Humanizing Nursing Care: An Analysis of Caring Theories Through the Lens of Humanism

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Abstract

Humanism's tenets are rarely described in regard to the theories of our discipline. In this article, we outline the historical origins of the humanism movements along with its etymology in order to analyze the assumptions that were brought up by selected North American nursing scholars related to human caring. We then detail each perspective while linking their premises with the roots of humanism. While discussing humanistic caring theories in nursing, we clarify relational concepts such as mutuality, reciprocity, authenticity, and human potential. We finally conclude with a summary of the main tenets of humanism and its implications for nursing practice.

Keywords: humanism, humanizing care, caring, nursing theories, human potential, relationship

Introduction

As outlined in the Francis (2013) report, humanizing nursing care continues to be a clinical and educational challenge despite the number of initiatives and disciplinary knowledge pertaining to caring and compassionate care. Although there are few contradictory publications about humanism in nursing (Joseph, 1985; Mulholland, 1995; Playle, 1995; Traynor, 2009), the understanding of these philosophical movements and their early origins (in the 1300s) remains limited in our body of knowledge. Most of the publications found in the nursing literature implicitly refer to humanism by discussing the topics of humanization of care or humanizing or dehumanizing practices or describing a humanistic perspective of nursing (Clark, 2014; Rolfe, 2015; Rose et al., 2016; Scammell, 2014, 2015), rather than providing a better understanding of the relationship between humanism and nursing.

However, Fagermoen (2006) wrote an insightful chapter on humanism that focused on caring theories such as Watson's (1979). Fagermoen argued that, historically, humanism and caring have been foundational to our discipline since the impetus of Nightingale (1860). As a pioneer of nursing, Nightingale, as well as other renowned authors (Bishop & Scudder, 1985; Boykin & Schoenhofer, 1993; Leininger, 1984; Roach, 1984; Watson, 1988/1999, 1999), contributed to clarify the professional identity of the discipline of nursing by referring to the meaning of care and caring as its foundation. This clarification shaped nursing's professional identity through the expressive and affective dimensions of care as more importance was put on the relational and humanistic side of caring (Benner & Wrubel, 1989; Saillant, 2010). Rather than relying solely on relationships, humanism brought nurses to be preoccupied with the human being as a whole (holistic vision) and to renew a nursing practice that humanly accompanied their patients (Cara et al., 2016; Castell, 2008; Kleiman, 2005; Pepin, Kérouac, & Ducharme, 2010). Generally speaking, many theories of our discipline describe nursing as an art of caring that emphasizes a human flourishing aspect of care (Fagermoen, 2006). Even if there are several caring interpretations and different philosophical perspectives on this vital component of nursing practice, humanism remains one of the inspirations of contemporary caring theories. However, this is nuanced by Traynor's (2009) critique of humanism, for he concluded that ''some of the presentations of humanistic nursing lack rigour and can be seen as doing little more than reproducing professional ideology'' (p. 1560). In other words, Traynor asserted that this ''humanistic agenda'' in nursing was not critically scrutinized by scholars, but rather professionally promoted. Although this humanistic promotion appears to be true in nursing, the author's critique mostly addressed the instrumental use of humanism as a means to justify the relevance of qualitative research over quantitative traditions. Little attention was given to humanism's claims for nursing practice, other than stating that it was ''highly prized'' (Traynor, 2009). Perhaps one of the reasons why nursing scholars, educators, and policy makers reproduce this ''humanistic professionalizing project'' over time is because of the evidence of its worthiness for patients (Cantrell & Matula, 2009; Cox, 2012; Delmas, O'Reilly, Iglesias, Cara, & Burnier, 2016; Dewar & Nolan, 2013; Finch, 2006; Griffiths, Speed, Horne, & Keeley, 2012; Merrill, Hayes, Clukey, & Curtis, 2012; O'Reilly, Avoine, Cara, & Brousseau, 2010a, 2010b; O'Reilly, Cara, & Delmas, 2016; Papastavrou, Efstathiou, & Charalambous, 2011; Papastavrou et al., 2012; S. Smith, Dewar, Pullin, & Tocher, 2010; van der Cingel, 2011). These fairly recent studies strengthen the need to reinforce humanistic nursing care for patients and, as a result, it seems to be more than a mere ''professional ideology,'' as claimed by Traynor.

Notwithstanding this considerable amount of literature on caring, very few writers analyzed the philosophical influences of humanism on the development of caring theories. This analysis could lead to a better understanding of caring theorists' foundational ideas and could raise nurses' awareness about humanization of care. Therefore, the aim of this article is to describe a synthesis of the historical origins of humanism and to progressively analyze its postulates within the context of caring theories in nursing. First, we will elaborate on the etymological roots of humanism by defining the two principal movements, that is to say, the Renaissance and the Enlightenment, and their most influential philosophers identified as great inspiration for nursing theorists. We will then discuss how humanism appears within each selected caring theory in nursing inspired by the foregoing humanistic philosophers. Finally, we will conclude with a summary of the main tenets of humanism and its implications for nursing practice.

The Origins of Humanism: Renaissance and Enlightenment Movements

As Traynor (2009) and Davies (2008) explained, we agree that humanism is a broad concept that includes heterogeneous meanings in the literature. In fact, many British and American encyclopedias and dictionaries of philosophy, sociology, and history (Baldick, 2008; Blackburn, 2008; Craig, 1998; O'Leary, 2007; Vauchez, 2002; Wright, 2006) refer to humanism as a philosophy, an attitude, a political stance, a doctrine, a way of thinking, or an intellectual/ethical position. However, when humanism emerged itself in language back then, it was mostly considered a literary culture (Blackham, 1968).

To understand the etymology of humanism, we have to go back to the Italian Renaissance (∼1300–1600), in which the Latin term *studia humanitatis* appeared in the second half of the 1300s (Blackham, 1968; Craig, 1998; Mazzocco, 2006). This term designated a program of studies, grounded in the classical texts of Romans and Greeks, which centered on grammar, rhetoric, poetry, history, and moral philosophy, called today ''the humanities'' (Craig, 1998; Norman, 2004; Vauchez, 2002). Derived from *studia humanitatis* in the 1400s, there are the terms *umanista* (Latin) and *humanista* (Italian), both meaning the scholars who devoted themselves to the study of the previous subjects, also entitled the ''humanists'' (Blackham, 1968; Craig, 1998; Norman, 2004; Vauchez, 2002). On the one hand, the German term *humanismus*, probably derived from *humanista*, was used in the early 1800s to differentiate the humanities from the classical curriculum, which emphasized practical

education, mathematics, and sciences (Craig, 1998). On the other hand, the study of philosophy, as well as ancient Greek and Roman texts, is still currently represented by the term *literae humaniores* at the University of Oxford (the ''classics''), referring to the historical roots of the humanities (Speake & LaFlaur, 2002). What seems important to understand here is that all these terms do not necessarily refer to a philosophy per se, but rather to a cultural and educational program focusing on the study of ancient texts (Craig, 1998; Lalande, 2010).

Nonetheless, there is evidence that there has been a philosophical and intellectual movement walking through the Renaissance, generally called ''Renaissance humanism.'' As Wright (2006) pointed out, mankind from this historical period wanted to rediscover Latin, Greek, and Hebrew texts, rejecting medieval scholasticism. Because this medieval conception of Man was founded in asceticism (Baldick, 2008), humankind from these centuries appeared more focused on *preparing* themselves for the afterlife (i.e., immortality) than *living* their daily life on Earth. Instead of living blindly under God's wills, Man had to use the potential he was given in order to further an ideal of human existence, described in the ancient texts (Blackburn, 2008; Norman, 2004). Thus, Renaissance humanism assigned Man a more positive value, precisely about his dignity and infinite potential (Baldick, 2008; Mazzocco, 2006). Nonetheless, religion remained omnipresent in the Renaissance era and one of its prominent humanists, Desiderius Erasmus (1459–1536), used his erudition to combine elements of Christianity to Renaissance humanism, forming a variety of ''Christian humanism'' (Baldick, 2008; Blackburn, 2008; King, 2014). In summary, Renaissance humanism distanced Man and human dignity from theological determinations and believed humankind was born with moral freedom (Norman, 2004).

As Man untied himself from religious domination, Enlightenment humanism sought to understand human existence in an even more secular or atheistic worldview (Davies, 2008). As explained by Craig (1998), thinkers of the Enlightenment movement believed that the central concern of human existence was the shaping of human life and society according to reason instead of pseudoscientific superstition. This humanism endorsed dignity of all human beings, affirming they had the autonomy and the power to use their rational capacities without being restrained by religious dogmatism (Craig, 1998; Davies, 2008). Although many French and English philosophers of the Enlightenment, respectively Voltaire (1694–1778), Diderot (1713–1784), Rousseau (1712–1778), Hume (1724–1804), and Kant (1724–1804) articulated different points of view, they generally agreed on humans' freedom, responsibility, equality, tolerance, and potential, ''encouraging individual creativity and exalting the active over the contemplative life'' (Audi, 1999, p. 397).

As Lamont (1997) pointed out, the two above-mentioned movements have been affiliated with 20th-century humanists, but their humanism does not share the same philosophical assumptions regarding knowledge, existence, ethics, and politics. Therefore, post-Enlightenment humanism is actualized in various contemporary perspectives that do not converge into one congruent philosophy, some being more secular, others more religious (Craig, 1998; Scott & Marshall, 2009). Several authors (Craig, 1998; Davies, 2008; Lamont, 1997; Scott & Marshall, 2009) enumerated various kinds of humanism, for instance ''Marxist humanism'' from Marx (1961/2007), ''existentialist humanism'' from the French philosophers Levinas (1972/1987) and Sartre (1946/1996), ''antihumanism'' from the German philosopher Heidegger (1954/2008), and ''Hebrew humanism'' from Buber (1970/1996). Despite their insoluble ideas, most of these influent thinkers were cited in numerous publications in nursing, more specifically in phenomenological studies and papers inspired by an existential perspective. However, for this analysis, we will focus on Martin Buber's humanistic thoughts about dialogue because they inspired several scholars (Cara et al., 2015, 2016; Cara & Girard, 2013; Leininger, 1984; Paterson & Zderad, 1976; Roach, 1984; Watson, 2012) who clarified humanism in nursing.

Moreover, several papers (Chinn, 1991; Smith, Turkel, & Wolf, 2013; van Hooft, 2006; Warelow, 1996) have stated that Martin Buber (1970/1996) and Milton Mayeroff (1971/1990) have been two philosophers who supported the development of humanistic nursing theories. Another pioneer from the humanistic psychology movement, Carl R. Rogers (1961, 1995/2012a), significantly contributed to this development and gave rise to nursing theories centered on the therapeutic relationship. Because of their acknowledged legacy in nursing, we will summarize the ideas and key concepts of these three philosophers in the next section.

Humanistic Philosophies

Martin Buber: I–Thou Relationship

Martin Buber (1878–1965) was a humanistic, Hebraic, and Zionist philosopher well known in nursing for his work on dialogue, *I and Thou* (1970/1996). As Silberstein (1989) suggested, there is evidence of existentialism in Buber's dialogue because he described two different attitudes toward human existence (''I–It'' and ''I–Thou'') and he proposed a relationship with God, the ''Eternal Thou.'' To be more precise, Buber (1970/1996) argued that we could enter in relation to people and objects of this world by two types of attitude: (a) a subjective, person-to-person (or subject-to-subject) relationship called the I–Thou, and (b) an objective person-to-object relationship, called the I–It (Blackburn, 2008). While ''I'' stand alongside Thou, one ''sees'' the other as a whole (rather than as a ''sum of things'') and the relationship is characterized by reciprocity and mutuality, which is not present in the detached, objectified, and fragmented I–It relationship (Buber, 1970/1996). Although objectification and instrumentalization were useful to humans in apprehending the world, this philosopher thought that humankind could hardly live without the encounter of the Thou because it would shallow the depth of human existence. For that genuine ''encounter'' to happen, the person needs to engage in immediacy, through openness, to the Thou as an active participant. It is also this encounter that leads to the I–Thou relationship, wherein occurs what Buber called a transformative moment of reciprocity for the two persons: I transforms Thou, and conversely. However, the philosopher emphasized that a person could not encounter the Thou intentionally, as ''the [Thou] encounters [the I] by grace—it cannot be found by seeking'' (Buber, 1970/1996, p. 62); putting this another way, the encounter rather springs from the relationship itself. Though this encounter does not last eternally, Buber believed that both persons (I and Thou) grew mutually by their reciprocal commitment within the relationship. To sum up Buber's humanism in simple words, we need, as a human being, a degree of openness and authenticity in order to be able to encounter others in a truthful way. When we get to the point that we have established this particular relationship, it is presumed that we will mutually grow as persons because of our shared reciprocity.

Carl R. Rogers: Person-Centered Approach

In 1957, Carl R. Rogers (1902–1987) met Buber at a conference and, as they engaged in an intellectual discussion, both discovered they shared a similar approach to human relationships (Anderson & Cissna, 1997). It is thus no surprise that Rogers (1961) has drawn on Buber's philosophy and made numerous parallels in his writings. In fact, the belief of ''growing as a person'' (explained in the previous section) was fundamental to Rogers, who worked, along with other humanistic psychologists (Jourard, 1971; Maslow, 1970; Murphy, 1958), to humanize psychotherapy in a time where it was practiced within behaviorism and psychoanalysis (Frick, 1989). He summarized one of his principles in this unique sentence: ''If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth, and change and personal development will occur'' (Rogers, 1995/2012a, p. 33). His profound positive regard toward the

potential of human beings is closely related to Renaissance and Enlightenment humanism: he alleged that ''the individual [had] within himself the capacity and the tendency, latent if not evident, to move forward toward maturity'' (Rogers, 1995/2012a, p. 35), what he also named ''self-determination.'' His approach to psychotherapy, which he preferred to name ''counseling,'' is centered on the person and requires four core conditions: authenticity, acceptation, empathy, and space of freedom (Rogers, 1961, 1995/2012a, 1995/2012b; Rogers & Stevens, 1967). First, Rogers (1961) argued that a therapist needed to be authentic and congruent with himself or herself to help people look at their own reality as they really perceive it. It may sound obvious, but a person will be more likely to trust a therapist if there is a congruence between what the therapist thinks, feels, and does. This condition is perhaps a continuity of Buber's (1970/1996) thoughts on dialogue between I and Thou. Second, Rogers and Stevens (1967) believed that the person needed to feel considered as a ''person,'' meaning that the therapist is encouraged to accept the individual unconditionally, whatever the person's behaviors, feelings or conditions are. Third, there must be a genuine commitment in wanting to understand the person, through a deep and sensitive empathy. In other words, Rogers and Stevens stated that the understanding of the person's deleterious feelings and thoughts was capital for the relationship to be therapeutic. Finally, the therapist must be able to create a space of freedom in which the person will be more likely to reflect on his or her feelings and thoughts, consciously or unconsciously. Rogers and Stevens explained that when these four conditions are met, the therapist plays the role of a companion for the person, accompanying the person through a relationship that invariably leads to positive changes and growth.

Milton Mayeroff: Ingredients of Caring

Similarly, the American philosopher Milton Mayeroff (1902–1987), influenced by the works of Buber (1970/1996) and Rogers (1961), also inspired many caring scholars in nursing. His greatest work, *On Caring* (1971/1990), proposed eight ingredients essential to caring, described as follows: knowing, alternating rhythm, patience, honesty, trust, humility, hope, and courage. Similarly to Rogers, Mayeroff believed caring was intended ''to help [a person] grow and actualize himself'' (Mayeroff, 1971/1990, p. 1), and that growth required commitment and intentionality from the carer. Put differently, one's desire of caring for somebody must be sincere in order to commit and devote oneself to the welfare of others. The philosopher was convinced that this devotion not only reinforced the therapeutic relationship by showing the person's commitment, but was imperative to caring: ''when devotion breaks down, caring breaks down'' (Mayeroff, 1971/1990, p. 10). However, there should be congruence between what the carer *thinks the carer should do* and what the carer actually *wants to do*, distinguishing a caring devotion from a noncaring obligation. Also, as Chinn (1991) pointed out, it is assumed that the relationship between the one caring and the one cared for might be reciprocal. Mayeroff's concept of ''reciprocity'' is related to caring as opposed to Buber's, which is more metaphysical and related to the relationship: ''my caring for the other helps activate his caring for me; and similarly his caring for me helps activate my caring for him, it 'strengthens' me to care for him'' (Mayeroff, 1971/1990, p. 47). Mayeroff nuanced that the relationship between a nurse (the carer) and a patient (the one cared for) might not be reciprocal in this professional context, because the patient is not necessarily ''caring for'' the nurse. Mayeroff's caring, as it is transposed in nursing, is a process embedded in the relationship between a patient and a nurse, who tries to help the patient in becoming what *the patient* wants to become. This affirms indirectly that, whenever possible, the nurse should put efforts in understanding the patient's priorities and maintaining a relationship coherent with the last, as the nurse might not be the one who can define what the patients have to turn into. Also, this assumption reinforces the previously explained humanistic idea that every human being has, at least, growth potential that can be honored through relationship.

Consistent with Rogers (1961), Mayeroff (1971/1990) reinforced the importance of genuinely understanding the person's concerns, perspectives, and needs in order to help the person grow. Certainly, empathy is vital in ''knowing'' (first ingredient) the patient and the amount of knowledge needed for caring to happen is extensive: to get to know the *whole person* (instead of *patient's parts*) may already be a concern in contemporary nursing practice. Along the process of caring, the nurse should be able to reflect, from specific situations to wider contexts, on his or her actions taken toward the patient's growth. Mayeroff called this second ingredient ''alternating rhythms.'' True caring occurs when the nurse shows ''patience'' (third ingredient) and lets patients grow at their own pace, as much as possible. Mayeroff reminded us that moments of wastefulness are characteristic of a normal growth. As asserted earlier, there should be congruence in devotion, and this principle is also applied to ''honesty'' (fourth ingredient): the nurse must ''ring true'' in order to be ''present for'' the patient, else incongruence might interfere with her ability to relate to him. Moreover, the nurse needs to ''trust'' (fifth ingredient) the patient as he grows in his own way and at his own time, indicating that the nurse initially has to believe in the patient's growth potential (Mayeroff, 1971/1990). Once more, this idea of human potential reveals the influence of Rogers's (1961) view of self-determination on Mayeroff's conception of caring. Furthermore, ''humility'' (sixth ingredient) encourages nurses to adopt a positive attitude in learning from the relationship they have with their patients, but also from their own mistakes. In sincerely believing in the patient's growth, the nurse should have ''hope'' (seventh ingredient) that patients develop themselves through the nurse's caring. Yet Mayeroff emphasized that such hope is not unfounded expectations, but rather a sense of possibilities for the future, harmonious with the present. Lastly, caring requires the nurse to have ''courage'' (eighth ingredient) because the nurse's relationship with the patient might lead them in unknown directions. Mayeroff also draws attention to the interconnectedness of hope and courage, as the nurse's hope might provide the nurse with courage to stand beside the patient in uncertain experiences. To sum up, Mayeroff's caring is humanistic because it follows the idea that the person's growth can be potentiated through a reciprocal relationship, supported by the interrelated ingredients and the authentic presence (''being with'') of the carer.

Finally, these three humanistic philosophers all considered humans' growth as a central component of their work. In fact, they clearly stated that human development is enhanced through a relationship, nurtured by both persons involved. These authors also shared a similar belief about authenticity (or congruence), understood as a quality of the relationship and as a prerequisite for its establishment. Despite their abstract nature, these thoughts echo in nursing practice and health experiences, as nurses shape relationships with their patients through their caring, which might contribute to their growth. In the next section, we will analyze several caring theories that were inspired by these philosophers' thoughts.

Humanism in Nursing

In nursing literature, the concept of humanism is rarely defined, yet it appears in several ''humanistic'' nursing theories classified under the ''caring school of thought'' (Pepin et al., 2010) or ''grand theories about care or caring'' (Smith & Parker, 2015). For this article, we looked for theorists that were inspired by at least one of the three philosophers described in the previous section, Buber (1970/1996), Rogers (1961), and Mayeroff (1971/1990), exemplifying what humanism means in general and how we can witness it in these caring theories. To achieve this, we first reviewed the theorists sorted in the classic collections (Alligood, 2014; Pepin et al., 2010; Reed & Shearer, 2012; Reed, Shearer, & Nicoll, 2004; Smith & Parker, 2015; Smith et al.,

2013) and then explored other unsorted conceptualizations of caring known to have a humanistic focus (McCance, McKenna, & Boore, 1999). Consequently, we have included the writings of the following scholars, namely (a) Paterson and Zderad (1976, 1976/1988), (b) Watson (1979, 1985, 1990, 1994, 1997, 1988/1999, 1988/2007, 2007, 1979/2008, 2012), (c) Roach (1984, 2002, 2013), (d) Boykin and Schoenhofer (1993, 1993/2001), and (e) Cara et al. (2015). In order to demonstrate how these nursing theorists were inspired by the aforementioned philosophers, we generated a summary of their main concepts (see Figure 1).

Josephine G. Paterson and Loretta T. Zderad: Humanistic Nursing

Integrating their phenomenological study results along with the ideas of Buber (1970/1996) as well as Rogers (1961), Paterson and Zderad (1976, 1976/1988) developed a humanistic nursing theory that focused on nurse–patient relationships. From an existentialist and phenomenological perspective, nursing is described as ''an experience lived between human beings'' (Paterson & Zderad, 1976, p. 3), where the core of nursing becomes meaningful through daily activities of nursing practice. Their theory shows that they believed in humans' potential to grow because the goal of nursing is not only the achievement of persons' well-being, but also the promotion of their ''more-being.'' Indeed, ''nursing's concern is . . . helping [the person to] become more as humanly possible in his particular life situation'' (Paterson & Zderad, 1976, p. 12), a tenet consistent with the person's growth within a relationship, found in humanistic psychology (Rogers, 1961). There are numerous ''I–Thou'' references in the theorists' work, and it is also possible to outline many associations with Buber's writing. First, Paterson and Zderad (1976) described the relationship between the nurse and the nursed as an intersubjective transaction, which is similar to Buber's (1970/1996) concept of reciprocity. Second, the authentic commitment ''is . . . existential [and] directed toward nurturing human potential'' (Paterson & Zderad, 1976, p. 15). This also represents one of Buber's principles: between two persons, there should be authentic presence and commitment through encounter and dialogue. Third, Paterson and Zderad (1976) described a lived dialogue as a ''particular form of intersubjective relating . . . in seeing the other person as a distinct unique individual and entering into relation with him'' (Paterson & Zderad, 1976, p. 25). This concept resonates with Buber's (1970/1996) definition of dialogue. Fourth, Paterson and Zderad (1976, 1976/1988) addressed the concept of mutuality as an active coconstitution of the relationship that the nurse and the patient hold together, a definition akin to Buber's (1970/1996). However, they preferred the concept of ''presence'' over Buber's ''encounter.'' They defined ''presence'' as a form of irreducible and intersubjective connection, which cannot be appreciated as an object. It is impossible, as argued by the theorists, to command or invoke this presence; it rather introduces itself and it is the persons' choice to engage or not, an idea that Buber (1970/1996) also emphasized. Overall, humanistic nursing means to nurture the person's potential (more-being) through an intersubjective transaction found between two human beings, whereas the nurse should be authentically present and committed to sustain the other's potential and to establish a mutual relationship.

Jean Watson: Human Caring

Watson (1979, 1985, 1990, 1994, 1997, 1988/1999, 2007, 1979/2008, 2012), an internationally renowned dedicated caring scholar, was influenced by the works of Buber (1970/1996), Rogers (1961), and Mayeroff (1971/1990). Her theory indicates that caring is the moral ideal of nursing and its biggest interest resides within a commitment to the preservation of human dignity and humanity (Watson, 1985, 2012). The foremost elements of her theory are the 10 carative factors (later evolved as Caritas Processes), the transpersonal caring relationship, the caring occasion and caring moment, and the caring–healing modalities (Watson, 2012). Her most recent works have incorporated more spiritual aspects and, as the theorist explained elsewhere (Sitzman & Watson, 2014), it can be a challenge for practicing nurses to apply this highly abstracted theory in clinical practice. In spite of this, her writings have been and are still used to guide academic curricula and research projects (Woodward, 2010). For nursing practice, it is possible to inspire humanism through Watson's lens (Alligood, 2014; Birk, 2007; Clarke, Watson, & Brewer, 2009; Hôpital du Sacré-Coeur de Montréal, n.d.; Lussier & St-Jacques, 1993; Roy & Robinette, 2005), but it often requires a partnership between scholars and managers in order to support nurses' familiarity with her theory. Besides, humanism appears omnipresent in Watson's writing, mostly because the relational dimension of nursing, the caring transpersonal relationship, is put on the front lane (Cara, 2009/2010). To establish this kind of relationship, Watson (2007) mentioned that the encounter between the patient and the nurse (caring occasion) might evolve to a caring moment, depending on the nurse's conscience, authenticity, and intentionality, the last being borrowed from phenomenology as well as the writings of Mayeroff (1971/1990) and Rogers (1961). The relationship is said to be transpersonal because it honors the subjective world of the person cared for (as with Buber's [1970/1996] I–Thou subjective relationship), and in the process it establishes a spiritual connection with the person, enhancing the development of its human capacities (Cara, 2003; O'Reilly, 2007), an idea that Rogers (1961) also reinforced. According to Watson, a transpersonal caring relationship transforms both the nurse and the patient, or in other words, is characterized by mutuality and reciprocity (Buber, 1970/1996). Moreover, the nurse's commitment, another concept evoked by Buber (1970/1996), Rogers (1961), and Mayeroff (1971/1990), aims at helping the patient find meaning in his or her life and health experiences. The influence of the aforementioned philosophers (Buber, 1970/1996; Mayeroff, 1971/1990; Rogers, 1961) can be noted among the Caritas Processes, more specifically in the second, the fourth, and the seventh. For example, Watson's Caritas Processes encourage the nurse to be authentically present for the patient and invite the patient to engage in a relationship of mutuality and reciprocity in order to promote hope, learning, and harmony for the cared-for person. To sum up, Watson's (2012) caring approach is humanistic because it encourages the development of human capacities (growth) by the conscious and intentional commitment of the nurse, whose authenticity and empathy radiate, potentiating the patient's healing and promoting the patient's dignity and freedom of choices (Cara, 2009/2010).

M. Simone Roach: Caring Attributes, the Six C's

Roach's (1984, 2002, 2013) writings are usually not included in the classic collections of nursing theories because they ''[have] not been described formerly as a theory, but [they have] been frequently quoted in writing relating to conceptualizations of caring in nursing'' (McCance et al., 1999, p. 1390). Moreover, Roach's initial work (1970) elaborates explicitly on ''Christian humanism,'' and the spiritual dimension of this philosophy can be witnessed in her later works (Roach, 1997) as well as in her understanding of ''compassion,'' her first caring attribute. Roach (2002) described compassion as an immersion into the patient's experience, leading the nurse to answer and to be particularly present to the suffering of others. On the one hand, this theorist stated that compassion is meaningless and possibly harmful if it is not used with ''competence'' (second attribute) and, on the other hand, competence without compassion may be brutal and inhumane (Roach, 2002). A glimpse of Mayeroff (1971/1990), more specifically on the concept of congruence, may be found in Roach's (2002) description of authentic presence, represented as a harmony between the self and the ''conscience'' (fourth attribute). Additionally, Roach (1997) asserted that true caring required a state of moral awareness, the conscience, which guides the nurse's behavior and decision making.

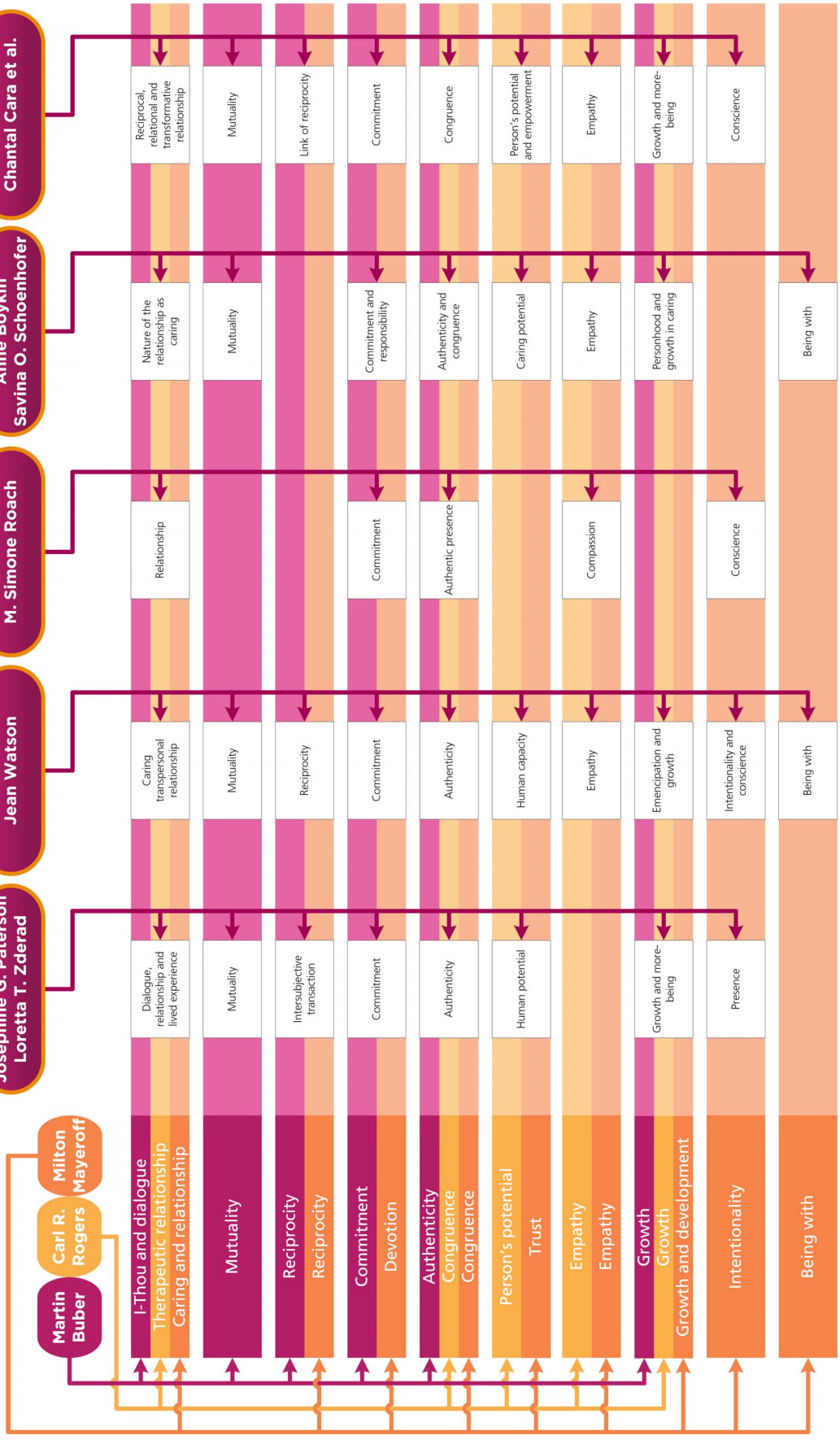

Figure 1

Summary of Humanistic Concepts

Furthermore, she defined ''commitment'' (fifth attribute) as an affective and deliberated answer to the patient's needs and preoccupations, converging with the nurse's own desires to care, a definition very close to Mayeroff's. Perhaps one of Buber's (1970/1996) influences on Roach's ideas resides in her belief that caring is a way of being. Indeed, both authors asserted respectively that caring is a form of dialogue and ''a way of being rather than action'' (Chinn, 1991, p. 4), that caring is a human mode of being in relationships (Roach, 1997), and that the capacity to care is innately human, even if it may lie dormant (Roach, 1987). In summary, Roach's best-known contribution to nursing, the ''six C's'' (compassion, competence, confidence, conscience, commitment, and comportment), represents a humanistic perspective on caring that is naturally embedded in human existence.

Anne Boykin and Savina O. Schoenhofer: Nursing as Caring

Drawing on the thoughts of the two previous authors (Roach, 1984; Watson, 1979), Boykin and Schoenhofer (1993, 1993/2001) were also inspired by the work of Mayeroff (1971/1990) to elaborate their theory. For these scholars, all persons grow in their capacity to express caring in addition to being caring by virtue of their humanness (Boykin & Schoenhofer, 1993/2001). In other words, this implies that each nurse has the potential to be a caring practitioner, but their capacities may need to be drawn forward. This assumption is suitable to patients as well, meaning that they are considered to be caring persons and one of the nurse's responsibilities is to help them grow in their caring. This growth and its caring potentialities are expounded together in a slightly different way than Mayeroff intended, but their view remains compatible with his philosophy. According to Boykin and Schoenhofer's (1993/2001) perspective, the development of competence in caring occurs throughout human life, that is: ''[1)] to understand what it means to be a caring person, [2)] to live caring, and [3)] to nurture each other as caring'' (p. 2). Another concept of their theory, ''personhood,'' is described as a process of living grounded in caring, requiring congruence—a concept articulated by Mayeroff (1971/1990)—between beliefs and behaviors among nurses and patients. The nature of a nurse–patient relationship is transformed by caring, and being caring corresponds to a mutual responsibility to self and others, meaning that it is lived in a context of relational responsibilities (Boykin, Schoenhofer, & Linden, 2010). Furthermore, to *be with* a patient in a relationship underlines the nurse's authenticity, empathy, and commitment, also evoking Mayeroff's (1971/1990) understanding of caring. To sum up, the strong belief in human beings' potential to grow as persons in caring and the core of nursing considered to be very relational, both demonstrate humanistic principles within Boykin and Schoenhofer's (1993/2001) theory.

Chantal Cara et al.: The Humanistic Model

The Humanistic Model of nursing care (Cara, 2012, 2014; Cara & Gagnon, 2014; Cara et al., 2016; Cara & Girard, 2013; Cara et al., 2015; Girard & Cara, 2011) is inspired by the writings of the past four nursing theorists (Paterson and Zderad, Watson, Roach, Boykin and Schoenhofer), as well as the humanistic ideas of Buber's dialogue and of Rogers' person-centered approach. This conceptual model encourages nurses to care while focusing on empowering the patient's growth potential, one of the principal assumptions of humanism explained earlier (Buber, 1970/1996; Mayeroff, 1971/1990; Rogers, 1961). Also, nursing starts from the patient's preoccupations and health experiences' meanings, inciting nurses to consider the latter in their choice of interventions (Cara et al., 2015). Furthermore, nursing is relationship based, meaning it is aimed at humanly accompanying the patient in a relational and transformative way, which underlies caring tenets. According to Cara et al. (2016), caring can be recognized in nurses' competence in daily practices, and there should be congruence between their values, knowledge, attitudes, and behaviors (Cara, 2004). This interpretation of congruence is similar to the meaning of the same concept in both inspirational nursing theorists (Boykin, 1994; Roach, 1987) and philosophers (Mayeroff, 1971/1990; Rogers, 1961), as we have previously specified in this analysis. Caring emerges from the nurses' conscious commitment in helping their patients to grow in what they wish to become, a definition consistent with humanistic philosophers (Mayeroff, 1971/1990) and nursing theorists (Paterson & Zderad, 1976/1988; Roach, 2002; Watson, 2012). In a sustained partnership with the patient, nurses aspire to improve the patient's harmony—as defined by the patient—while preserving the patient's well-being, more-being, and human dignity (Cara et al., 2015). Overall, some humanistic values are favored in this conceptual model, such as respect for human dignity, freedom of choices, and trust in the person's potential to grow. In other words, the relational dimension of nursing is the cornerstone of the Humanistic Model of nursing care, where caring, empathy, commitment, and congruence enable links of reciprocity between the nurse and the patient, where both are believed to grow mutually within that relationship; such a perspective highly supports the ideas put forward by all three philosophers (Buber, 1970/1996; Mayeroff, 1971/1990; Rogers, 1961).

Conclusion

Humanism, as a philosophy, has its roots in the Renaissance and Enlightenment movements, and many contemporary caring theorists have contributed to renewing its relational tenets in caring for patients, families, and communities. Although there are numerous ways of understanding caring theories of our discipline, our paper sought to demonstrate how core elements of humanism were transposed in nursing's modern identity.

Humanism in nursing implies a therapeutic attunement between self and others, but to be therapeutic, there is a need for authenticity in one's intentionality or commitment to care for others. As outlined in the introduction, this may be a challenge within the complex context of nursing care, where productivity and efficiency appear to be interfering with nurses' capacity to be compassionate and caring practitioners (Curtis, Horton, & Smith, 2012; Ward, Cody, Schaal, & Hojat, 2012). Surely, we are convinced that most, if not all, nurses want to provide humanistic and excellent nursing care as they aspired to when they were nursing students (Beagan & Ells, 2007; Crick, Perkinton, & Davies, 2014; McLaughlin, Moutray, & Moore, 2010), but face barriers that may not support such practices. Humanizing a culture of care is yet another challenge, but prior to that, we invite nurses, and nursing managers, to reflect on the meaning as well as the added value of humanism within their daily practice. As emphasized in a recent umbrella review about caring (Wiechula et al., 2016, p. 732), ''nurses need to recognize that patients can and do distinguish between technical and compassionate aspects of care, [and] these two elements are not separate and have to be managed together.'' In acknowledging and being mindful about this, nurses might also rethink the fundamentals of human dignity's preservation, especially where patients experience vulnerable events such as loss, grief, suffering, and death.

As nurses, we have the privilege to encounter the life trajectories of human beings, and in a humanistic perspective, each encounter may give birth to new directions (Mayeroff, 1971/1990), depending on our conscious commitment to their welfare, well-being, and more-being (Cara et al., 2016; Paterson & Zderad, 1976/1988). In fact, humanistic theories remind us that our own growth (at both a personal and a professional level) may be promoted in every act of caring and genuine kindness (Watson, 2012), but they also reveal how bounded we are to others, as human beings (Buber, 1970/1996), and that our existence is highly lived within the relationships we establish and nurture. Because the foregoing relationships might blossom into human growth, nurses would benefit from understanding and envisioning humanism in their everyday living. We believe this paper may help nurses achieve this goal as we

strive for a pragmatic and accessible analysis of humanism that makes sense for clinical practice.

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