A Unitary-Caring Conceptual Model for Advanced Practice Nursing in Palliative Care

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Advanced practice nurses provide expert clinical care for patients and families experiencing chronic and terminal illnesses. However, there is no theoretical framework that guides praxis in palliative care. This article describes a unitary-caring model that transforms national standards of palliative care into a values-based praxis focused on healing and caring. Key Words: advanced practice nurse, palliative care, Rogers' Science of Unitary Human Beings, Watson's Transpersonal Caring Science

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Advanced practice nurses (APNs) in palliative care are qualified to provide comprehensive, effective, compassionate, and cost-effective care.1 As palliative care in the acute care setting becomes integrated within the healthcare system, its value-added emphasis and outcomes-based evidence are igniting interest about its possibilities for the future. New evidence is supporting the likelihood of palliative care programs, reducing Medicare and other third-party payer’s expenditures for patients during their hospitalization.2

Although there are national guidelines designed to improve the quality of life for patients and families contending with life-threatening illness, there is no theoretical framework that guides the palliative care APN’s praxis. The APN, using a nursing theory–guided model for care delivery, enhances the possibilities of healing. Specifically, a unitary-caring approach derived from Rogers’ Science of Unitary Human Beings and Watson’s Transpersonal Caring Science provides the APN with a values-based framework to guide healing-caring praxis.

The purpose of this article is to describe a unitary-caring model for APNs in palliative care. I will outline the national standards of palliative care, introduce a theory-guided conceptual framework for advanced nursing practice, and articulate the integration of a unitary-caring model into praxis. A narrative exemplar is presented to illustrate the unitary-caring model in action. A discussion and brief conclusion offers implications for new knowledge development.

THE PALLIATIVE CARE APPROACH

Palliative care is an interdisciplinary approach to healthcare focused on alleviating suffering and improving the quality of life for patients and families facing or living with a chronic and/or terminal disease/illness.3–6 Quality of life is defined by the patient and family unit and is expressed through their wishes and goals. A comprehensive multidimensional assessment of the patient and family’s physical, psychological, social, spiritual, and cultural needs is completed by members of the palliative care interdisciplinary team (IDT). The palliative care IDT, consisting of an APN, a social worker, a chaplain, and a physician, collaborates with the patient and family to identify their wishes and goals. A care plan is designed to focus on the identified wishes and goals and may include interventions from allied health personnel (ie, physical therapist, nutritionist, pharmacist, and others.). Members of the IDT support the patient and family through the disease/illness process with ongoing assessments and interventions based on their multidimensional needs.

Palliative care can be difficult to articulate. It is not a level of care (ie, critical care, rehabilitation, hospice, and others) or a disease management program but rather a “philosophy of care and an organized, highly structured system for delivering care.”24(p3) Palliative care originated from the traditional hospice...
perspective to address quality of life concerns for those patients living for prolonged periods with a progressive, debilitating diseases. However, unlike hospice, palliative care incorporates both curative- and comfort-based approaches to healthcare through the trajectory of patients’ illness. Although there are different variations of the model (Appendix A), the overall consensus reflects a combination of curative treatments (eg, chemotherapy, organ transplant, and pharmacological interventions) and comfort modalities (eg, pain and symptom relief, long-term care planning, and support for existential suffering). The palliative care team supports the wishes and goals of the patient and family through the disease/illness process including end-of-life care and bereavement services for survivors following the patient’s death.

Financial outcomes are beginning to emerge from the interventions of palliative care consult services in the acute care settings. Recently, Morrison et al2 illustrated an improvement in care for adults with serious illness and examined the cost savings secondary to interventions provided by palliative care consultations. The authors analyzed administrative data from 8 national hospitals with established palliative care programs and found net savings of $1696 to $4908 per admission. These findings suggest the possibility of mandatory palliative care consults for all those covered under Medicare, Medicaid, and commercial carriers during their hospitalization.

However, there is no prejudged agenda for care planning. The purpose of palliative care is not focused on funneling patients into hospice or comfort care programs. Rather, palliative care acknowledges the particulars of the patient and family’s human experience and supports patients’ healthcare preferences while educating them on alternatives and options for care. The IDT works with the patient and family, examining the intended and unintended consequences of their healthcare preferences and recognizing that decisions are fluid and may change at any time. Regardless of the decision or preference of care, palliative care supports the patient and family through the disease/illness process.

**CLINICAL PRACTICE STANDARDS OF PALLIATIVE CARE**

The World Health Organization (WHO) views palliative care as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. This has been the universal foundation and context for palliative care in all settings.

In 2004, the National Consensus Project for Quality Palliative Care (NCP) developed detailed clinical practice guidelines for palliative care programs using the WHO definition. The genesis of the NCP guidelines stemmed from integrating the knowledge gained with the ongoing growth of palliative care and hospice programs in the United States. The NCP originates from a consortium of 5 national palliative and hospice organizations: the American Academy of Hospice and Palliative Medicine, the Center to Advance Palliative Care, the Hospice and Palliative Nurses Association, the Last Acts Partnership, and the National Hospice and Palliative Care Organization. “The purpose of the National Consensus Project for Quality Palliative Care is to establish Clinical Practice Guidelines that promote care of consistent and high quality and that guide the development and structure of new and existing palliative care services.” The NCP guidelines were updated in 2009 to include 38 preferred practices that were recommended by the National Quality Forum.

There are 8 domains focused on the goals of palliative care outlined in the NCP. These domains have been cited throughout the growing body of knowledge in the palliative care literature as guidelines for care. Appendix B identifies the 8 domains and summarizes a description of the assessments and interventions that are addressed while providing care to the patient and family in palliative care. “The guidelines rest on fundamental processes that cross all domains and encompass assessment, information sharing, decision-making, care planning and care delivery.” “While these guidelines reflect a multidisciplinary interest and concern about improving care at the end of life, the nursing profession is particularly well suited to these efforts.”

**NURSING’S UNIQUE ROLE**

Advanced practice nurses have a unique ability to integrate the roles of leader, consultant, coach, clinician, and researcher. APNs in palliative care are qualified to provide comprehensive, effective,
compassionate, and cost-effective care and serve as a role model for members of other disciplines in promoting quality of life and quality of dying.\(^1\) With advanced knowledge of the physical, emotional, social, and spiritual needs of seriously ill patients, APNs are well prepared to model optimal care and to assume leadership roles in palliative care.\(^1\) The advanced practice palliative care nurse specifically grounded in a unitary and caring perspective can translate the human experience of health, illness, death, and dying into a comprehensive, holistic,\(^{10,a}\) interdisciplinary care plan aimed at alleviating suffering and promoting healing to improve the quality of life for the patient and the family.

**A UNITARY-CARING MODEL REVEALED**

Kenney\(^{11}\) describes theory-based nursing practice as the application of various models, theories, and principles from nursing science and the biological, behavioral, medical, and sociocultural discipline to clinical nursing practice. Since the concept of palliative care is essentially wholistic,\(^{10,a}\) a theoretical framework governed by a unitary and caring perspective is most appropriate to guide APNs in their praxis. Praxis is the integration of practice, experience, interpretative reasoning, and reflection applied toward a purposeful action. The unitary-caring perspective originates from the converging commonalities between Watson’s Transpersonal Caring Science and Rogers’ Science of Unitary Human Beings.

**Tenets of Watson’s Transpersonal Caring Science\(^{12,13}\)**

Transpersonal caring begins with the nurse’s energetic pattern of consciousness, intentionality, and authentic presence in a caring relationship with the patient. Authentic and authentic presence refers to the nurse’s genuine truthfulness and desire to be present in the moment, focused, without hesitation, and without distraction. The nurse’s authentic intentionality and consciousness of caring has a higher frequency of energy than noncaring consciousness. This higher frequency of energy opens up connections to the universal field of consciousness, allowing greater access to one’s inner healer. The connection manifests into a caring moment where the ego of both the nurse and the patient transcend time, space, and physicality (unity of mind, body, spirit, nature, universe).

**Tenets of Rogers’ Science of Unitary Human Beings\(^{12,14,15}\)**

The fundamental unit of the living and nonliving is the energy field. Field is a unifying concept. Energy signifies the dynamic nature of the field; a field is in continuous motion and is infinite. The environment (environmental field) is an irreducible, indivisible, pandimensional energy field identified by pattern and integral with the human field. Pandimensionality is a nonlinear domain without spatial or temporal attributes. The distinguishing characteristic of an energy field is pattern. Unitary human beings (human field) is an irreducible, indivisible, pandimensional energy field identified by pattern and manifesting characteristics specific to the whole, which cannot be predicted from knowledge of the parts (the whole is greater and different than the sum of its parts).

Little literature is available that explores the integration of these “two parallel, often controversial, seemingly separate and unrelated trees of knowledge for nursing science.”\(^{12(p453)}\) Smith\(^16\) originally identified 5 constitutive meanings of caring, which emerged from the literature that represented the concept of caring from the perspective of the science of unitary human beings: (1) manifesting intentions, (2) appreciating pattern, (3) attuning to dynamic flow, (4) experiencing the infinite, and (5) inviting creative emergence. Watson and Smith\(^12\) examined the shared notion of the concepts in Rogers’ Science of Unitary Human Beings and Watson’s Transpersonal Caring Science. They revealed a transtheoretical integration and extension of the shared commonalities between the 2 differing perspectives. Their work was the foundation for an emerging “Unitary Caring Science.”\(^{12(p460)}\)

A literature review focused at finding theoretical frameworks guiding the palliative care APN within the unitary-caring framework yielded no results. However, recently, Cowling et al\(^{17}\) revealed common theoretical perspectives from a unitary and caring context further describing the connection between caring science and the science of unitary human beings. Using these common perspectives, the authors revealed a nexus of concepts/values emerging across Transpersonal Caring Science and the Science of Unitary Human Beings that could guide nursing praxis.

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\(^{a}\)Erickson refers to wholism as the sum of the parts equaling the whole. “The implications are that the parts can be separated, studied and treated.”\(^{10(p141)}\) In contrast, “Holism is an inseparable integration of all components of the person, creating a whole that is greater than the sum of the parts.”\(^{10(p142)}\)
The “nexus” of pattern, wholeness, consciousness, caring, transformation and transcendence, relationship, and meaning provides a conceptual framework that can uniquely guide the palliative care APN’s practice. Although the goal for palliative care is to alleviate suffering, the APN guided by the nexus creates an opportunity for human healing during the journey of health, illness, death, and dying. This is in effect, the APN’s “caring-healing praxis.” The concepts/values of the nexus are described as the basis of a conceptual theory–guided framework aimed at proliferating human healing within the domains of palliative care.

**Pattern**

Pattern is the distinguishing characteristic of a human field and gives identity to and distinguishes one person from another. It is the uniqueness of the human manifested by the person’s history, experience, and journey. Pattern is nonstatic; it changes, evolves, and transforms, manifesting into the authentic self. It is beyond the constraints of what can be seen, heard, touched, and smelled. Pattern includes the physical, emotional, mental, social, and spiritual facets of the human, but it is not confined to these domains. The APN experiences the patient’s pattern through a process of appreciation.

In the practice of appreciation there is shift away from the attention on the interrelatedness of aspects and a focus on sensing and emerging pattern that reflects the wholeness of human life. Thus, aspects of human life, namely the experiences, perceptions, and expressions associated with living, are viewed together in an inclusive way to reveal the fullest picture of the inherent wholeness.

Appreciation of the patient’s pattern moves away from the assessment and diagnosis of disease/illness and disorders and into a nonjudgmental approach to the human experience of health, illness, death, and dying.

**Wholeness**

Wholeness is defined as an ontological viewing of the patient as greater than and different from the sum of his/her parts. In other words, when approaching the patient through the eyes of palliative care, the APN views the whole patient, the whole family, and the whole community as a unified irreducible whole. The implications of wholeness allow the APN to treat the part, while manifesting healing to the whole. The irreducible whole cannot be accessible through the physical, psycho/social, and/or spiritual/cultural assessment but rather an appreciation of the entire pattern.

**Consciousness**

Consciousness is the awareness of relating in continuous mutual process. It is characterized by nonjudgment, focus, and genuine/authentic presence as it relates to the present. Consciousness is one’s intention and attention to shape experiences. The relationship among the APN and the patient and family whole manifests into a connection and thus a mutual process. Attuning to the dynamic flow of this continuous mutual process begins with a dance whereby the APN follows the lead of the patient and family through their journey, giving voice to their thoughts and honoring their experiences. Attention to this event bound by the nurse’s genuine truthfulness and desire to be present (authentic presence) results in what Watson calls a caring moment/caring occasion. “The nurse’s authentic presence, consciousness and intention in a caring moment manifests caring field patterning.” The continuous mutual process evolves, transforms, and transcends the pattern of the patient, APN, and their relationship.

**Caring**

Caring is defined as the relational mutual process through which wholeness is addressed, motivated by an ethic and intention toward new patterning and possibilities of healing. “The primary goal of nursing is healing—the facilitation of transformative and transcendent life patterning consistent with wholeness and human flourishing.” The APN, grounded in an ontological and philosophical underpinning of caring literacy, seeks to participate in the co-created journey of caring and healing with the patient and the family. The APN manifests ways of caring through humility, love, and kindness; heart-centered authentic presence; compassion; appreciation for pattern; attuning to the dynamic flow of the continuous mutual process; and the invitation of creative emergence.

**Transformation and transcendence**

Transformation and transcendence are manifested through the caring connections of the patient and the APN. Transformation begins with pattern recognition and implies a changing of form in a literal sense, as in seeing things from a different angle. Transformation occurs when the APN reframes hope with the
palliative care patient from a focus of curing the disease/illness and into identified wishes and goals. Transcendence moves beyond transformation and involves a shift to another dimension. Transcendence occurs when the palliative care patient and the APN engage in a caring moment/caring occasion where time, space, and physicality pause. Smith and Reed described this moment as “sanctuary,” a sacred place of renewal and transformation characterized by feelings of peace, comfort, and unity.

**Relationship**

Relationship “connotes a spirit to spirit unitary connection within a caring moment, honoring embodied spirit of both nurse and patient, within the unitary field of consciousness.” This is the APN’s connection with the palliative care patient. Relationship manifests into dialogue, “The nurse-patient encounter suggests ongoing dialogue, negotiation, and meanings created and understood but not finalized.” As dialogue unfolds, meaning is found and is shared between the mutual process of the nurse and the patient. The nurse and the patient share meanings moment by moment.

**Meaning**

Meaning is the integration and search for purpose, truth, expression of the unspeakable, and understanding in all experience that reflects the individual’s human experience at infinite levels of interpretation. When meaning is found, healing begins. The APN, in mutual process and in relation with the palliative care patient, reflects the patient’s pattern into potential meanings. Although the APN does not define the meaning of the patient’s human experience, the nurse guides the patient’s exploration of his or her experiences into an evolution of transformation and transcendence, which thus leads to meaning.

**Praxis**

The synthesis of the nexus guides the APN’s caring-healing praxis. Watson defines praxis as informed practice; integrative practice informed by one’s values, intentionality, consciousness, one’s ethic, and full self. “Caring-healing praxis integrates doing, knowing and being into transformative caring, healing and health care within a given moment.” The nexus of pattern, wholeness, caring, consciousness, transformation and transcendence, relationship, and meaning allows the APN in palliative care to be an active participant in the patient and family’s journey, in the moment of the human experience of health, illness, death, and dying. This type of praxis integrates the power of the particulars in the human experience and offers an invitation of creative emergence such as co-created human healing.

**INTEGRATION AND PRAXIS**

Although the NCP4,6 domains are a valuable resource in directing the palliative care APNs in their practice, they are not a substitute for theory-guided advanced nursing praxis. “Many nurses unconsciously use a medical or institutional [or national] model as their perspective for organizing care.” APNs using only practice guidelines, empirical evidence, and medicalized interventions to guide their practice consequently remain constrained. Here, unintentionally, APNs do not contribute to the body of knowledge within the discipline of nursing. Their actions fail to give voice to the “timeless disciplinary values—the ontological, ethical, epistemology of nursing practices.” APNs practicing without a theoretical framework to guide their praxis actively contribute to the potential extinction of the profession of nursing. As Watson warns us, “a profession that loses its values is soul-less; it becomes heartless and therefore becomes worthless. The worth of a profession is in clarifying, articulating, and manifesting its values through action.”

The absence of theory-guided praxis at the advanced practice level potentiates palliative care into another service line in the acute care setting. As an example, from a unitary-caring perspective, the APN acquires an appreciation of the patient’s pattern in contrast to a comprehensive assessment of the patient’s response to the disease/illness. The latter reflects a medicalized, empirical model of care where the unitary-caring perspective values a holistic acceptance of the patient’s human experience of health, illness, death, and dying.

In fact, a unitary-caring framework guiding palliative care APNs transforms the NCP4,6 domains into a crescendo of maximized healing potentials for the patient and the family. A unitary-caring perspective is constructivistic in that it invites the APN to travel with the patients through their journey instead of being an outside observer. This co-created journey becomes pandimensional, giving insight to APNs, allowing them to be transdisciplinary with intention to manifest human healing. Appendix C depicts a visual
schematic illustrating palliative care APNs as an open system, using a unitary-caring perspective to guide their praxis.

PRAXIS EXEMPLAR

The following exemplar offers narrative evidence demonstrating the integration of a unitary-caring model for the palliative care APN. This exemplar takes place in a community hospital where an APN leads an interdisciplinary palliative care consult service. In this exemplar, the concepts of pattern, wholeness, meaning, consciousness, relationship, and transformation and transcendence are expressed.

Dr Williams, an oncologist, requests a palliative care consult with Mrs Austin and her family regarding her goals of care and a referral to hospice care services. The APN begins by reviewing her chart to collect relevant information and gains a perspective of Mrs Austin as a whole. She is 81 years old and has metastatic breast cancer. She was admitted to the community hospital with fresh blood emesis. About 5 days prior to this event, she came to the hospital with a similar episode and was diagnosed with an upper gastric intestinal bleed and hemorrhagic shock. At that time, Mrs Austin was discharged home with hospice care. However, since the etiology of the bleeding was unclear, Mrs Austin wanted further evaluation and active treatment until the cause of her bleeding was established. Mrs Austin has a history of metastatic breast cancer, hypothyroidism, depression, osteoporosis, and multiple red blood cell antibodies resulting in difficulties in transfusing her.

During this hospitalization, Mrs Austin is admitted to the intensive care unit and receives packed red blood cells and frozen plasma. Dr Williams discusses her metastatic breast cancer and prognosis with Mrs Austin and recommends her to transfer to an in-patient hospice setting immediately. However, the APN notices Jim is getting up; he is crying and turns away from everyone and looks outside the window. Greg is crying, sitting next to his mother. Mrs Austin turns to the APN and whispers, “they’re having a hard time with my cancer.” The APN looks at Mrs Austin and asks if she feels going to hospice means giving up. She does not answer, and they look at each other in silence. The room is quiet, she looks at her son, and then turns to the nurse and says, “I don’t know, I think when its time its time. I’m knocking on the door.” The APN responds, “What does that mean, knocking on the door?” Mrs Austin replies, “It means I’m dying. I know I’m dying, I don’t want to die, but I’m not afraid. I am not going through this alone. He is with me, he is always with me.” The APN asks, “Who is he?” She replies,

God. He has been with me all my life. I wish others would understand that God is always with them. It’s a shame that people can’t see what he can do for you, and see what he has given you. I feel bad for those who have no faith, they are walking by themselves in the darkness.

The APN listens as Mrs Austin describes her life as a stay-at-home mom, maintaining a home and raising her 2 sons. Through their dialogue, the APN begins to see Mrs Austin as the dominant figure in her family. She is the “manager” of the family, and her husband and sons are very devoted and close to her. She shares with the APN “I am very proud of what I’ve done.” The APN begins to review her distressing symptoms and finds them to include pain, nausea, vomiting, and fatigue. She denies depression but feels anxious. The APN explores Mrs Austin’s wishes and goals. She decides that she wants to return home but realizes she cannot care for herself anymore. Mrs Austin and her husband live in the mountains about an hour away from the hospital. She has not decided on hospice care at this time but has decided that she will need a private duty nursing service to help her stay home.

The next day, the APN visits Mrs Austin. Her pain and anxiety are well managed, and she states that she is feeling comfortable overall. She reports no nausea or vomiting and has been sleeping well; she indicates she feels rested. The APN asks where her family might be. She shares, “They are at home, meeting with hospice. Jim and my sons are meeting with them and
setting things up so I can go home.” The APN asks if Mrs. Austin has then decided to go home with hospice. She replies,

Yes. I think it’s best for Jim and my sons. I think they will need help with me at home. I don’t want to be a burden on them, and I don’t want them trying to help me, clean me up, take me to the bathroom. I’d rather have someone else take care of me at home.

The APN and Mrs. Austin continue to expand their relationship and dialogue about the meaning of hospice, discussing and reframing hope as a goal to return home. The APN explores Mrs. Austin’s plans for memorial and burial services. Both Mrs. Austin and her husband had made arrangements for their funeral planning years ago. The APN and Mrs. Austin talk about how Jim and her sons are coping. She tells the APN that Jim and her son Mark are still having a difficult time, but her son Greg has been very quiet. “He’s always been like that,” she explains, “I feel he is doing much better than the other two.”

In the late afternoon, the APN performs a follow-up visit and finds plans to transfer Mrs. Austin to her home with hospice services in the morning. Jim, Greg, and Mark are at the bedside and verbalize their intention of getting Mrs. Austin home. Jim indicates, “We all just want her to get home so she can be in familiar surroundings, and her friends can visit her.” The APN Mrs. Austin if this is what she wants to do and she replies, “Yes.”

The next morning when the APN visits, there is unease in the room. It is quiet, there are no smiles; everyone is focused on trivial distractions. The APN asks Mrs. Austin how she feels about returning home today. She looks at the APN with anger and protests, “I don’t want to go home!” Jim stands up and says, “No, no. You want to go home mother. We have it all set up, the ambulance is coming to pick you up here in about an hour and we have a hospital bed all set up in the living room so you can look outside and see your garden.

Mrs. Austin is crying now and says she is not going home.

The APN sits down by Mrs. Austin and asks her to share her feelings on what it means to go home. Mrs. Austin cries, “I don’t want to go home and have them take care of me.” Her son Mark replies,

Mom, we want to take care of you. We have nurses coming to be with you all day and night. We set up hospice to make sure you’re taken care of. Do you still think you’re gonna be a burden? It’s not a burden to us. Why are you doing this?

There is silence. The APN takes Mrs. Austin’s hand. There is a pause in the room. Mrs. Austin points to her family and says, “I don’t want them to see me at home like this. I’m not going home!” Jim is shaking his head no, Greg is crying, he wipes his tears, stands up, and begins to speak, “Mom, you said you wanted to come home. We did what you said. Don’t you want to go home? You told us what you wanted and we did it. Why are you not wanting to come home?”

The APN asks Mrs. Austin “What does going home mean?” Mrs. Austin is crying, she pauses then says, “It means I won’t be able to do the things I want to do. I can’t take care of myself and I don’t want anyone helping me!” The room is still, and then Mrs. Austin whispers, “I won’t be the same person I once was.” Jim and Mark leave the room quietly. Greg continues to be at the bedside. He is sitting next to his mother, crying, and listening. “If it’s too painful to return home, Mrs. Austin,” the APN asks, “where would you rather go?” Mrs. Austin looks at the APN and states, “I don’t know. I’m not making any more decisions. I’m tired. I’m really just sick and tired. I can’t do this anymore. I’m done making decisions.” She squeezes the APN’s hand tight and adds, “I don’t know what I want to do.”

The APN asks, “Mrs. Austin, are you saying it’s becoming too hard to make the decisions for your own end-of-life care?” She nods her head crying and replies, “Yes.” The APN asks Mrs. Austin if it would be appropriate for her husband and her sons to make some decisions for her. She nods her head, looks at Greg and says, “Yes, I think I can trust them.” Greg cries. There is a sense of relief in Mrs. Austin’s face. She takes Greg’s hand and motions for him to hug her. After they embrace, the APN and Greg leave the room to find Jim and Mark and share with them Mrs. Austin’s wishes.

Jim and Mark are in the waiting area. The APN reviews the dialogue that has taken place in Mrs. Austin’s room. They do not believe this is what she really wants. Mark is angry and leaves the waiting area. Greg talks with Jim and shares what he heard from his mother’s own voice. Mark returns.

The APN hears Jim and Mark talking. “She doesn’t want to die somewhere else, she wants to die at home.” Questions are directed at the APN including the possibility that Mrs. Austin has too much morphine to...
know what she really wants. The APN reframes the discussion to center on the wishes and goals of Mrs Austin, sharing with the family that Mrs Austin is on a journey, and they can only follow and support her as best as possible. At some point in the journey, Mrs Austin will have to continue onward alone, knowing that her family loves and supports her always. The family begins to discuss and strategize on alternatives including transferring Mrs Austin to an in-patient hospice care center.

The APN accompanies Jim and the sons back to the room. Jim shares with his wife the new plans of transferring her to an in-patient hospice care center. A smile returns to Mrs Austin’s face. There is a pause, another moment of silence, and it is quite peaceful. The APN holds Mrs Austin’s hand and asks how she feels about this new plan. She whispers, “I think I’m ready to go.” The APN leaves Mrs Austin to be alone with her family and begins setting up the transfer to the hospice care center.

**DISCUSSION**

The elements of pattern, wholeness, meaning, consciousness, relationship, caring, consciousness, and transformation and transcendence are woven through the entire narrative. As the APN reviews Mrs Austin’s medical history as well as the experience from her last hospitalization, a story of her journey unfolds. The APN views Mrs Austin as a unique whole. Through listening and authentic presence, the APN begins to appreciate Mrs Austin’s pattern, recognizing that it is not accessible through her physical, psychological, social, and even spiritual evaluation but as an irreducible whole. With openness and nonjudgment, the APN witnesses Mrs Austin’s pattern change/evolve as she finds meaning to her illness and meaning to returning home.

The exemplar illustrates the relationship between the APN and Mrs Austin. A spiritual unitary connection occurs within the caring moments of hand-holding. When the APN consciously and intentionally takes Mrs Austin’s hand, it becomes a symbolic dance. The APN waits to be led by Mrs Austin to the next piece of dialogue. The APN is open and willing to embrace Mrs Austin and help support whatever evolves from the discussion. This connection extends to the unitary consciousness of the universe when a pause in the physicality of the room occurs.

Transformation occurs when the APN begins to reframe hope into an identified wish and goal: Mrs Austin no longer wants to die at home and wishes for her family to make final decisions for her. Transcendence is witnessed toward the end of the exemplar when Mrs Austin gives permission for the family to make her care plan. When the final decisions are made and shared with Mrs Austin, another pause in physicality occur, a moment of silence that is characterized as peaceful. Mrs Austin shares with the APN through a whisper that she is ready to go, suggesting that Mrs Austin’s healing has begun.

**CONCLUSION**

In this article, a unitary-caring theoretical framework is revealed to guide palliative care APNs in healing-caring praxis. This new knowledge contributes to the profession and discipline of nursing in several ways. First, this knowledge invites the profession to review and explore its trajectory in guided practice. Second, the unitary-caring model for APNs’ healing-caring praxis validates the work of Cowling et al as evidenced by the exemplar. Third, this article is an invitation for nursing to expand its body of knowledge and explore the unitary-caring perspective as a potential paradigm of science within the discipline of nursing.

The unitary-caring model expressed in this article transforms ordinary standards of palliative care practice from national guidelines into a nursing values–based praxis of healing and caring. Integrating the values of caring, wholeness, pattern, meaning, relationship, consciousness, and transformation and transcendence into praxis upholds the worth of the profession and discipline of nursing. “By not being mindful of Values, we can beget the opposite, which can be harmful to self, other, the system, our world.”

This framework for caring-healing praxis brings into perspective an epistemological concern asking how the discipline of nursing might test this unitary-caring framework. Research focused from a constructivist foundation will help direct future endeavors surrounding the testing of this unitary-caring theoretical framework. Narrative inquiry will be an initial starting point to further exploration of wholeness, pattern, consciousness, caring, transformation and transcendence, relationship, and meaning. Narrative inquiry involving
the APN and the participant collectively and in full collaboration co-create a story or journey offering opportunities to gain deeper personal knowledge and meaning of phenomena surrounding palliative care. This type of narrative inquiry not only focuses on the particulars of the human experience but also invites an observation of the irreducible whole instead of a part.

Secondary qualitative data analysis can be instrumental in describing a unitary-caring praxis that has been hidden behind qualitative descriptive research. Reviewing participants’ experiences in the health, illness, death, and dying may reveal an unseen or underappreciated theme captured from a unitary-caring perspective. Cross comparisons of qualitative data between participants during caring moments/occasions may reveal shared commonalities that translate and validate this unitary-caring theoretical framework.

Finally, demonstration projects guided by a unitary-caring framework are needed to clarify this model’s meaning, language, value, utility, and relationship with the discipline of nursing. This unitary-caring framework may be conceptualized in other disciplines such as chaplaincy, social work, medicine, and other allied health professions. Adapting this unitary-caring framework would enhance care in populations (ie, pediatrics, women, and geriatric), service lines (ie, intensive care unit, long-term care, and spine), settings (ie, intensive care unit, long-term care, and home health), and independent practices (ie, primary care, psychiatric). Concept analysis on caring, wholeness, pattern, meaning, relationship, consciousness, and transformation and transcendence from a unitary-caring lens is necessary to proliferate disciplinary dialogue. Indeed, evaluation and critique of this unitary-caring framework needs to be extended for further knowledge development within the discipline and the profession of nursing.

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Appendix A

Continuum of care

Appendix B

NCP\textsuperscript{a} domain and summarized guidelines

| Domain 1: Structure and processes of care | Comprehensive interdisciplinary assessment of patient and family  
Addresses identified and expressed values, goals, and needs of patient and family |
| Domain 2: Physical aspects of care | Management of pain and other symptoms (ie, nausea/vomiting, diarrhea, constipation, and other conditions)  
Assessment of patient functional status  
Management of treatment side effects |
| Domain 3: Psychological and psychiatric aspects of care | Stress  
Emotional responses (ie, anxiety, depression, and other conditions)  
Anticipatory grief counseling  
Coping strategies discussed  
Patient understanding of disease process, symptoms, side effects, and their treatments  
Assessment of caregiving needs capacity and coping strategies  
Family understanding of disease process, symptoms, side effects, and their treatments  
Treatment decisions based on goals of care and assessment of risk and benefit  
Support emotional growth, healing, reframing, completion of unfinished business  
Bereavement services |
| Domain 4: Social aspects of care | Family structure and geographic location assessed  
Quality of relationships identified  
Establishing lines of communication  
Existing social and cultural network  
Perceived social support identified  
Medical decision making  
Finances  
Sexuality/intimacy  
Living arrangements  
Caregiver availability  
Access to transportation  
Access to prescriptions, over-the-counter medication, and nutritional products  
Access to needed durable medical equipment  
Community resources  
Access to respite services |
| Domain 5: Spiritual, religious, and existential aspects of care | Spiritual assessment  
Religious or spiritual/existential background  
Preferences identified  
Honoring related beliefs, rituals, practices of the patient and the family  
Access to preferred pastoral/spiritual care  
Education to staff, upholds dignity, respect and honor rituals, beliefs  
Meaning of disease process  
Hope, reframing |
| --- | --- |
| Domain 6: Cultural aspects of care | Cultural background assessed  
Communication with patients and family consistent with preferences regarding disclosure, truth-telling, and decision making  
Respect to accommodate the range of language, dietary and ritual practices of patient and family  
When possible, use of interpreter services  
Education to staff upholds dignity, respect and honor rituals and beliefs |
| Domain 7: Care of the imminently dying patient | Patient’s and family’s transition to actively dying phase is recognized, documented, and communicated appropriately to patient, family, and staff.  
End-of-life concerns, hopes, fears, and expectations are addressed openly and honestly  
Symptoms at end of life are assessed and treated with appropriate frequency  
Higher intensity and acuity of care during active dying phase is met and documented  
Patient/family wishes and goals regarding care setting for death are documented  
Hospice referrals  
Educating family in signs and symptoms of approaching death in a developmental-age and culturally appropriate manner |
| Domain 8: Ethical and legal aspects of care | Identify and resolve ethical dilemmas related to specific interventions such as withholding or withdrawing treatments (including nutrition and hydration)  
Instituting/verifying DNR/DNI/AND orders  
Appropriate use of sedation in palliative care  
Ethical issues documented, referrals to ethics consultants or committee as appropriate  
Medical decision making  
Advanced care planning  
Roles and responsibilities of surrogate decision makers  
Pronouncing death documented |

*aFrom National Consensus Project for Quality Palliative Care.*

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Appendix C

The palliative care advanced practice nurse (APN) in a unitary-caring praxis framework