theme three

I think [that] with these profound connections, you learn and acknowledge bearing witness within yourself....Over all [what’s required] is a sense of [being] respectful of the moment, [having] sort of an awe [of] that privilege of being in the moment to be able to bear witness to it. And that,...I guess, comes from both the ethos of the organization and the cultural spirit of the individual mentor,...down to the individual....An organization should encourage people to do things that...exercise that element within us to be connected with people,...whatever nurtures a sensitivity of one person to another....bringing [bearing witness] to the fore so it’s recognized, nurtured, and developed....It would be really important, then, in bringing along or teaching/mentoring people to help them know the difference...between bearing witness and being...over involved....Maybe this research will elucidate that [difference] even better....You know, I think something as simple as...retreats, or those kinds of things where we share outside of a work situation, [might help]....Finding...out [how to teach about bearing witness] would be the essence because we can teach a psychomotor skill....but in bearing witness, I think [that comes] through story telling, through literature, through...shared experiences.

Participant 2: Leah’s description expressing study theme three

During our interview, Leah expressed her hope that bearing witness be seen as “more than just the whipped cream” and as “the substance and foundation” of practice. She went on to say:

What incredible experiences we had...to just grow and learn from...experiences [of bearing witness]....One of the things that would help somebody take action would be decent workloads....[and the] ability to work as a team, you know....So what does that mean for these young nurses coming in? I think it's probably about helping them get so solid in their skills that they can then move past the skills and enjoy the people....[That means giving them] the time and the mentoring,...helping them and...nurturing. And then I think after whatever length of time,...they get competent enough in the basics that [they learn to bear witness]....Then, you know, even when they're just getting competent, I think that you have experiences as a student nurse, too, that are, and as a young nurse, that are still choice. That are still sacred moments.

#### Participant 3: Maria's description expressing study theme three

I think you change....I think there's a growth that occurs....I do wonder...[about the] long term...effects, the emotional and physical drain....It's a fine balance of keeping up your professional standards and also taking care of yourself. But I don't want to compromise what I perceive as my standards of nursing....I don't think we're gentle enough with ourselves....You've got to be careful. You've got to take care of yourself or you will totally crash....I do feel very strongly...that there needs to be...a lot more support and a lot more education....[and] psych-social discussions because I think we all need help dealing...with patients and family. Maybe more case reviews. We used to have them. We used to do debriefings....Nobody's got the time to debrief anymore. Nobody's got any time. There's no spirituality on the floor anymore....[Once we said that] the essence of who we are and what we're trying to do is...helping people live until they die....That phrase has almost been negated....[People say], “This is a medical floor. We've got to have a symptom.”...[It's like a] conveyer belt...the sort of one body in and one body out thing that keeps happening. They're trying [but],...I don't know, there's something missing. It's got into too much of a rat race....We need...somebody coming in and saying, tell me how you're really doing. Tell me your story. I mean, even like this [interview].

#### Participant 4: Jo's description expressing study theme three

You learn by this process of watching or journeying with patients.... You learn you don't always have the right answers.... You can't watch it without having your soul touched in some way, and then it spills over and so next time you're different.... You change as you go along.... I think that we have less opportunity to go into the mystery of it all; and because of that...you get a much more clinical

approach, a much more task-oriented approach....Being in those places [of mystery] requires something that we might not have a lot of, and that is time and space and the opportunity to rejuvenate....In order to keep coming back [to work] you really need the time to bear witness, to rejuvenate, to process it, to talk about it with somebody so [others] can bear witness to your experience and validate it for you....At one time [this organization] took it more to heart that it was their responsibility to provide you with the opportunities to rejuvenate, where I think they felt that they were involved in that process more so than they feel they are now. Now I think—and I'm not saying [that] one thing's right or one thing's wrong. It's just what is—and whereas now it's seen more as your own responsibility to do that. I think it should be a more shared responsibility....I think it would be nice if we could earn sabbaticals....I think it would be a good idea if there was more supervision....and...learning circles or whatever.

Participant 5: Jen's description expressing study theme three

I think that I've just become more comfortable with things,...It could be worse. And *not* that I'm saying that in a bad way,...you know, "Suck it up. This is what you've got for today. Deal with it and move on." [I'm saying that] you can't change it by feeling sorry for yourself. You have to actively work on what needs to be done. So I think that you're always bearing witness,...and I think that, you know, people that shut downwards or are very inward are missing out on this opportunity to bear witness on what's going on....I think that bearing witness,...being able to be present and allow people to do what needs to be done, with or without your assistance, is very important in any line of work....I think that this is something that should be focused on.

[Think of] all the times that we've looked at the competencies for palliative nursing and what makes them different from regular...nursing....[My hope is] that everyone would do it [ie. bear witness];...And I think that it makes it easier for everybody: for yourself as the person who's being present and bearing witness, and for the family and the clients and all the caregivers and all your co-workers and everyone else....I think if more people were *aware* of their bearing witness and just how much of an influence their presence has on other people—good, bad or otherwise—they might be willing to present more of a positive persona....You can't bear witness if you're not comfortable with who you are....That doesn't mean you have to have the best self-confidence....I think [what is necessary is] just going that little bit deeper, not being so shallow—just being comfortable with who they are, I think, would help people bear witness.

Participant 6: Margot's descriptions expressing study theme three

I've learned a lot....I realize I'm growing,...because I've had this experience and the opportunity to work in a field that is challenging....In some

form I'd like to pass on my knowledge, my experience. Whether I ever do it, I don't know, but either in talking about it or...pass[ing] it on through poetry. Pass it on through, you know, anonymously recording all the funny little bits or the odd bits....So...if there is an opportunity for something like that, you know, perhaps in the future...I wouldn't mind stepping up at...[a] conference and giving a half hour lecture on spiritual stuff. I'm not volunteering myself, but I mean, if it's meant to be, it'll approach, you know....I do talk about...how I view things at work. I do share it with staff. But I don't shove it down everybody's throat....If by me speaking out it can open one person's eyes a bit to the miracle of what's going on, then that's OK. So that's my bearing witness. That's why I think of all these stories and I keep them going.

I really had concerns that the staff are being ignored. The nursing staff are 50% of the workforce here...[but] we're outnumbered on days when there are administrative people and everyone [else]....The nurses are in the minority. It...does cause me, not anger, but sadness that...when we get some really good staff that aren't coping, that...it's all right to let them go because...they've done their job. I'm thinking of [someone]...would have stayed if...[she had been] treated...differently, but [they] just said, "Well, maybe this isn't the right job for you anymore."

#### Participant 7: Sophia's description expressing study theme three

[It's] just staying open and keeping communication and talking it [through] and...making people feel as though they're supported....We say the same thing every time we have a meeting and the same issues come up and they never address them. Well, I think they do their best but...it's a big organization now....It's within each one of us to try and, you know, hold tight to what's important to us, and I guess if you're unable to do it, then you know, move on or...do something. I mean, a lot of the people that bitch don't come [to staff meetings and events]; they just bitch. They don't come to the updates; they don't put their name forward to be on the support committee; they don't make their way to trying to make it, but...they say, "I've tried and tried and tried and no one's ever listened." So it's hard, and it's a fact—or it's their living. It's their fact and we all hear about it; and I don't know how to change that other than trying to support them when they're there,...just trying to help, trying to be there.

Everybody else seems to feel that we have lost our...heart and soul; that we don't have *time* to do what it is we need to do. And I can't say that that isn't *their reality*....I can't negate that,...but I don't have that feeling....I just know you have to have it. You've got to have the heart and soul in your practice, and if you don't, it just eats away at what it's all about. So we have to...figure out a way of making people...feel heard and honored and that we're trying to change....There're places that...aren't even trying to work on it....They're not even recognizing it and they're not aware of it or they're only aware of it in that they're so...unhappy.

I think that we try, I think we try....I just think we have to be *gentle* with each other. Everyone's doing the best they can do,...and that's the bottom line....Everybody does the best that they can do. And I just try to remember that,...but, you know, you've got to step back and have a look at it and try and look at it in the full context of what's happening....I also know that if they [staff] aren't validated and made to feel like...the powers that be are listening, they'll [the organization] lose them [the staff]....It's not going to be a happy place if something doesn't happen....but...it's pretty powerful stuff...bearing witness to their...angst and pain and unhappiness.

*Discussion of study theme three.*

The theme of *fostering continuing competent practice* arose as participants referred to experiences of and continued hopes for personal, professional, and organizational changes related to bearing witness. Participants spoke of learning, growth, change, awareness, recognition, confidence, and competence. They looked forward to and worked for continued and enhanced awareness of experiences of bearing witness, and spoke of possibilities and challenges associated with their experiences and hopes. Participants placed significant importance on such experiences, but wanted to work with greater confidence, recognition, and acceptance for their personal practices. Further, they wanted to continue to support others and enhance supports for others in their learning and practice.

Specifically, Anne spoke of “bringing [bearing witness] to the fore” to nurture others in learning and further develop this important aspect of practice. Leah actively shared stories with others, working toward a time when bearing witness could be viewed as “not just the whipped cream”, but the “substance and foundation” of nursing practice. Over time, Maria experienced a profound degree of change in herself and within her work environment related to experiences of bearing witness. She made changes in her own practice, and, concerned about possible long-term effects of such experiences, she identified a need to enhance existing opportunities for education and support, and refocus on “helping people live until they die”. Jo spoke of her own learning related to experiences of bearing witness, and she suggested the organization take “more to heart” the responsibility for providing employees with opportunities to “rejuvenate” and

“process”. Jen spoke of enhancing awareness of experiences of bearing witness. Margo shared her thoughts and stories to enhance the awareness of others, and looked forward to additional opportunities to “pass on...knowledge”. Although Sophia did not refer specifically to learning or teaching, she was aware of changes taking place and worked so that others could see changes were possible or taking place. She spoke of trying to “figure out” new ways of supporting her colleagues and helping them to recognize that the organization and staff were “trying to change”. Hence, in the richness and complexity of their own experiences of bearing witness in nursing practice, participants voiced hopes, concerns, challenges, and possibilities for the future.

As participants indicated that experiences of bearing witness were an important aspect of practice for themselves and to those they served, they related ideas about how nurses could be nurtured in learning and competence throughout their careers and within their organization. Participants explained that what was necessary or helpful included finding ways of recommitting to what was important to them in nursing practice, with an emphasis on gaining competency in aspects of nursing practice beyond or in addition to those of medical and technical skills. Strategies for doing so involved focusing on shared exploration and experience through the use of story-telling, learning circles, debriefing sessions, and team building activities such as retreats. Sabbaticals were suggested to assist nurses in maintaining energy levels necessary for continued engagement in intensive work. Mentoring others was cited as a possibility for supporting and fostering new nurses in experiences such as bearing witness. One participant thought that enhancing personal awareness was important. She believed that greater personal knowledge and understanding related to practice could give greater confidence in experiences such as bearing witness. Another participant pointed out that there was much yet to be learned about the experience of bearing witness with respect to nursing practice, and indicated that it was important to find out how to teach and mentor others within such experiences.

Several participants indicated or alluded to the notion that supporting nurses was a responsibility shared by both the person and organization. Exploring and describing

experiences of bearing witness included telling about the challenges of working within organizations and strategies and their hopes for something different. In this way, participants took opportunities to convey hopes and work for change by participating in the interviews, nurturing an awareness of challenging situations related to work load, staffing, values, and interrelationships.

#### *Summarizing Chapter 4*

The purpose of this chapter was to introduce each participant and provide a description of the meaning of the experience of bearing witness for each participant. Study themes common to all participants were presented and discussed along with relevant participant quotes. In the language of the participants, study themes were written as *enduring commitment surfaces gifts and burdens*, *telling-not telling mingles with closeness-reserve*, and *fostering continuing competent practice*. In the language of the researcher, study themes were written as *tenacious devotion engenders exquisite encumbrances*, *guarded intimacy*, and *honoring cherished confidence*. Study themes are further considered in chapter 5, which encompasses theoretical interpretation and a discussion of relevant literature.

## Chapter 5: Presenting Theoretical Interpretation and Discussing Relevant Literature

This chapter fulfills several purposes. One purpose is to discuss study themes in light of the principles and concepts of the theoretical framework of this study, that of the theory of human becoming (Parse, 1981, 1992, 1998). This contributes to enhancement of the theory (Bunkers, Petardi, Pilkington, & Walls, 1996), offering new understandings to the knowledge base of nursing. Specifically, Parse (2001c) states, “interpretation of findings is to be done in light of the original conceptualization and requires connecting the identified themes to the discipline-specific frame of reference and elaboration on the new knowledge gained from the study” (p. 59). Thus, another purpose of this chapter is to present a discussion of study themes in light of relevant literature.

### *Discussing Study Findings Related to Theoretical Theme One*

Addressing the theoretical theme of meaning, principle one of the theory of human becoming states: “Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging” (Parse, 1998, p. 35). Meaning refers to the particular importance and interpretation a person chooses to give something (Parse, 1998). For example, as participants engaged in interviews of this study, they freely chose and conveyed meaning in the moment with respect to their experiences of bearing witness. In their discussions of meaning, participants described bearing witness as *enduring commitment surfaces gifts and burdens*. Conceptualized in the language of the researcher, this theme was written as *tenacious devotion engenders exquisite encumbrances*.

The three concepts within theoretical principle one are imaging, valuing, and languaging. While all of these concepts are recognizable within the data, some are more explicitly so than others. In this study, I link theme one predominantly with the theoretical concept of valuing. Parse (1981) states that valuing refers to a person’s process of “choosing from imaged options and owning the choices” (p. 45), reflecting whatever or whomever in the moment is held dear. Valuing, as illustrated by participants in this study, included referring to aspects of their experiences as “essential”, “very important”, “integral”, and/or “very helpful” within nursing practice.

For participants in this study, valuing was closely linked with their enduring commitment, which was interpreted as tenacious devotion to the persons they served. Although enduring commitment was prized by all participants, it was lived in unique ways by each participant. For example, participants in this study lived their devotion to others even as their inability to control situations and persons was realized. Anne described her commitment to not abandon others, saying that the only thing she could promise was to “not abandon anybody in their direst moment”. Leah spoke of her commitment as following through with promises made to persons. In this way, she sought to foster trust with others, even when there were not answers and nothing could be changed. In other examples of valuing, Maria spoke of her “mandate...to bring people comfort” and Jo shared her ongoing commitment to journey with others. As Jo explained, you bear witness with others even when it is difficult to do so, even when you “have no control over [things] or you have no ability to change [things]”. Valuing surfaced as Jen described her time with a girl struggling with severe dyspnea. While Jen desperately wanted to ease the girl’s breathing by administering medication, the girl was clear that she did not want medication. Wanting to honor her patient’s decision, Jen said, “Who are we to go and change it because it’s more comfortable with us?”

Valuing is a process of selecting, treasuring, and acting upon whatever a person chooses as meaningful in cocreating his or her reality (Parse, 1981). As participants lived their enduring commitment to others within experiences of bearing witness, they described both gifts and burdens, which prompted new appreciation for what was important to them. For participants, the many gifts and burdens revealed to them over the years of their work, can be seen as exquisite encumbrances, held close and prized in long-time memories. These gifts and burdens influenced participants’ choices in living. For example, Anne said that there was “extreme sadness or...suffering”, but “it’s never all bad....and some good comes out of it”. For her, the experience of bearing witness meant accepting and carrying the weight of what she saw and experienced. Coming to see her experiences as “bearable” burdens, she chose to enjoy the gift of each day. Jo described experiences that were wearing and exhausting, yet immensely engaging and interesting to

her. In a process of valuing, she became more comfortable being “in the mystery”, believing that her presence could be a comfort to others even when there were times she could not change what seemed inevitable. Within these experiences, she prized “gems” of new understanding that helped her work in better ways with others. Through a process of valuing, Leah said, “I’ve come to understand a lot more that if I’m needed and if the time’s right, it’ll work out”, thus she chose to worry less about whether and how she could be helpful to others. Maria prized her ability to bring knowledge and comfort to others; through the years she experienced great weariness, but also gained understanding and an expanded vocabulary with which to comfort others in their grief. Maria said she needed to “work from a place in [her] heart”, follow her intuition, and work in a way that was congruent with her process.

Although I do not identify the theoretical concept of imaging as predominant in theme one, it is present in the data of the study and reflected in the way participants engaged in the process of interviewing. Imaging refers to a “reflective-prereflective coming to know the explicit-tacit all-at-once” (Parse, 1998, p. 36). It is “picturing or making real of ideas or events” (Pilkington & Jonas-Simpson, 1996). As such, a person continuously poses questions and proffers answers for himself or herself while searching for “certainty in knowing” (Parse, 1998, p. 36). For participants, exploring and describing experiences was an explicit-tacit process of clarifying the depth, significance, and variety of meaning related to experiences of bearing witness. For example, imaging her experience as “walking into the environment” of others, Maria said that sometimes that environment was like witnessing a “tsunami”. Here, she strived to bring about calm, to understand what was happening for others, and to decide what information to offer. She used her intuition and gathered information in order to come to some understanding, “peeling the layers off the onion to try and get to what’s actually going on”. Participants’ imaging of reality unfolded through valuing and languaging.

Parse (1998) writes, “languaging...is signifying valued images through speaking-being silent and moving-being still” (Parse, p. 39). As such, each person in process with others cocreates his or her own reality, using symbols to explore and express meaning

(Parse, 1981, 1998). The theoretical concept of languaging was not represented in a study theme common to all participants, but was represented in some of the data for this study. In this study, participants languaged valued images within the interviews through choosing to share certain stories and emphasize some aspects of their experiences. Participants chose to speak and be silent, move about or be still. Within experiences of bearing witness with others, participants shared stories and reminisced, asked assessment questions and conveyed information, pondered life questions, watched and waited, sat quietly or turned away. Several participants referred to both doing and not doing things for others within experiences of bearing witness. In all these ways, they languaged their cherished values by focusing on attending to tasks and/or being with the person.

#### *Discussion Study Findings Related to Theoretical Theme Two*

Pertaining to the theoretical theme of rhythmicity, principle two of the theory of human becoming states: “Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing, enabling-limiting while connecting-separating” (Parse, 1998, p. 42). The theoretical theme of rhythmicity refers to paradoxical ways of becoming as lived in the human-universe process (Parse, 1998). Paradoxical rhythms of human relating include revealing-concealing, enabling-limiting, and connecting-separating (Parse, 1981, 1991, 1998). As participants in this study described patterns of relating in experiences of bearing witness, the paradoxical notions of *telling-not telling* and *closeness-reserve* surfaced. When written in the language of the researcher, study theme two was written as *guarded intimacy*.

Lived paradoxical rhythms are found in all three principles of the theory of human becoming (Parse, 1981). A paradoxical pattern is “one phenomenon with two dimensions” (Parse, 1998, p. 34). Within the human becoming tradition, paradoxical rhythms are ever-evolving and emerging as new rhythms surface and old ones fade (Mitchell, 1993; Parse, 1987). Mitchell (1993) emphasizes that lived paradox is neither a contradiction nor problem to be resolved, but is a demonstrable, inherent aspect of reality.

Following the theoretical stance that all human patterns of relating are paradoxical (Parse, 1981), bearing witness was revealed as a paradoxical experience in several ways.

For example, as illustrated in study findings, several paradoxical notions including telling-not telling and closeness-reserve surfaced within descriptions of bearing witness. In addition, a paradoxical rhythm of bearing witness-not bearing witness was revealed as participants spoke of bearing witness and not bearing witness, or of being present with others in ways that did not encompass bearing witness. Anne, for example, spoke of times of doing something other than bearing witness, of being overly enmeshed, not closely attending in being present with others, or not connecting deeply with whatever was witnessed. Similar to Anne, several other participants said that they could not bear witness unless they were somehow closely involved with others or connected to a situation. Leah referred to both witnessing and bearing witness, distinguishing the latter as holding the promise to take action for the person. Other participants told of choosing for various reasons to not attend to what others were telling or experiencing. This happened, for example, when one participant described turning away in sorrow as a man told of his displeasure with the care provided. Several participants spoke of deeply painful experiences of being unable to bear what others were experiencing or said that there were times when conditions at work did not support them to be present in the ways they wished.

I link the notion of closeness-reserve predominantly with the theoretical concept of connecting-separating. Parse (1998) explains that connecting-separating “is being with and apart from others, ideas, objects, and situations all-at-once” (p. 45). In this study, all participants referred to experiencing being connected, yet separate from others. For example, Anne spoke of being profoundly connected to others through her experiences of being “moved” within the experience of bearing witness. However, she said, “you’ve got to be separate to bear witness”, relating a story of a person she thought had overstepped boundaries between personal and professional relationships. Maria described an experience during which she felt very close and over involved with a friend. Similar to Anne, she was troubled by this experience and emphasized the importance of maintaining personal and professional boundaries. Interestingly, both Anne and Maria also indicated that the ability to form very close relationships was important in nursing practice. In

connecting-separating, Leah and Sophia described times of great intimacy with others during which they set limits on their availability to others. Jo's descriptions of rhythmicity encompassed times of being deeply engaged with others and her work, and other times when she chose to be "very insular" by "crawling into herself". Similarly, Jen worked so that she and others could create a close team, yet there were times when she was distracted and less involved or present with others. When Jen felt vulnerable or threatened, she established personal boundaries so that she did not risk injury. In a process of connecting-separating, Margot identified a strong connection with all humanity, yet there were times when she could not relate to another's perspective or for other reasons did not feel in touch with a person. She was aware of a need to be vigilant so that she did not become too involved with others. Sophia described experiences wherein she felt both welcome and connected, but quite separate from the experiences of others. Hence, the notion of closeness-reserve is linked with the theoretical concept of connecting-separating.

The experience of telling-not telling most closely linked with the theoretical concept of revealing-concealing. Revealing-concealing "is disclosing-not disclosing all-at-once. Fundamental to this rhythm is the notion of the human as mystery" (Parse, 1998, p. 43). This means that within interrelationships, one can never know or reveal all there is to know or reveal.

The human as mystery is illustrated by Margot's words:

[There was] a man who came to us with HIV,...and his best friend came...to be with him....It was the first he'd realized that probably his friend had [HIV/AIDS and led] a double life, and it just, I think he really thought that they were such close friends there was nothing hidden.

The concept of revealing-concealing surfaced in other ways within study data. For example, Maria remarked that even though she patiently persisted in finding out what was happening for others, she was not always able to comprehend the situation or convey what she knew was important in her charting. Revealing-concealing is reflected as Leah responded to a woman's question about what to expect when she was dying. Leah shared what she knew, but there was much that she did not know about this process. Later, when

the woman was near death, there were aspects of what the woman was experiencing that she could not share with Leah. Sophia described a process of revealing-concealing as she offered personal care and listened closely to what a woman chose to tell her. Then, Sophia did not chart what was revealed for others to read, but treated this information as private, between the two of them. In Anne's experiences, persons revealed aspects of who they were through speaking and in their actions. She said that sometimes there were opportunities to convey to others the details of a person's life that might tell another caregiver what was important to that person. At other times, opportunities to share with others did not arise.

The third concept within theoretical principle two of the theory of human becoming is enabling-limiting. While I do not identify this concept as represented in a study theme common to all participants, enabling-limiting was revealed in study data. Enabling-limiting "is living the opportunities-restrictions present in all choosing all-at-once" (Parse, 1998, p. 44). As people choose from various options in life, they are at the same time both enabled and limited (Parse, 1981, 1998).

Patterns of relating with other persons and organizational structures were paradoxically enabling-limiting in several ways. For example, participants set limits in interactions with others for various reasons, including those related to how they experienced and chose to work within organizational structures. Sophia and Leah in their own ways set time limits with others, which created both opportunities and restrictions. Specifying times of availability when with others allowed Sophia and Leah to be present in the moment, yet limited interactions in other ways, at other times, and with other persons. The concept of enabling-limiting was also illustrated as several participants described how their choices to work according to personal standards contributed to a sense of satisfaction, but offered challenges with respect to fulfilling needs for self care, or conflicted with the expectations of managers and other workers. Participants also described immensely stressful situations related to demanding workloads and expectations. Although participants also described being distracted and delayed by the need to complete a multitude of daily tasks and duties, they identified that doing things

for others brought them into closer proximity with patients and families, creating more opportunities for bearing witness. In these ways, the theoretical concept of enabling-limiting is illustrated within the data of this study.

JOURNAL ENTRY: Ok. This process of linking study themes with theoretical themes and concepts is really challenging. What's that all about? I guess it's about having only a beginning understanding of theoretical principles, themes, concepts. My understanding is shifting all the time. In addition, I think about how within non-empirical views, perspective is seen to inform all processes and dimensions of a research study. Further, each person understands and interprets any one perspective in his or her own way. To me, this means that each reading or theoretical interpretation is unique to each researcher in the moment. The thing is that, on some level, all of the theoretical themes concepts of human becoming seem linked with all of the findings of my study. This is problematic just now, because I keep seeing ways I should perhaps alter study themes and their links with theoretical concepts. Still, it's also very interesting. I think it has to do with how the theoretical framework and principles are non-linear. Further, I guess it is in the very struggle of interpreting and linking study findings with theoretical principles and concepts that continue to expand my (momentary) understandings of the theory...

#### *Discussing Study Findings Related to Theoretical Theme Three*

Reflecting the theoretical theme of cotranscendence, principle three of the theory of human becoming states, "Cotranscending with the possibles is powering unique ways of originating in the process of transforming" (Parse, 1998, p. 46). In clarifying new ways of being and living hopes and dreams, humans grapple with the familiar and unfamiliar (Parse, 1992, 1998). Linked with theoretical theme three, the third objective of this study was to describe personal hopes, concerns, and possibilities related to the experience of bearing witness. In their discussions of cotranscendence, participants described bearing witness as *fostering continuing competent practice*. Conceptualized in the language of the researcher, study theme three was *honoring cherished confidence*.

Theoretical principle three encompasses three concepts: powering, originating, and transforming. Transforming is defined as "shifting the view of the familiar-unfamiliar, the changing of change in coconstituting anew in a deliberate way" (Parse, 1998, p. 51). In a continuous process, persons initiate and intentionally choose "a new view and, in so doing, a new way of becoming" (Parse, 1998, p. 53). I link the study

theme of fostering continued competent practice predominantly with the concept of transforming.

Exploring and describing their experiences of bearing witness, participants told how they were engaged in ongoing processes of changing aspects of personal and professional. In a process of transforming, they shared ideas directed at nursing practice what would assist them to continue in that process of becoming and advancing their competence and confidence. For example, in light of her own experiences, Anne gained confidence in her knowing what she could and could not provide for others. She spoke of finding ways of bringing the experience of bearing witness “to the fore so it’s recognized, nurtured, and developed” for other nurses in practice. Thus, she hoped to encourage other nurses to engage confidently in close, professional relationships with those they cared for. Leah actively mentored and nurtured new nurses in getting “solid in skills” or more competent so that they could focus more readily on being present with people. In a process of transforming or moving beyond concerns that expressions of spirituality were inappropriate in practice, Leah also encouraged caregivers to share and honor stories of how they helped support persons’ spiritual practices. Transforming was illustrated as Maria identified her concern that something needed to change in her practice and in the organizational structure so that human spirituality was honored. Seeking to maintain her standards of practice, she called attention to the need for more support and education to assist her and others to work ways that meet both personal and organizational expectations. Jo saw the possibility of moving toward a situation of more “shared responsibility” so that staff were energized and continuing to learn in practice. Jen described bearing witness in practice as related to competencies for hospice palliative care nursing. She spoke of helping nurses to be more aware of what they do and more “comfortable with who they are”, allowing them to work in greater depth in relationships with others. As Margot learned more about what was important to her grew, she wanted others to be more aware and took opportunities to share her knowledge with others. She looked forward to continuing to do so in the future. Sophia spoke of recognizing that people and the organization were doing their best in difficult times. In bearing witness,

she remained engaged in her work and looked for ways of being with others in ways that supported and honored them in their work and through ongoing change. In all of these ways, participants lived a process of transforming. Participants spoke of enhancing awareness, recognition, support, growth, learning, and development within experiences of bearing witness in nursing practice, honoring cherished confidence.

The concept of transforming also surfaced within the process of interviewing. For example, in Anne's interview, transforming was illustrated as she experienced an "aha", coming to new understanding of how she bore a weight or burden as an aspect of bearing witness to the experiences of others. Similarly, Jo conveyed her pleasure as new thoughts and different ways of seeing things surfaced during the interview. In a process of shifting the unfamiliar to the familiar, Margot mused, "I've never thought of it like that before [now]". Thus, in a process of transforming, these participants came to view their experiences in new ways.

Although not specifically represented within a single study theme, the concept of powering was also evident in research data of this study. Parse (1998) writes, "that the human being exists means that the human is powering. One cannot not power" (p. 47). In powering, persons move toward possibilities creating tension and sometimes conflict in a process of pushing-resisting (Parse, 1992, 1998). As such, persons are "affirming-not affirming being in light of nonbeing" (Parse, 1998, p. 47). Nonbeing addresses not only the possibility of dying, but also of not being appreciated, honored, or acknowledged in ways that are important to the person (Parse, 1981, 1998). For example, the concept of powering surfaced in several participants' steady drive to do whatever is possible for others while resisting various structures of the organization. Powering was revealed in Maria's statement: "I don't ever want to stop searching for the answer of how to control [symptoms]", in her regret for what was different from the past, and in her struggle to continue work in her own way despite the judgments of others.

The theoretical concept of originating also surfaced in the research data, although I do not view it as represented in a study theme common to all participants. Originating refers to "inventing new ways of conforming-not conforming with the certainty-

uncertainty of living” (Parse, 1998, p. 49). In other words, humans live certainty-uncertainty as they conceive of and work out unique ways of being, varying in consonance with the ways of old and of others (Parse, 1981, 1992, 1998). Originating was illustrated as participants presented a variety of ideas for fostering support, education, and awareness related to experiences of bearing witness. Most of their ideas were not developed in detail but, believing that something needed to be changed, participants introduced and pondered possibilities, considering old strategies and new approaches in a desire to work with greater competence and confidence related to experiences of bearing witness.

#### *Study Themes and Relevant Literature*

A literature search related to study themes surfaced no new research studies related to bearing witness and nursing practice, and only a few new resources specific to the topic of bearing witness. This prompted me to revisit previously reviewed items and explore related resources in the broader literature in preparation for the discussion of possibilities and challenges in nursing practice, education, policy, and research as outlined in chapter 6.

#### *Study Theme One and Relevant Literature*

Research theme one of this study in the language of the participants was *enduring commitment surfaces gifts and burdens*. Interpreted in the language of the researcher this theme was *tenacious devotion engenders exquisite encumbrances*. This research theme arose as participants spoke of gifts and burdens revealed in an enduring commitment to honor others through experiences of bearing witness. It is perhaps not surprising that experiences of commitment, and feelings of being gifted and burdened arose in findings of this study. As outlined in chapter 2, notions of commitment, devotion, challenge, and benefit, as well as related topics such as woundedness, traumatization, and vulnerability, are central to many articles and studies related to bearing witness. In addition, such topics abound in discussions in the broader literature related to professional caregivers’ practices in hospice palliative care settings.

Although framed within a perspective different from human becoming, similarities to the notion of enduring commitment are found in Riley-Giomariso's (1998) discussion and personal comments in her study focusing on the experiences of student nurses in critical care settings. For example, she states that even if

bearing witness to suffering is asking too much,...bearing witness to suffering is a command that is generated from somewhere within you. It comes to you, and you answer. Some say it is a calling or an aptitude. I think it is a conscious decision to hear the voice of the other. (Riley-Giomariso, p. 175)

Thus, I read something similar to the notion of enduring commitment as she refers to nurses' "professional obligation as oral agents" (p. 162), although it is sometimes experienced as "unbearable" (p. 166).

Theme one of my study resonates with findings reported by Cody, Bunkers, and Mitchell (2001), a study also framed within the human becoming perspective. The first concept reported by Cody, Bunkers, and Mitchell was expressing a commitment sparked by veneration, interpreted as incarnating devotion in the language of the researcher and linked with the human becoming theoretical concept of languaging. Aspects of these findings are similar to my own in that participants in my study also spoke of their commitment to honoring others, represented in the theme of enduring commitment surfaces gifts and burdens and linked with the theoretical concept of valuing. For me, valuing is also illustrated in one example given by Cody, Bunkers, and Mitchell (2001) whereby a caregiver was "not simply 'expressing a commitment, but living it'" (p. 248) as that caregiver described climbing onto a bed to hold someone who was afraid and asked to be held.

The notion of commitment also surfaced in a hermeneutic study on the topic of mendacity as a refusal to bear witness. In this study, Cody (2001c) discusses commitment related to bearing witness as a willingness to "stand for the truth as one understands it" (p. 213). Cody points out that "to have one's truth witnessed by others is all-at-once as vital for living as who one is, yet potentially devastating" (p. 215). For example, some "truths" may be experienced as shocking or harmful. Further, I consider how an enduring

commitment to honor others can be experienced as both affirming and devastating, according to perspective and related to how that commitment is lived. For example, a nurse's commitment to honor others that is lived as providing information or assuming that persons "live as they die" may be welcomed or not depending on the preference and experience of that person.

While Eifried (2003) did not refer directly to commitment or devotion in her themes, she wrote, "the students sensed that their patients who were suffering needed them, and they did not want to let them down" (p. 63). Further, she wrote, "when students are face to face with patients, they sense their responsibility and respond. In their woundedness, they may respond haltingly to suffering but savour opportunities to reach out and make a difference" (Eifried, p. 63). Thus, she wrote that "bearing witness to suffering patients called students to an awareness of their own vulnerability" (Eifried, p. 59).

Several participants in my study referred to feelings of vulnerability related to experiences of bearing witness. Maria described feeling vulnerable on occasions of witnessing the severe shock of family members at the death of a loved one. Leah spoke of putting herself in a "vulnerable place" of not knowing. Jen spoke of vulnerability related to the possibility of "getting hurt". The prevalence of discussions in the literature about the vulnerability of nurses and persons leads me to wonder how perceptions and experiences of vulnerability influence how we live our choices and commitments in being present and bearing witness with persons living their dying.

Even though the experience of bearing witness is often thought of as challenging and linked with suffering, it is noteworthy that participants in my study identified many gifts related to experiences of bearing witness. As outlined in chapter 2, other authors also highlight this aspect of bearing witness. For example, Drought (2002) refers to bearing witness as a "privilege...at the heart of our profession" (p. 238), saying that "we learn, we grow, we become greater because of the hope, trauma, relief, sorrow, integrity, despair, joy, and love that we witness every day in practice" (p. 238).

Findings similar to the notion of gifts and burden within experiences of bearing witness are present in various ways in several studies. For example, Pellico (2004) briefly addressed the theme bravery and bearing witness surfacing in her study focusing on experiences of student nurses. The notion of burden is reflected in one student's journal entry where she wrote, "What does it mean to bear witness? bear witness Weight, tolerate, hold, lift, pressure, see observe, watch, passive. Is it a passive process? I don't think so" (Pellico, p. 166). In her conclusion, Pellico speculates that students may suffer secondary trauma, and notes that this has implications for recommendations for support and education. The notion of gift surfaces for me as Pellico also describes some students as "retaining and...treasuring the memory [of encounters with patients] for a lifetime" (p. 139). It was surprising to me that only some of the participants in my study explicitly referred to the importance of active remembering related to experiences of bearing witness. Yet, they, too, seemed to treasure their stories and memories. Thus, on a more tacit level, memory and remembrance underpinned our interview process and participants' experiences of bearing witness as they recalled and shared treasured stories and lessons gleaned throughout years of service.

The pediatric nurse participants in Melnechenko's (2002) study described both loss and enrichment in experiences of bearing witness to suffering. Loss was identified in her study as a loss of "familiar sense of self" (Melnechenko, p. 87) referring to physical and personal integrity, and related to the experiences of the nurses and the experiences of the children and parents as interpreted by the nurses. Through seeking meaning in loss, "opportunities for discovery and growth" (Melnechenko, p. 89) were created as expressed in the fourth theme of her study: lived time experienced as seeking meaning. As one participant said, "even though it's a very taxing process to go through as far as emotionally draining, it's very rewarding at the same time" (Melnechenko, p. 72).

Riley-Giomariso's (1998) students refer to "the weight of bearing witness to suffering" (p. 173). Riley-Giomariso says further that the students "often prefer that witnessing suffering be passed on to another. They become weary from their experiences" (p. 173). Although she does not view bearing witness to suffering as a paradoxical

experience, she notes that in addition to the weight of this experience, students “were happy to care for their patient and ease their suffering” (Riley-Giomariso, p. 167).

This highlights for me how a researcher’s perspective determines what a researcher views and how he or she interprets findings. For example, in interpreting students’ drawings, Riley-Giomariso (1998) describes “sacred and profane experiences of patient encounters in critical care” (p. 174), referring to a “dichotomy” (p. 38) or opposition rather than paradox in experiences related to bearing witness. Similarly, although Melnechenko (2002) makes some analytical links to human becoming theory, she does not frame her study within it and does not describe experiences as paradoxical. Yet, as a student of the human becoming perspective, I identify the paradox of human experiences in many instances throughout these studies.

The findings of the study by Cody, Bunkers, and Mitchell (2001) also resonate with theme one of this study. Specifically, I identify similarities with their finding written as a hard-won serenity amidst ongoing joy-sorrow, which the authors linked with the theoretical concept of transforming. As Cody, Bunkers, and Mitchell (2001) explained, participants described “a kind of bittersweet peace and contentment” (Cody, Bunkers, & Mitchell, 2001, p. 250) in bearing witness to suffering. The notion of an experience as bittersweet seems similar in some ways to the notion of gifts and burdens as articulated in my study.

JOURNAL ENTRY: I think often about the phrase: “Practice is the irreversible incarnation of one’s values and beliefs” (Cody, 1999a, p. 5). Don’t ask me why, but when I read the word incarnation, I think of music and poetry. (Something to do with meaning, rhythmicity, cotranscendence, I guess.) A line of Rumi’s poetry comes to mind: “Poems are rough notations for the music we are” (Barks, 2001, p. 134)...What if we believe that we are music?

Working within the framework of the human becoming school of thought (Parse, 1998), Bournes (2000) suggests that paternalism has to do with the assumption that “others need to be protected, because they do not know what is best” for their own health and quality of life (Bournes, p. 18). This assumption is contrary to the assumptions of human becoming, and, within that perspective, Bournes challenges nurses to consider what it means to live a belief and commitment to honor person’s choices. Bournes makes explicit that if a nurse believes persons know about their own health and can take responsibility for their own choices,

then a nurse is “bound” (p. 23)—that sounds like committed—in a big way—to serve as witness with persons as they live their choices, no matter what those choices are. If we were bearing witness with others in this way, would we then hear—and be? —music?

I received in the mail today a staff survey requesting feedback regarding a draft statement of values meant to underpin our practice with others within our organization. One of the values chosen is commitment. The statement about commitment proposes that, “Commitment to quality end-of-life care is fundamental to our work and our relationships. Through our dedication, we honour the people we serve, each other and ourselves.” I think about the study theme *enduring commitment surfaces gifts and burdens*, and wonder about the ways in which each participant lived and experienced that uniquely. So, I wonder: What does “commitment to honor the people we serve” mean to each person who created or read this draft statement of values? I’m learning that there are many ways that we can live that commitment, depending upon our assumptions about people.

#### *Study Theme Two and Relevant Literature*

Study theme two in the language of the participants was *telling-not telling mingles with closeness-reserve*. In the language of the researcher, study theme two was written as *guarded intimacy*. As with study theme one, study theme two as written here does not surface in the literature. However, there are many similarities and points of intersection related to notions of telling-not telling, closeness-reserve, and intimacy among the findings of previously reviewed studies. In addition, I identify some links within the broader literature.

Theme two of this study is similar in some ways to Melnechenko’s (2002) explanation of how “being intentionally involved included setting limits and boundaries for nurses in their relationships with children and parents” (p. 76). Melnechenko’s theme of lived other as intentional involvement encompassed the sub-themes of developing a bond and responding to a call. As I interpret Melnechenko’s comments, choosing to be open with another involves showing aspects of who one is through expressing emotions and investing oneself within chosen personal limits. As such, the notions of both telling-not telling and closeness-reserve are similar to aspects of Melnechenko’s findings.

Within a human becoming perspective, the theoretical concept of connecting-separating is strongly linked with bearing witness. In Cody's 1992 study of the experience of grieving, bearing witness to aloneness with togetherness surfaced as a theme and was linked with the theoretical concept of connecting-separating. Similarly in my study, connecting-separating is a strongly represented theoretical concept expressed as closeness-reserve. A concept of the study findings reported by Cody, Bunkers, and Mitchell (2001) was attentive presence with one in anguish, also linked with the theoretical concept of connecting-separating. They remark that attentive presence with one in anguish is "the essence of the phenomenon of bearing witness to suffering itself" (Cody, Bunkers, & Mitchell, p. 249). For me, this highlights and affirms bearing witness as "uniquely constituent with presence" (Cody, 2001a, p. 97).

Regarding Riley-Giomaso's (1998) study, the notion of telling-not telling and the theoretical concept of revealing-concealing surfaces for me as I read the statement: "We need to tell the story so the experience of suffering comes to light" (p. 175). Similarly, Riley-Giomaso remarks that the students' drawings "attempt to make one aware of suffering and bearing witness to the experience of suffering" (p. 170), bringing to light what is often hidden. Whereas I interpret data in my study as focusing on a wide variety of aspects and experiences of living-dying, Riley-Giomaso's findings focus on bearing witness as mostly associated with revealing the experience of suffering.

Similar to Riley-Giomaso's (1998) findings and theme two of my study, Eifried (1998) writes that "bearing witness to suffering is the telling of" (p. 82) stories of suffering. "The stories they tell are about the truth as they [the students] know it" (p. 82). Yet, in such experiences "students often feel overwhelmed and hopeless and seek a place to which they can escape" (Eifried, 2003, p. 62). They were also described as wanting to share "feelings of helplessness, sadness, and loneliness" (p. 63) but sometimes reluctant to do so with instructors due to feelings of vulnerability, fearing that they would be perceived as inadequate or that their sharing was inappropriate.

Considering the notion of telling-not telling, I attend to a resource that refers to something as unspeakable and attend to an article entitled "Bearing witness to the

Unspeakable". In this article, Young (1997), a clinical psychologist, writes of what she describes as the "powerful and profound impact" (p. 23) of her experiences of bearing witness. Young describes becoming more aware of both the horror and hope of living as she is present with a woman who tells of her experiences of being tortured. In many ways, the woman's experience is unspeakable, yet she chooses to share something of it with Young. Young states that she herself "felt compelled" to share her experience of bearing witness with another person. In the midst of telling-not telling, she describes a strengthened commitment towards her work, and a greater appreciation for the importance of caring for herself and other workers.

In being present with persons, there are many factors that influence choices regarding how persons live connecting-separating. For example, Riley-Giomariso (1998) writes of the intensity and intimacy of encounters portrayed in students' descriptions, referring to "interconnectedness...present between nurse, patient, and family" (p. 166). She also comments on how some of the students' drawings and reflections describe a "distancing and indifference" created through technology and "professional idioms" (p. 168) in language.

Findings in Pellico's (2004) study also reveal intimate interrelationships, surfacing notions similar to telling-not telling and closeness-reserve within student nurse-person processes. Pellico writes that students' narratives related to bearing witness "spoke of connecting with patients, hearing their stories, and bearing witness to patients' lives" (p. 139). This is illustrated in the following journal entries made by students:

By hearing Donald's story, I was his witness. I witnessed is [sic] gentleness and compassion, and that he loved the world and his life, and that he had fears and desires. I witnessed his existence, and in return, he honored mine. (Pellico, p. 182)

And I was, indeed, moved. Not simply to see suffering, but to bare [sic] witness to that all too human struggle—so terribly brave and desperate—of one being willing to take on any and all pain and indignity imaginable, in a last gasp effort to save that which one holds most dear. (Pellico, p. 182)

About bearing witness; it's about providing a voice. Bearing witness might be a start, but maybe the point is to lend (restore) voice, and more importantly,

meaning to the process—for the patient, and anyone else who will listen. (Pellico, p. 140)

Pellico speaks of the students as seeing persons as “loved ones” (p. 193). Although she refers to this as a “pretense” (p. 193), in that the patients may *resemble* but *are not* family members, she later refers to a “seemingly universal need to identify patients as loved ones” (p. 204). Several participants in my study referred to their interrelationships with other persons as loving.

Overall, the findings of other studies as discussed in this section also resonate with the study theme of guarded intimacy. The topic of intimacy is explored in the broader literature related to nursing and hospice palliative care. For example, Barnard (1995) writes that “the most important question...is not so much whether to have intimate encounters in palliative care but rather, what challenges and opportunities confront us when those encounters do occur and how we respond to them” (p. 22). He suggests that experiences of intimacy often come as a surprise and hold a fear “of our own undoing in confrontation with chaos and disintegration” (p. 26). This leads him to wonder how often opportunities for greater intimacy are avoided or missed. Yet, he remarks, intimacy holds great promise for “feeling connected to others, for meaning, hope, and even joy in the midst of great suffering” (p. 22).

JOURNAL ENTRY: Barnard (1995) says that we are often surprised by intimate encounters in palliative care medicine, yet he recommends that practitioners “give full weight” (p. 23) to such encounters. He discusses the notion of “undoing” related to intimacy, referring to the possibility of becoming sort of overwhelmed and/or transformed. Following Barnard, de Hennezel (1998) refers to a paradoxical “intimate distance” (p. 56) that professional caregivers create through “a fear of encountering our own helplessness, vulnerability or powerlessness in the face of the chaos and disintegration that is happening to the other person” (p. 59). Even so, both authors advocate for more fully and humanly engaging with others.

This is interesting when considering nurse-person processes and the human becoming perspective, and in light of the discussions of some of participants of this study who spoke about maintaining personal-professional boundaries. Should or can such boundaries be undone? Or merely redrawn? Or, are there other ways of looking at the notion of intimacy? I guess there are. How is intimacy

interpreted and experienced if human-universe is viewed as inseparable and as growing ever more complex?

Wilbur (1979) refers to a “no-boundary” (p. 28) reality: a non-dual universe without the illusion of any boundaries. I guess that this is similar in some ways to how Parse (1981, 1992, 1998) views human-universe. So, what does this view have to contribute to the discussions related to maintaining personal boundaries and keeping personal and professional aspects of life separate? I know it’s important on some level to discern for ourselves what it means to be a professional, but sometimes I regret that such discussions bring us to focus more on assessing risks and questioning whether and to what degree to “have intimate encounters”, and less on what things are like for the person and how they’d like things to be. Why is it sometimes seen to be contradictory or difficult to be human and work as a professional? Especially when you are a nurse...

Although experiences of bearing witness are not often researched, nurse authors are questioning existing conceptualizations of personal-professional interrelationship, intimacy, and boundaries. For example, Hem and Heggen (2003) conducted an ethnographic study with psychiatric nurses “to find out how nurses experience and interpret the contradictory demands of being both fellow human beings and health professionals in their work with patients” (p. 102). In light of their study, they challenge the “harmonious and narrow” (p. 101) conceptualization of nurse-person processes and suggest that more space be created to explore expectations for “individuals to be both intimate and distanced, ‘human’ and professional” (p. 106). In her literature review, Williams (2001) demonstrates that there is informal and theoretical consensus as to the importance and complexity of experiences of intimacy within nurse-person relationship, yet a significant lack of conceptual clarity and research. Since 2001 there have been several studies conducted with respect to experiences of intimacy and nursing practice, at least one of them framed within the human becoming perspective (Parse, 1992, 1998) but not related directly to bearing witness. This is a topic for further study.

#### *Study Theme Three and Relevant Literature*

Study theme three in the language of the participants was *fostering continuing competent practice*. In the language of the researcher, this theme was written as *honoring cherished confidence*. This theme arose as participants described their experiences as

contributing to their personal and professional learning, and how they worked toward further recognition and competence related to experiences of bearing witness for themselves and others. Similar to study themes one and two, theme three was not expressed in the same way in existing literature related to experiences of bearing witness. However, notions of nurturing, fostering, advancing, or enhancing professional learning, awareness, competence, confidence, and development are represented in several previously reviewed studies (Eifried, 1998; Pellico, 2004; Riley-Giomariso, 1998) related to bearing witness.

Riley-Giomariso (1998) suggested that it is necessary for students to share their stories of bearing witness to suffering so that they can be supported in continuing to bear witness with the persons assigned to their care. Questions raised for me in relation to this statement and the messages of participants in my study include the following: Where, when, and how might such stories be told? Who will listen and bear witness? How can students, nurses, and others enhance awareness of and work competently within experiences such as bearing witness? What does the literature have to say about supporting experiences that are “about the ineffable” (Riley-Giomariso, p. 225) and, according to several participants in my study, about being and not necessarily about doing?

Similar to Riley-Giomariso (1998), other authors call to attention aspects of or ways of being in nursing practice that are not necessarily about performing concrete skills and tasks. For example, Melnechenko (2002) identified the importance of both being present with others and communicating with others, saying that

nursing education must also find ways to teach nurses how to establish and maintain synchronous interpersonal connections through presence and compassionate communication in which nurses do not feel obliged to withdraw or distance themselves from the other to be with them therapeutically. (p. 96)

Melnechenko viewed nursing practice as encompassing presence and communication, with a therapeutic approach. This view is congruent with an interventionist perspective. Yet, she challenged commonly accepted notions of maintaining a distance from others.

In her study with student nurses, Pellico (2004) called for nurse educators to remove “the terms detachment and objectivity from our language of communication competencies” (p. 204). Further, she remarked, “we should be able to do better than providing lists for communication that seem to bestow a false sense of security” (p. 204). Thus, I turn to existing competencies to see how nontraditional perspectives are represented.

A College of Registered Nurses of British Columbia (CRNBC) (2005b) document states that nurses practice in “environments of constantly changing resources, expanding expectations, and evolving technologies for treatment and care. Given the challenges of practice, it is critical that we continue to develop our knowledge and competence throughout our careers” (p. 2). Thus, all nurses in British Columbia are legislated to meet performance standards and fulfill the requirements of continuing competency. Meeting the requirements of continuing competency includes completing requirements for practice hours, conducting an ongoing self-appraisal, participating in discussions with peers about one’s practice, and engaging in learning activities designed to support professional development. Self-appraisal focuses on six categories of professional standards for registered nurses of British Columbia. These encompass the areas of professional responsibility and accountability, specialized body of knowledge, competent application of knowledge, code of ethics, provision of service in the public interest, and self-regulation. It is suggested that the CRNBC professional standards can be utilized to support personal practice, identify and address professional practice issues, and articulate what nursing is and what nurses do (CRNBC, 2005b).

The summary under the category of Specialized Body of Knowledge indicates that nurses “base practice on the best evidence from nursing science and other sciences of humanities” (CRNBC, 2005b, p. 4). The document does not make additional or detailed references to scientific nursing theories, but does state that nurses use “relationship and communication theory appropriately in interactions with clients, colleagues and others” (CRNBC, 2005b, p. 4). The summary for the category of Competent Application of Knowledge states that the nurse “makes decisions about actual or potential problems and

strengths [of the client], plans, and performs interventions, and evaluates outcomes” (CRNBC, 2005b, p. 5). In light of the the problem-based approaches outlined above, it appears that empirical perspectives are well represented in this document. Non-empirical views, approaches, and goals related to practice, as well as terms such as *nursing presence* and *bearing witness*, are noticeably absent.

Empirical, interventionist views are also well represented within a Canadian Hospice Palliative Care Association (CHPCA) (2004) document discussing hospice palliative care nursing standards. The CHPCA is a national organization with a mission to provide leadership in hospice palliative care. According to the terms of reference of the nurses interest group within the CHPCA, a national objective is to seek to “maintain and promote standards of care for hospice palliative care nursing practice” (CHPCA, 2004, p. 4). According to a monograph available on the CHPCA website, standards can serve as a measure of professional performance, and can support nurses in promoting “safe, competent, and ethical practice” (Peden, Grantham, & Paquin, 2005, p. 2). The CHPCA Nursing Standards of Practice include the dimension labeled *Connecting*, which states, “the hospice palliative care nurse establishes a therapeutic connection (relationship) with the person and family through making, sustaining and closing the relationship” (Peden, Grantham, & Paquin, p.3). These standards may serve to articulate views and support nurses to practice competently within empirical traditions, however they do not represent practice within non-empirical traditions.

If non-empirical perspectives and approaches are not yet represented in standards, then they are likely lacking in other documents that might support continuing competent practice. Further, Cowan, Norman, & Coopamah (2005) recommend that due attention be paid to making a distinction between competence and competency, since competency refers to “the behavior underpinning” (p. 358) performance of aspects of work. If competencies primarily take into account behaviors and skills, it may be that aspects of practice such as being present with persons and bearing witness to health choices should be articulated in other ways or conceptualized as something other than a competency. Thus, it seems important to continue to explore which views are and are not articulated in

standards and competencies. It also seems important to ensure that all aspects of nursing practice, including non-traditional approaches valued by nurses and persons alike, are represented.

*Summarizing Chapter 5*

In chapter 5, findings were discussed in light of the themes and concepts of the theoretical framework of the study. Findings of this research study were identified as similar, yet different from findings of previously reviewed studies related. A search of literature related to study findings did not reveal any additional research related to experiences of bearing witness in nursing practice. The above discussion of study findings and relevant literature contributes to further challenges and possibilities for practice, education, policy, and research (Bournes, 1997; Burns, 1989). Several possibilities and challenges are outlined in chapter 6.

## Chapter 6: Considering Possibilities and Challenges for Practice, Research, and Policy

The goals of this qualitative study were to (a) offer new understandings of the human health experience of bearing witness; (b) discuss implications of bearing witness for nursing practice; (c) discuss implications of study findings for nursing policy; and (d) contribute to the expansion of the theory of human becoming. The final chapter of this thesis focuses on discussing new understandings of and possibilities for nursing practice, education, research, and policy. As throughout this thesis, personal reflections are offered as journal entries.

### *Reflections*

JOURNAL ENTRY: I remember reading Behar's book called *The Vulnerable Observer* during one of my first courses in grad school. (Behar is an anthropologist.) The last sentence of her first chapter reads: "If you don't mind going places without a map, follow me" (p. 17). I was curious and excited about such an invitation, thinking: An Adventure! I do love an adventure!

Well, it's been some kind of adventure, all right. Frankly? It's been a little too adventurous, a little too exciting. I feel like I've been on some crazy combination of prolonged pilgrimage and high-speed, guided tour. You know: thirty-seven cities in, like, three weeks. Over and over and over again. Sometimes crawling, sometimes sprinting to the next attraction in an effort to take full advantage of the sights (ok, this description is a little dramatic, but what the heck...). I keep reminding myself to pay attention, to ask questions. I ask: What messages are participants conveying? What am I seeing and hearing, or not seeing and hearing? What's important to me and to others involved,...and why?

It's been an intense, (over)stimulating few years. While I initially avoided creating a detailed map or itinerary outlining my grad school adventure, there were some pretty significant choices to be made in narrowing down a course of study. Indeed, part of the intensity of being a graduate student was related to the challenge of drawing the boundaries of study and choosing a framework within which to explore a phenomenon of interest.

Considering the notion of a framework, I remember how in one course I was encouraged to take a close look at nursing theory. Here again, curiosity and possibility underpinned classroom discussions. This time, for me, there was the possibility of adventure in something called the human becoming school of thought (Parse, 1998). And as an adventure, it held many surprises and challenges, both expanding and narrowing my focus to encompass learning about researching, exploring a new-to-me theory of nursing, and re-creating my practice.

Engaging in this amazing adventure, I am curious now about how things can seem so simple, yet at the same time so complex. It's a paradox, I guess. I think of Frankl (1984) who after recounting a story wrote: "It's a simple story. There is little to tell and it may sound as if I invented it; but to me it seems like a poem" (p. 90). Perhaps the poetic aspect of any story rests in how the richness and complexity of human experience can be artfully conveyed in understated ways. Yet, within the apparent simplicity of a story, a poem, a phrase, or even a single word, I have been taught to pause and consider further.

Exploring the theory of human becoming, I have learned that even when things are viewed as simple and, by association *evident*, a close look from a new perspective may reveal surprising complexities and new understandings. Thus, I wonder, what will I see if I look at the data of my study in a year or two? I already know from discussions with my committee members that different assumptions about "reality" bring different understandings of and emphases to the data. In other words, one lens may bring into focus some things but not others, while a different lens shifts a person's focus, shedding light on things not previously held within one's gaze. For example, framing a study within a human becoming perspective addresses questions related to meaning, rhythmicity, and cotranscendence within human experience, but does not attend to notions of social justice, balance of power, etc. that would be underpinned by a different ontological stance. So, there are many ways to view and understand human experience.

I consider an experience at a thesis defense in which the student was defending a thesis based on research framed within Parse's theory of human becoming (Parse, 1981, 1992, 1998). Referring to the notes I took as a spectator, I recall that one of the examiners puzzled over why what Parse wrote and espoused was significant and why the language of the theory was so difficult. The implication was that there were less difficult, more familiar ways of saying what Parse wanted to convey. The examiner then moved on to consider the notion of *paradox*, referring to this quality of human experience as a matter of common sense and understanding. The implication here was that it was unnecessary to emphasize the paradoxical aspect of human experience. Yet in the next sentence, the examiner equated *ambiguity* with *paradox*. This word substitution was very interesting to me because the meaning of paradox and ambiguity can be understood as quite different from one another. (Indeed, I think there are profound implications in nursing practice related to whether human experience is viewed as paradoxical or ambiguous.) In that moment, I understood that by attending to apparently simple or evident aspects of whatever I was studying, hearing, and writing about in my chosen perspective, I might see some surprising complexities—and glimpse new possibilities and challenges—related to nursing practice.

So now, I get to thinking about the findings specific to this study. They, too, can be seen as sort of...simple-complex. Consider, for example, all those transcript- and tape-hours of spoken words and pauses, as well as numerous pages of something called analysis-synthesis, expressed in three small, perhaps deceptively simple, themes. It seems important to note that there is much more to the participants' experiences than three themes. So, too, there is more to be gleaned in seeking to disseminate and articulate implications of study findings for practice and future research. For the purposes of completing this thesis, it is for me and other readers to see what possibilities, challenges, and new understandings surface in the complexities of the findings of this particular study.

### *Considering Possibilities and Challenges*

Contrasting empirical and non-empirical scientific traditions, Northrup (2005) clarifies that non-empirical study findings, such as those of this study, do not aim to promote certainty, prescribe actions, or predict events. As a non-empirical process, sciencing rests on “ a belief in multiple truths and realities with an emphasis on experiences, values, and relationships, context, and meaning” (White, 1938, p. 34). In this way, research data and findings are unique to each study. Burns (1989) describes findings as context-specific, meaning that they are not considered transferable to other populations or circumstances. Thus, in the words of Smith (1989), “If research findings cannot be generalized, then what does one do with them?” (p. 3). She suggests that readers must first seek to understand findings, considering if and how study propositions “make sense” (Smith, p. 3) or correspond with others' experiences of the phenomenon. Study findings contribute to further exploration and understanding of the theoretical framework, offer new possibilities for nursing practice and policy, and suggest additional foci and questions for research.

Findings from this study address the question: What is the meaning of the experience of bearing witness for nurses in practice with persons living their dying? Addressing study objective one, the participants' description of the meaning of bearing witness was *enduring commitment surfaces gifts and burdens*. In the language of the researcher, this theme was interpreted as *tenacious devotion engenders exquisite encumbrances*. Related to study objective two, the participants' descriptions of

rhythmical patterns of relating was *telling-not telling mingles with closeness-reserve*. In the language of the researcher, this theme was interpreted as *guarded intimacy*. Focusing on study objective three, the participants' description of cotranscending was *fostering continuing competent practice*. In the language of the researcher, this theme was interpreted as *honoring cherished confidence*. Overall, these findings enhance understanding of the phenomenon of bearing witness. Findings discussed in light of the theory of human becoming (Parse, 1981, 1992, 1998), contribute to the expansion of that theory, which guides nurses in everyday practice. According to personal perspective, each reader decides for him or herself how findings and theoretical interpretations "make sense" or resonate. In addition, I offer for your consideration new understandings, challenges, and possibilities surfacing for me and related to nursing practice, education, policy, and research.

#### *Nursing Practice and Education*

Integrated and interpreted within a nursing theoretical perspective, research study findings hold implications for nursing practice (Burns, 1989; Cody, 1992; Jonas, 1992; Smith, 1989). Jonas points out that new descriptions of human experiences enhance the "opportunity for creativity in practice" (p. 175). Significantly, consideration of research findings can challenge nurses to examine personal values and guiding theories, possibly revealing and fostering new approaches and purposes in practice. For example, Smith remarks that upon reading a research study, a nurse may be moved to listen to and be present with persons in new ways.

Overall, participants in this study offered strong statements illustrating how bearing witness was an integral, valued aspect of their practice. Study participants told how they as well as others benefited through experiences of bearing witness. Specifically, participants valued opportunities to honor others and work intimately with them. They spoke of gaining new personal and professional insights within experiences of bearing witness. They shared challenges and possibilities related to organizational structures. Through experiences of bearing witness, participants believed that their practice with others was enhanced. Bearing witness with persons who experienced both immense

difficulty and great joy, participants themselves were subtly or explicitly challenged by those they served, thus encountering opportunities to examine their practice and process with others.

Referring to challenges, I draw particular attention to the voices of the persons that are revealed as nurse participants explore and describe their experiences of bearing witness. Most insistently, I still hear the voice of a woman asking Jen, “Why do you need to do these things? Are you just doing them so that you can write them down?” As Jen shares these questions and her learning, we are all invited to find ways of focusing our process with others so that it is centered with the person, rather than in tasks, agendas, or elsewhere. In another story, someone said to Anne, “If you know I’m dying, tell me so I can have a submarine sandwich”. This I contrast with a situation in which Maria struggles with living her own belief in the necessity to warn of an apparently imminent death as a woman asks to be “left in her denial”. Attending to the different preferences of these persons, I hear a challenge for caregivers to learn about and honor what is uniquely important to each person.

Once again, I consider Jo’s story, told in chapter 4 of this thesis, revisiting it this time with a curiosity about what it might highlight with respect to nursing practice.

A young man...was dying.....but his family wanted...us to pull him back from the brink....so that...he could have a longer time, so that he could get it right, so he would die right...How do you answer that?...One of the things we did...was we...sat with the family and the patient, and just sat there....[I noticed that] the patient was sometimes present and sometimes not, and so I said to the family..., “You notice now how a little while ago he was focusing and trying to focus and be here with us, and now he’s gone somewhere. I don’t know where he’s gone, but he’s gone somewhere.” And I said, “I think that that going somewhere is him getting ready to go....He is spending some time looking at where he’s going and trying to decide if he wants to stay here or if he wants to go.” And the patient looked at me and said, “You’re lying to my family. Stop lying to them.” And I said, “OK,...I’m *really* sorry...I didn’t mean to lie to your family, but I can’t get rid of this feeling that you actually are...going over to the other side and looking and getting ready.” And he said, “No, I’m not. I’m going to visit...Baba and we’re having a visit and I’m spending time with her.’...The family [was amazed] because [Baba had] died, you know. And so for them, when it was all done, when we went through that process and everything, they said, ... “He’s ready, we’re not”....and that gave them a great deal of comfort, a lot of comfort.

I draw attention to another story as told by Leah:

I was with this lady one day and she'd been a bit restless....The family were there and this woman woke up; and she sat at the edge of her bed so I sat down and she fell asleep with her head on my...breast here.....She said, "Uhm", and she fell asleep, and the family said to me, "Do you think she hears us? Do you think she can hear any of this?" And I said, "You know, I think it's like when you have a deep sleep in the late afternoon and you can just hear things on the periphery, but you just don't have the energy to respond. Everything's OK, you can hear it at a distance, and it's OK, but it's just too much to open your eyes and spit out an English answer. So you know, people ask you things and you kind of think it's already answered in your head.... You just don't have the ability to respond, but you hear it." And the...[woman] opens her eyes and she sits up and she says, "That's perfectly correct!"

My intention in placing these stories one after the other is to consider how difficult—and from some perspectives, impossible—it is to know about another's experience, yet how accustomed we are to offering information rather than asking about another's experience. Even as the young man's family are comforted by new meanings gleaned through this experience, there are subtle differences between the experience of the young man and Jo's interpretation of that experience. While different interpretations seem inevitable in that, from a human becoming perspective, one can never fully understand the experience of another, the young man tells us that such distinctions are important to him. In the next example, even as Leah's description resonates for the woman and her family, I wonder how the woman and her family might describe their experiences? Recalling similar situations in my own practice, I am more aware now of opportunities for me to ask about another's experience and bear witness with another person, rather than to quickly offer information or my own interpretation. I believe this is possible even if a person seems unable to respond promptly or in conventional ways. For example, I think about possibilities for bearing witness with persons who are living with delirium or dementia or who are in a coma. This involves a new way of being with others; my practice is changing. Considering findings of this study, other nurses also may hear challenges and possibilities for attending in new ways to the unique preferences, meanings, and messages of persons met in everyday practice.

All of the stories and challenges shared by participants in this study are rich with mystery and possibility, and hold tremendous potential for learning. As a professional, a member of the discipline of nursing, and a relatively new nurse educator, my challenges in practice lead me to recall old questions and raise new ones, just as participants in this study so generously offer theirs through exploring and describing experiences of bearing witness. Revisiting some of my questions in chapter 1, I continue to ask: How in practice can we honor our own values and live with respect for what others tell us is important to them? What might persons have to tell us if we choose to listen in new ways? How do assumptions and judgments influence what persons chose to tell and not of their experiences? What other pointed questions, heartfelt desires, and personal experiences might come to light if we, as nurses, are open to hearing and attending to them? As Sophia emphasized, "It's within each one of us to...hold tight to what's important to us" in practice. Attending to this message, I propose that each nurse ask himself or herself: What is important to me and to those I serve? How do I hold tight to what is important and how do I live my practice in that way?

Echoing findings of other studies (Eifried, 2003; Pellico, 1998; Riley-Giomariso, 1998), participants of this study hoped for and envisioned additional and ongoing learning related to bearing witness, and recognition of the importance such experiences hold in practice. Hence, Anne eloquently suggests, "bringing [bearing witness] to the fore so it's recognized, nurtured, and developed". In my experience, a focus on bearing witness in being present with persons is still thought of as an "extra" or unusual approach in practice, especially in the busyness of current day conditions. Similarly, some of Maria's colleagues thought that her willingness to bear witness with others was "an extraordinary thing to do". Thus, it seems important to create opportunities to invite discussion and exploration of experiences of bearing witness in both learning and practice environments. It is important to examine organizational structures to see how they support and hinder nurses and others in practicing in ways that are congruent with their values.

As noted earlier in this thesis, educating and supporting nurses in being present with persons is sometimes seen as particularly problematic. Yet, students, educators, and practitioners may choose to consider how nursing practice might be lived if bearing witness in being present with persons was seen to be as important as conducting assessments and administering medications. This possibility surfaces the question of how such change might be viewed in light of discussions about evidence-based and competency-based practice. Specifically, how might a change of focus influence or be interpreted within existing curricula, codes, and competencies for generalist and hospice palliative care nursing practice? How might professional and institutional organizational structures support such changes in practice?

I am learning that the challenges and possibilities in such questions are uniquely addressed within the framework of the theory of human becoming. Viewing the human-health-universe process as indivisible, unpredictable, and everchanging (Parse, 2004), has significant implications for nurses and nursing practice. As one of many nursing theories that nurses may choose to guide practice, the theory of human becoming offers a specific practice methodology of illuminating meaning, synchronizing rhythms, and mobilizing transcendence (Parse, 1992). (Specifics of this practice methodology are outlined in chapter 1 of this thesis.) Parse (1990, 1992, 1994) and many others working within the human becoming perspective also provide detailed, innovative discussions focusing on true presence. With the goal of quality of life as described by the person, the practice methodology provides guidance for nurses who choose a practice that focuses on being present and bearing witness with another, rather than seeking to alter or predict how a person will act or what he or she may believe, choose, or experience. As I understand it, from a human becoming perspective, bearing witness in being present with persons is not an applied technique or skill, but a way of living practice guided by the principles of human becoming. As such, I suggest that the human becoming school of thought (Parse, 1998) offers guidance and a focus for study to nurses who believe it is important to bear witness in being present with persons.

Participants in this study referred to experiences of bearing witness in joy, celebration, and suffering. As Leah poignantly remarked that in her experiences of bearing witness, she “never cried so much, but...never laughed so much, either”. If alerted to experiences of bearing witness in their practice, other nurses in various circumstances and situations may work with an enhanced appreciation for and attention to opportunities for bearing witness. This echoes other authors’ (Cody, 2001b; Drought, 2002; Pilkington & Jonas-Simpson, 1996) contributions related to bearing witness in nursing practice who remark on the importance of bearing witness with others and of bearing witness to “the joys and sorrows of the person’s life” (Pilkington & Jonas-Simpson, 1996, p. 37). Thus, this study highlights possibilities in practice for bearing witness not only in experiences of suffering, but in richly textured and paradoxical human experiences. In addition, attending to Leah and other participants’ experiences suggests that there is great potential for attending to experiences of bearing witness not only in hospice palliative care nursing practice, but in other personal and professional settings.

Considering the richness, diversity, and intensity of experiences related to bearing witness, several participants raised points about supporting nurses in practice. For example, Maria wondered at the “long term effects” of such experiences. Leah emphasized the importance of taking time during and outside of shifts for reminiscing, sharing, and learning. Importantly, the desire for sharing included bearing witness to experiences of suffering and joy in living and dying. Participating in research interviews for this study provided welcome opportunities to explore and describe experiences of bearing witness. It seems vital to continue to explore such experiences by evolving other strategies and venues for nurses and students in daily practice and teaching-learning settings. As specified in chapter 4 of this thesis, participants put forward alternatives to be explored, including sabbaticals and learning circles.

Several participants indicated that experiences of bearing witness were linked with staff satisfaction and retention. They took opportunities within interviews to discuss working conditions and staff relations that they valued or otherwise hoped would change. Sharing what they learned over time, participants spoke of the challenges of busy

schedules and environments, risks taken in sharing difficult experiences or uncommon ways of practicing, and fatigue accumulated through years of work. Study participants spoke not only of creating different strategies for support and learning, but also of evolving different ways of working together that respect personal choices and approaches in practice. Here again, the question of how the structures of agencies—including work sites, educational institutions, and professional organizations—can support such practices is raised. Although mentioned only briefly here, these points merit serious consideration, particularly in light of existing and projected staffing shortages.

### *Influencing Policy*

Oh no. Our people would be quite shocked  
by having to declare that one policy was completely  
right and another completely wrong. (Hilton, 1944, p. 134)

Research findings influence policy development by contributing views of policy that highlight how it is congruent and incongruent with personal and communal health care preferences as well as with the values and practices of health care providers. To illustrate, I refer back to an excerpt from the CNA's fact sheet on palliative care, which was quoted in chapter 1.

Palliative care is about life—the value, the meaning, and the enhancement of the quality of life. Palliative care teams provide pain and symptom management and recognize that patients and cultures bring individual views of suffering to the dying process. They are trained to deal with the dying process and offer support to clients. (CNA, 2000, n.p.)

Granted, this is only one paragraph of a somewhat obscure example of what could be called policy. However, the focus of the statement is highly relevant to today's health care system and the discipline of nursing. In addition, the document is available to the public and originates from a national nursing organization.

In light of discussions and findings of this study, I now have a clearer understanding of how this quote is congruent and incongruent with my changing world view, and what that means for my practice. From my new perspective, I note that an assumption of the uniqueness of persons' experiences is represented and an appreciation for personal meaning and quality of life is conveyed within the above paragraph. The

document also offers some recognition of human beings as living-dying. These points hint at some congruence with non-empirical perspectives. What now seems incongruent to me is the notion that, as members of teams, nurses *manage* and *deal with the dying process*.

JOURNAL ENTRY: Regarding Marge's class on policy: One assignment involves looking at policies through a particular "lens" so that we can see from the perspective of that lens how the policy is taken up and enacted. I see lenses as sort of enabling-limiting (Parse, 1981): focusing vision so that we see some things and not others. I think, I want...yes, I want to have *rose-colored lenses*. It's not so much that I want to see everything as rosy and delightful (ok, sometimes I do), but that I want to see power as something other than a thing to be had and wielded or not. I don't want to assume that certain people are powerless and vulnerable and therefore need protection, or need someone else to make and take responsibility for their health decisions. I want to refer to policies (including, I think, our everyday medical protocols) that don't make people and their experiences into problems that require a sort of...taming or management. I'm not certain (any more) that it's *possible* to manage symptoms (although I know it is important to make assessments of symptoms and offer options for relief), much less people. As a person, I prefer to live, rather than cope with human experiences. As a nurse, I prefer to somehow work with respect for, rather than deal with people.

Exploring the human becoming perspective, I am learning to focus on quality of life as the person describes it. As a nurse, I am learning to be guided by a practice methodology that does not seek to manage or deal with persons or their experiences. I agree that, in some ways and perhaps most commonly, many of us are "trained to deal with the dying process and offer support to clients" (CNA, 2000, n.p.). Yet, as voiced by participants in this study, some nurses want opportunities to enhance their competence and confidence (which is different from being trained) in ways to serve others, guided by theories that involve something other than dealing with experiences or managing persons who are living with dying.

One of the challenges in envisioning, evolving, and articulating new goals or intentions for practice rests in the way more familiar approaches and activities associated with nursing practice are so broadly recognized, valued, and established in and through existing policy. I suggest that a lack of policy introducing and supporting non-empirical approaches and perspectives in practice, and an accompanying lack of scholarly dialogue,

contributes to a belief that there are no other viable ways or intentions in nursing practice with persons, families, and groups. Policy that does not articulate and foster a range of alternatives for practice influences the evolution of nursing practice and the understanding of what that encompasses in very specific ways. Further, an absence of openness presents many challenges for practitioners who value and wish to explore, learn, and live new or different intentions in practice. In the process of conducting this study, I have come to believe that my practice, and perhaps that of others, could be enhanced and might evolve differently if non-interventionist models of practice were to become more visible in the descriptions, expectations, and directives of professional organizations and employees.

One possibility for fostering greater awareness of and confidence in practice encompassing experiences of bearing witness is for policy makers and analysts to create and view policies in light of a variety of nursing philosophical stances and theoretical frameworks. As noted above, when viewed through the lens of a non-empirical perspective and in light of new understandings of bearing witness, policy referring to nurse-person processes and nursing actions challenges understandings of nurses as problem solvers and health managers. I wonder what other possibilities, new understandings, and challenges might be revealed in examining policies and protocols through the lens of human becoming. What might be revealed, for example, in policies outlining job and agency descriptions, as well as nursing curricula, competencies, certifications, and in documents related to scope of practice?

Additional challenges and possibilities related to policy creation and analysis arise when considering the findings specific to this study. For example, participants in this study conveyed *an enduring commitment* to honoring others and envisioned greater recognition for the experience of bearing witness as an aspect of nursing practice. Should or how could this be represented in relevant policies? What does it mean for nurses if they can't live their commitment in the ways they envision? Consideration of the study theme *telling-not telling mingles with closeness-reserve* may prompt an examination of prevalent understandings of professional and personal boundaries as described in policies related to nurse-person interrelationships. Further, nurses might give some consideration

to how and what information they document in the course of daily work. In light of the study theme *fostering continuing competent practice*, managers and educators may be encouraged to review how nurses, students, and others are or are not fostered in education, and supported and honored in practice through existing policies.

#### *Future Research*

Parse (2001c) specifies that through exploring, explicating, and interpreting research findings, suggestions are made for further research related to the focus and process of inquiry for this study. Given the relevance of bearing witness in health care services and the lack of formal study related to this topic, there exist many possibilities for additional research. Interviews conducted for this study could be incorporated with data from future studies, further shedding light on the meaning of experiences of bearing witness. Further research could be conducted with other participants including those of other disciplines and professions, persons in a variety of circumstances, and nurses in different specialty areas of practice. The experience of bearing witness is a topic of significant interest for nursing students and nurse educators, and understandings of this experience could be expanded through research with these populations. Nursing knowledge could be further enhanced through research conducted within various nursing theoretical frameworks. Future studies might explore and discuss further the ethical implications of bearing witness-not bearing witness. In addition, understandings of bearing witness could be enhanced by future studies incorporating in-depth reviews and discussions of philosophical literature related to bearing witness.

Additional possibilities for further research relate to the themes surfaced within this study. Study theme one, *enduring commitment surfaces gifts and burdens*, suggests possibilities for research foci related to the meaning of feeling committed for nurses, the experience of feeling gifted and/or burdened, bearing witness to suffering, and bearing witness to enjoyment/joy/celebration. Study theme two, *telling-not telling mingles with closeness-reserve*, suggests possibilities for research related to feeling close with and apart from others, and experiences of intimacy. For example, a study might focus on the meaning of intimacy for professionals and the people they serve. Another topic of study

might explore the meaning of choosing to tell-not tell. Study theme three is *fostering continuing competent practice*. This theme suggests directions for further research related to the meaning of feeling competent, supported, or confident for professionals or others in various of settings.

During the course of conducting this research, I found it helpful to share ideas and experiences with other students and researchers. Fellow students also found support in discussing challenges related to processes of research including interviewing and data analyzing-synthesizing. Thus, I chose to include in this thesis many personal questions and reflections. One possibility and challenge for beginning or experienced researchers is to continue to offer accounts of their experiences related to the processes and dimensions of research, thereby contributing to discussions related to conducting research.

#### *More Reflections*

FINAL JOURNAL ENTRY: We were talking about deadlines and defenses. Referring to master's theses, someone declared, "They're never done, they're only due." Well, it happens that this thesis is 'due' [. (Er, I leave it up to my committee to decide if it is finished, or perhaps, *enough*?!) Somehow, though, this process of writing a thesis will never be done.

Hutchings (2003) describes how the voices of participants remain as a lingering presence (Parse, 1994) for her upon completing her thesis. I, too, find that something of the experience of being with the participants in this study has...settled in. This experience—along with the experiences of being with Kate and her family (see chapter 1) and many others over the years—nurtures my curiosity about experiences of bearing witness, affirms my interest in the processes of research, and refreshes my commitment to the work that I do and my love for the people that I serve. For me, much of the value in this project is in engaging in the process of research itself. There is value, too, in choosing something to closely examine: in choosing a lens through which to view, explore, and describe something of human experience and of nursing practice. Somehow, all of these aspects of this project endure.

Remaining with me also are the many questions and messages revealed as participants explored and described their experiences of bearing witness, living their personal values and priorities in hospice palliative care nursing practice. I was struck by the paradoxes surfaced in the data. I was struck by how, in one participant's words, telling and listening to stories in interviews surfaced "many tender moments". Anne, Leah, Maria, Jo, Jen, Margot, and Sophia shared many,

many precious memories as a way of surfacing and illustrating their experiences. Their stories are vivid, evocative, and strikingly detailed, possibly serving many purposes: describing their experiences; honoring people; recreating memories; posing questions; and bringing new insights. Personal experiences and stories were conveyed as deeply meaningful to participants, and the learning and questions identified throughout were freely and generously offered. Interestingly, several participants stated that for them the interviews included a process of bearing witness. All participants said that they found value and enjoyment in taking part in interviews. For me, it was a new endeavor to be present with persons during research interviews and serve in some way to facilitate explorations and descriptions of their experiences. I deeply appreciate the wondrous variety and rich paradox of experiences shared by participants, and note how each participant conveyed an abiding commitment to her patients, colleagues, and practice, as well as to this study.

Thus, the opportunity to be with each participant, hear of her experiences, and share questions related to bearing witness remains my privilege. Further, no matter what this thesis says or doesn't say, it seems important to continue to ponder how participants' and persons' messages and study findings bring to light existing and new visions for nursing practice.

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Appendix A:  
Nine Philosophical Assumptions of the Human Becoming Theory

1. The human is coexisting while coconstituting rhythmical patterns with the universe.
2. The human is an open being, freely choosing meaning in situation, bearing responsibility for decisions.
3. The human is a living unity continuously coconstituting patterns of relating.
4. The human is transcending multidimensionally with the possibles.
5. Becoming is an open process, experienced by the human.
6. Becoming is a rhythmically coconstituting human-universe process.
7. Becoming is the human's pattern of relating value priorities.
8. Becoming is an intersubjective process of transcending with the possibles.
9. Becoming is human evolving.

From: Parse, R. R. (1992). Human becoming: Parse's theory of nursing. *Nursing Science Quarterly*, 5(1), 35-42, p. 38.

Appendix B :  
 Criteria for Appraisal of Qualitative Research:  
 Conceptual, Ethical, Methodological, and Interpretive Dimensions

Conceptual

- how does the phenomenon under study relate to the phenomenon of concern to the discipline?
- how does the discipline-specific knowledge underpin the frame of reference?
- how does the research question flow from the frame of reference?

Ethical

- how does the plan of study meet standards of scientific merit?
- how does the study contribute to the unique discipline-specific knowledge?
- how are participants' rights protected?
- how does the researcher treat the data in light of accuracy and authenticity?
- are the credentials and experience of the researcher adequate for the conduction of the study?

Methodological

- is the method identified correctly?
- are participants, the text, or the art forms appropriate for the method?
- is the participant selection process appropriate for the method?
- is the data-gathering process appropriate for the method?
- is the data analysis-synthesis process appropriate for the method?
- how does the researcher show conceptual shifts in levels of abstraction?
- how do the abstract statements evolve from the participants' descriptions, the text, or the artforms?
- is the path of inquiry easily identifiable?
- is the path of inquiry logical from question to findings?

Interpretive

- how do the interpretive statements correspond to the findings?
- to what extent are the findings interpreted in light of the conceptualization of the study?
- how do heuristic implications reflect an accurate interpretation of the findings?
- how are the interpretations woven with theory, research, and when appropriate, practice?

From: Parse, R. R. (2001e). *Qualitative inquiry: The path of sciencing*. Sudbury, MA: Jones and Bartlett Publishers, p. 245.

## Appendix C: Invitation to Participate

**Subject:**  
**The Experience of Bearing Witness**

**Attention:**  
**Registered Nurses Working Within Vancouver Island Health Authority and Victoria Hospice Society**

Dear Colleagues in Nursing,

This is a letter inviting registered nurses interested in sharing experiences of **bearing witness** with persons living their dying to consider participating in a research project. I am conducting a study entitled *Bearing Witness for Nurses in Practice With Persons Living Their Dying*: a project contributing towards partial fulfillment of requirements for a degree of master in nursing in policy and practice.

Experiences of bearing witness can be associated with the intangible, but valuable contributions of nurses in being present with persons living their dying. Still, there are many questions associated with this experience. For example, what is the meaning of bearing witness for others? How do experiences of bearing witness influence human inter/relationship and nursing practice? Considering such questions, it is possible that insights into experiences of bearing witness may assist nurses to articulate aspects of practice that cannot be measured, and to find new ways of being with persons living their dying.

If you are a registered nurse interested in sharing experiences of bearing witness with persons living their dying, or if you would like more information about this study, please contact me, Coby Tschanz, at:

Phone: (250) 474-7901  
Email: [cobyt@telus.net](mailto:cobyt@telus.net)

Thank you for considering this invitation.

Appendix D:  
Informed Consent

You are being invited to participate in a study entitled *Bearing Witness for Nurses in Practice with Persons Living Their Dying*. This study is being conducted by Coby Tschanz, a graduate student at the University of Victoria, Faculty of Human and Social Development, School of Nursing. She may be contacted at (250) 474-7901 or [cobyt@telus.net](mailto:cobyt@telus.net).

If, after reviewing this document, you have further questions about this consent or study, you may contact any member of the student's supervisory committee as follows:

Dr. Deborah Northrup, supervisor, at (250) 47204609 or [dnorthru@uvic.ca](mailto:dnorthru@uvic.ca)  
Dr. Mary Ellen Purkis, committee member, at (250) 721-7953 or [mepurkis@uvic.ca](mailto:mepurkis@uvic.ca)  
Dr. Pamela Moss, committee member, at (250) 721-6297 or [pamelam@uvic.ca](mailto:pamelam@uvic.ca)

In addition, you may confirm ethics approval of this study by contacting the Associate Vice President, Research of the University of Victoria (250) 472-4362.

While the term bearing witness is used frequently by many health care workers, there are many questions associated with experiences of bearing witness. Objectives of this study are to: 1) explore and describe the meaning of bearing witness for nurses in practice with persons living their dying, 2) explore and describe patterns of relating for nurses in practice with persons living their dying, and 3) explore and describe personal hopes, concerns, and possibilities in relation to bearing witness for nurses in practice with persons living their dying.

It is anticipated that new information about the experience of bearing witness will contribute to the development of nursing practice and policy. In a time when it is important to define and articulate the science and scope of nursing practice, it is necessary to enhance descriptions of the many intangible, but immensely valuable contributions of nurses in practice. This includes bearing witness in being present with persons. Further, nurses relate many challenges in practice with persons living their dying, questioning where and how to glean support and guidance in being present with persons. Framed within the human becoming theory of nursing, this study will contribute to nursing science and descriptions of the experience of bearing witness. Thus, findings may contribute new insights for nursing practice and policy.

In volunteering to participate in this study, you will be asked to engage in one or two interviews with the researcher about your experiences of bearing witness. Interviews will take place at a time and place convenient to you. The researcher will ask open-ended questions related to the study objectives listed above. Face-to-face interviews will be audio taped and last from thirty to ninety minutes. You may reduce or extend interview times as you wish, and you and the researcher may agree to hold a second interview to

clarify or offer further information. It is anticipated that you will be one of five to eight persons participating in individual interviews with the researcher.

Your anonymity and confidentiality will be protected. The researcher will not reveal the identity of any participant, and a pseudonym will be assigned in any descriptions of participants. Any identifying information will be removed for the purposes of scholarly presentation or publication of study findings. Your signed informed consent will be kept separate from data. Tapes of interviews will be transcribed and tracked via a numerical code. A single list of participants' names, contact information, and codes will be kept by the researcher and separate from the audiotapes, transcriptions, and consents. The list will be shredded and recycled once the study is complete. Audiotapes will be stored in a locked metal box and placed in a locked cabinet available only to the researcher and members of the supervisory committee. Audiotapes will be erased once data analysis is complete. Printed copies of the data transcribed from the audiotapes will be made available for the researcher and committee supervisor for use during data analysis. These will be stored in locked cabinets. Transcriptions will be kept for a period of five years, permitting potential further study of the phenomenon by the researcher and inclusion of data in research studies with other persons. At the end of the five-year period, informed consents and printed copies of transcriptions will be shredded and recycled.

Potential benefits of engagement in this study are similar to those that might be experienced in sharing everyday experiences of nursing practice with persons living their dying. Specifically, the opportunity to explore and discuss your experiences of bearing witness may be meaningful and beneficial to you. In addition, data from interviews will be analyzed and presented within my written thesis. Findings may be shared with others via scholarly presentations or in scholarly journals. In this way, your participation contributes to the science and policy of the discipline of nursing, having the capacity to influence nursing care and persons' experiences of quality of living and dying.

Potential risks associated with participation in this study are similar to those that might be experienced in discussing everyday experiences of nursing practice with persons living their dying. For example, it is possible that you might experience fatigue or an emotional response associated with sharing your memories and experiences of bearing witness. Should you desire, you will be provided with the names and contact information of professional support services and resources. You may contact any member of my supervisory committee or myself to discuss any questions or concerns with respect to this project or the interview.

You are under no obligation to participate in this study. Your participation must be entirely voluntary. There is no monetary remuneration associated with participation in this study. You are free to disclose only the information that you choose, and may reschedule or discontinue the interview at any time without explanation or consequence. The decision to include or not include your descriptions in this study or possible future studies remains with you at all times.

Your signature below indicates that you understand the conditions of participation in this study and that you have had an opportunity to have any questions answered to your satisfaction by the researcher or a member of the supervisory committee.

\_\_\_\_\_  
Name of Participant (print)    Signature of Participant    Date

\_\_\_\_\_  
Name of Researcher (print)    Signature of Researcher    Date

**One copy of this consent will be left with you. The original consent will be retained by the researcher.**

Appendix E:  
Contract for Transcription of Interview Tapes

You have agreed to be a transcriptionist in the study entitled *bearing witness for nurses in practice with persons living their dying* that is being conducted by Coby Tschanz, a graduate student at the University of Victoria, Faculty of Human and Social Development, School of Nursing. She may be contacted at (250) 474-7901 or cobyt@telus.net . Further questions may be directed to the student's committee supervisor, Dr. Deborah Northrup at (250) 472-4609 or dnorthru@uvic.ca . You may confirm ethical approval of this study by contacting the Associate Vice-President, Research at the University of Victoria (250) 472-4362.

This contract for transcription of interview tapes constitutes an agreement between the Coby Tschanz, principle investigator, and \_\_\_\_\_, transcriptionist. In agreeing to this contract, the transcriptionist agrees:

- audiotapes will be transcribed verbatim, and in detail, according to formal instructions of the principle investigator.
- confidentiality and anonymity of participants will be maintained. No part of the interviews will be repeated. The identity of participants, if known, will not be revealed.
- audiotapes, disks, and hardcopies of data, when not being actively used, will be kept in a locked cabinet or box supplied by the principle investigator.
- once tapes and transcriptions are returned to the principle investigator, the transcriptionist will erase all computer files pertaining to this research.
- payment will be made upon completion of transcripts at a rate of \$20.00/hour of work. It is estimated that each one-hour tape will require three or four hours of transcription time:

Your signature below indicates that you understand the conditions of this contract and that you have had an opportunity to have any questions answered.

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Name of Transcriptionist (print), address, contact information

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Signature of Transcriptionist

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Date

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Name of principle investigator (print), address, contact information

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Signature of Principle Investigator

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Date

\_\_\_\_\_  
Name of Witness (print)

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**A copy of this contract will be left with you. The original contract will be retained by the researcher.**

Appendix F:  
Professional Support Services and Resources

Vancouver Island Health Authority, Employee and Family Assistance Program  
Phone: 1-800-663-9099