Version acceptée de l'article

Référence

Létourneau, D., Goudreau, J. et Cara, C. (2021). Humanistic caring, a nursing competency: Modelling a metamorphosis from students to accomplished nurses. *Scandinavian Journal of Caring Sciences, 35*(1), 196-207. https://doi.org/10.1111/scs.12834

Abstract

Background: Most nursing regulatory bodies expect nurses to learn to be humanistic and caring. However, the learning process and the developmental stages of this competency remain poorly documented in the nursing literature. *Methods:* The study used interpretive phenomenology and 26 participants (students and nurses) were individually interviewed. Benner's (1994) method was adapted and concretized into a five-phase phenomenological analysis to assist with intergroup comparisons. *Results:* Critical milestones and developmental indicators were identified for each of the five stages of the "humanistic caring" competency. Satisfaction and meaning at work seemed closely connected to the development of "humanistic caring". Links emerged between the development of "humanistic caring" and three other competencies. *Conclusions:* Nurse educators might insist on the fact that "humanistic caring" goes beyond nurse-patient communication and that it is integrated in nursing care. The findings highlight that nurses' working conditions should be improved in order to uphold humanistic caring after graduation.

Keywords

Humanism; caring; competency; development; phenomenology

Introduction and background

In the nursing literature, humanistic caring has been extensively studied under a myriad of perspectives, for instance theoretically (1, 2) and about experiences that support or hinder its development (3-10). On the theoretical level, several North American theorists renewed humanistic underpinnings in the context of caring (1). One of humanism's tenets that remained in these caring theories is the belief in human growth (1). Thus, caring is conceptualized as an approach, grounded in humanism, that shapes nursing care (11). As an approach, humanistic caring can be observed in subtle behaviours and it is a way of being in relationships (11). However, humanistic caring has rarely been conceptualized as a competency that develops in successive stages.

In 2001, the National Research Council (NRC) (12) gave priority to "the development of cognitive models of learning" and urged the scientific community to increase "research on how students learn in actual educational settings" (p. 299). The NRC asserted that such models, grounded in research results, would enhance the validity and fairness of students' assessment. It is presumed that these models play a pivotal role in competency-based education as they support educators in bringing their curriculum's learning targets closer to the actual developmental stage of their learners (13, 14).

Competency development and cognitive learning model

Tardif (14) postulated that a competency is a "complex know-act based on the effective mobilization and combination of knowledge, skills, attitudes, and external resources [that are] adequately applied in a specific family of situations." (p. 22) [free translation] He also defined a cognitive learning model (CLM) as a representation of a competency's critical milestones (also known as key learnings) that learners need to achieve in order to

move on from one developmental stage to another. A critical milestone is qualitative in nature, mutually exclusive at each developmental stage, and corresponds to a cognitive transformation or reorganization that may generate new practices in learners (14). Critical milestones may be materialized into one or several developmental indicators, which represent concrete changes in learners' practice (14). Tardif (14) specified that a developmental indicator is unique at each developmental stage in order to avoid ambiguity in the evaluation process of competencies, and that it may determine one or more critical milestones.

To the knowledge of the authors, humanistic caring has not been investigated through the lens of a competency that develops during nursing education and clinical practice. Three studies (15-17) aimed to identify developmental stages of caring for nurses. In these studies, the development of caring was divided into five (15, 17) or three (16) stages. In Paragas' study (17), caring evolved from being outcome-oriented (first stage) to an achievement of a transcendent level of self-fulfilment (fifth stage). An atypical progression of caring was found out in another study (16) in which intermediate nurses (second stage) expressed a lower amount of *caritas* processes in their narratives as compared to novice nurses (first stage). The last study (15) revealed the changing perspective of caring along the continuum: from responding to comfort needs (first stage) to demonstrating a deep understanding of the meaning of health and illness for patients (fifth stage). Although these three studies explored the development of caring, they only documented it after graduation and proved to lack explicitness about the critical milestones to be achieved from one stage to another.

Given these findings, a phenomenological study was conducted to develop a CLM of the "humanistic caring" competency from the lived experiences of nursing students and graduates of a competency-based program, and to identify related developmental indicators. The CLM is presented in this paper, but other phenomenological results of this study are reported elsewhere (18).

Method

Benner's (19) interpretive phenomenology was used to assist in interpreting the meanings of "developing humanistic caring" as lived experiences, from the perspectives of nursing students and graduates of a competency-based program.

Ethical Considerations

The study was approved by the ethical review board of the hospital where the recruitment of nurses took place (certificate No. FUM-8038). The university's ethical review board recognized this certificate. Before their involvement in the study, nursing students and nurses provided written consent.

Setting

A French-Canadian university was the setting where nursing students were recruited. This 3-year undergraduate nursing education program leads to registration as a nurse. This program has been grounded in a competency-based approach (CBA) since 2004 (20) and was oriented by a framework comprising eight competencies to develop, one of them being "humanistic caring" (21). An affiliated French-speaking university hospital was the setting where graduates from the same university were recruited.

Recruitment of Participants

This study used convenience and snowball sampling methods to recruit participants (22). In terms of inclusion criteria (there were no exclusion criteria), all participants (*n* = 26) had to speak and understand French and be interested in sharing their experiences pertaining to learning the “humanistic caring” competency. Also, all participants had to be a student or graduate from the same CBA program comprising a “humanistic caring” competency. As shown in Table 1, students were recruited in three groups depending on their progression in the education program, and nurses in three other groups according to their clinical experience. Accomplished nurses self-reported that they received eulogies from patients or their colleagues about being exemplary humanistic and caring individuals (23).

Data Collection

From September 2015 to February 2017, the PI collected data through a semi-structured individual interview with each participant (*n* = 26), supported by an interviewing guide (24). Participants were asked questions such as: “What is the meaning of caring for a person with humanism?”; and “Tell me of an experience where you believe you have been humanistic with a person, a family, or a community”. Interviews lasted between 40 and 119 minutes (average: 63 minutes). They were recorded, transcribed by an experienced typist and reread by the PI to ensure accuracy. Data collection and analysis were conducted concurrently.

Data Analysis

The verbatim were imported into ATLAS.ti 8, a software supporting qualitative data analysis. In Table 2, Benner's (19) phenomenological method, adapted for data analysis to reach intergroup comparisons, was conceptualized in five iterative phases (25). As data analysis started, the PI thought about and wrote down his pre-understanding (i.e. preconceptions and assumptions) regarding the studied phenomena. Among the 15 reflective statements that were written down, the PI posited that humanistic caring was relational in nature, that it could develop before and after graduation, and that it would most likely not be described in terms of reciprocity, mutuality, and belief in the growth potential of patients. Many aspects of this pre-understanding were reinforced while analysing the data, but others were challenged and evolved as well. For instance, the assumption that the conception of humanistic caring would be devoid of reciprocal relationships changed as it was rather salient for few participants. Other than these pre-understanding entries, the PI wrote down reflective notes after each interview; after rereading and analysing each transcribed verbatim; before analysing each group of participants.

Study's Rigor

The study's rigor was based on four criteria: authenticity, credibility, criticality, and integrity (26). To ensure *authenticity* (26), several interpretative iterations were performed through the five stages of data analysis as well as following Benner's method (19). In addition, the interpretation process was systematically reviewed by two researchers (JG and CC) in the five stages of analysis. It is worth mentioning that one of them (CC) was an experimented phenomenologist, having conducted several

phenomenological studies. Although the PI has reflected and noted his pre-understanding in the reflective journal, it is very likely that this, as well as the other two researchers' pre-understanding, influenced the process of interpretation and that they represent, according to Sandelowski (27), a threat to *credibility*. However, several findings of this study presented at conferences have been recognized by people who were in contact with students and nurses, suggesting credibility (27). The reflections written down in the reflective journal and the openness of the PI during discussions with the two researchers supported *criticality* (26). For instance, these iterative reflections led the PI to explore alternatives to his interpretations and to pay attention to atypical or ambiguous divergences that he perceived in participants' experiences. As for *integrity* (26), the interpretative process used in this study corresponded to numerous iterations between the parts and the whole of the narratives, which could bring the interpretation closer to the data collected. Integrity was further enhanced by the rigorous recording of the decisions that were made about the interpretation process in the PI's reflective journal (26).

Findings

The findings are presented in accordance to the five identified developmental stages of the "humanistic caring" competency. Each stage comprises a table (Tables 3 to 7) that presents its critical milestones and developmental indicators that are grouped together to highlight logical links between the two. At the end, a metaphoric representation of the CLM (Figure 1) is exposed. In the following paragraphs, the capitalization of the *Person* means that it can represent individuals, family members and relatives, the community or the population (11).

Stage 1: Conscientization to Humanization of Care

The first developmental stage of the "humanistic caring" competency takes place during the first year of the education program and is mainly characterized by a conscientization to humanization of care. There are five critical milestones that are concretized into 11 developmental indicators. The foremost critical milestone at the basis of the competency's development corresponds to the conceptualization of the Person as a human being. It appears that humanization of care may not take place without conceptualizing patients as human beings rather than "things" or "objects". Furthermore, it is during the first year of the education program that students are initially exposed to learning nursing care procedures. In this study, most first-year students appeared focused on and concerned about learning these procedures. One of the developmental indicators of this stage is to consider the existence of the individual when conducting a procedure, rather than being focused solely on its technical aspect. Yet, it appeared to be a challenge for first-year students as highlighted in the following excerpt:

[...] When you just have your procedure in mind, you can't be humanistic at the same time. It's really hard to insert a Foley catheter and then be like 'it's going to hurt,' you just think about 'how you can't spill [urine] in the bed'." (Justine, a first-year student)

A second critical milestone, which stems from students' observations and practice in clinical placements, is the realization of the potential benefits of humanization of care for the Person and the nurse. A third critical milestone is the sufficient mastery of active listening that the students experience in their clinical placements in order to establish a relationship with the Person. This milestone is concretized when first-year students seize the opportunities to develop said relationship with the Person. Few other indicators

embody this milestone, for instance when students actively listen to what is verbally shared by the Person. A fourth critical milestone, which is closely linked to the previous one, is an understanding of the influence of factors on the development of the relationship with the Person. Again, first-year students attempt to pay attention to their verbal and nonverbal communication, avoiding undermining the relationship they are trying to develop with the Person.

Stage 2: Assimilation of Communication Skills Integrated in a Humanistic Approach

The second developmental stage of the "humanistic caring" competency takes place during the second year of the education program and is characterized by primacy given to assimilating communication skills integrated in a humanistic approach. There are eight critical milestones that are concretized into 11 developmental indicators. It is common for second-year students to subordinate communication to other types of care, including care procedures and biophysical health assessment. This subordination seemed to arise from the students' understanding of which nursing care was considered "important" in their clinical placements, and this could be validated or not by their nurse preceptors. The excerpt of this second-year student underscores this subordination:

"I was providing care and when I had about fifteen minutes [available], I talked to my patient. I wasn't taking the time at the beginning of my shift to be 'super caring' [...] But it is true that there are clinical placements, depending on your nurse preceptor and the environment, which do not allow you to [talk] as much as you want." (Dencia, a second-year student)

Therefore, a critical milestone that ensures the development of the competency is the reconciliation of the importance given to the learning of communication skills with that of procedures and assessment of biophysical health. Second-year students practice several communication skills, including reflecting, closed and systemic questions, in addition to active listening. Despite this emphasis on communication skills, a second critical milestone of this developmental stage is the realization that a humanistic approach must be integrated into nursing care without being limited to communicating with the Person. Different developmental indicators materialize this critical milestone, especially when second-year students take time to explain their interventions and get to know the individual beyond his/her health problem.

A third critical milestone corresponds to a theoretical understanding of humanism and caring. However, second-year students are unable to bridge this theoretical understanding to their clinical practice. In this study, second-year students could explain humanism and caring quite extensively on the theoretical level, but when speaking about their practice, the scope to which it was applied remained rather narrow. In addition, students develop a relationship that brings them closer to the Person, but they remain concerned about respecting the nursing code of ethics regarding nurse-patient relationships. In order to ensure the development of the competency, a fourth critical milestone corresponds to a reconceptualization of the relationship between the nurse and the Person regarding relational proximity.

Moreover, three other critical milestones to be accomplished involve humanization and dehumanization of care. The first one is an openness to the understanding of the impacts of dehumanization of care for the Person (especially the individual). The second

milestone is a foundation of professional identity and ideal of practice on humanization of care. This is materialized when second-year students describe the ideal nursing practice in comparison to the one that they manage to implement. In the present study, second-year students started constructing the image of who they aspired to become as professionals, based on their observations of nurses in their clinical placements. In the third critical milestone, from the realization of the virtuous circle between humanization of care and its potential benefits, second-year students realize that these benefits and the gratitude expressed by the Person both constitute positive reinforcements that encourage them to continue their competency development.

Stage 3: Reconciliation of an Ideal of Humanistic Practice with the Responsibilities of a Nurse

The third developmental stage of the "humanistic caring" competency extends from the third year of the education program to the first 18 months after graduation. There are three critical milestones that are concretized into seven developmental indicators. This third stage is characterized by a reconciliation of an ideal of humanistic practice with the responsibilities of a nurse. In this context, there appears to be a slowdown in the competency's development during the student-to-nurse transition, particularly because of a duality between the third-year students' ideal of humanistic practice and what the newly graduated nurse manages to put into action. In this study, this slowdown is observed in the newly graduated nurse by a reduction in developmental indicators that were more present in third-year participants. In connection with the duality discussed above, several third-year students voiced their concerns related to the maintenance of their ideal of humanistic practice after their graduation. The following newly graduated nurse points

out the subordination of humanization of care and she expresses her dismay facing a duality with her desires to provide such care:

“It's true that when you have time and you’re done with your care, well, this is when we [nurses] will go talk to the family, I think it's secondary [...] But it's true, you have to be done with your care [...] But it's not because we don't want to, we don't have time, honestly, it’s unfortunate, I'd like to have more time to talk with the family but, yes, it's often secondary.” (Emeley, a newly graduated nurse)

Thus, a first critical milestone of this developmental stage is the integration of the reality of clinical practice into an ideal of humanistic practice, otherwise newly graduated nurses may experience a serious disenchantment resulting from the impossibility of practicing according to said ideal. In this regard, it is imperative that newly graduated nurses realize, on a practical level, that the adoption of a humanistic approach does not necessarily depend on the temporal factor. For instance, that the quality of their presence, even if it is brief, can humanize care. In other words, the understanding of the potential benefits of the nurse’s authentic presence for the Person and his/her family is a second critical milestone. These two milestones are concretized when students explain their professional role from an ideal of humanistic practice and identify opportunities for humanization of care with a full nurses’ workload. However, to grasp these opportunities, the conception of humanism and caring of students and nurses must integrate the relational dimension of nursing (third critical milestone). Indeed, students’ and nurses’ conception of humanization of care must expand beyond communication skills.

Stage 4: Integration of a Humanistic Approach in Nursing Care

The fourth developmental stage of the "humanistic caring" competency, between two and four years after graduation, is mainly characterized by the integration of a humanistic approach in nursing care. There are five critical milestones that are concretized into ten developmental indicators. At this stage, experienced nurses reconnect with their ideal of humanistic practice to the extent of conceptualizing humanization of care as the nurse's professional duty, which corresponds to a first critical milestone. Indeed, the importance that experienced nurses place on humanization of care grows to the point of initiating an expression of clinical nursing leadership to their peers so that they humanize care in return. This is operationalized into two developmental indicators, including recognizing the humanization of care of the nurse's peers and opening a dialogue with them about dehumanizing practices.

Faced with work overload, the experienced nurse learns to tap into the meaning and satisfaction at work, which emerges from the gratitude expressed by the Person, in order to persevere and humanize care. This developmental indicator is highlighted in the following excerpt:

"The 'thank you's' are what matters to me, because sometime in a chaotic day, to receive 'one' smile, to see 'one' patient ambulating, 'one' patient who says 'thank you', it makes you feel good. You know, you're tired, you're depleted at the end of the day, but you come back the next day, and not reluctantly." (Kim, an experienced nurse)

In addition, experienced nurses realize that they humanize care by focusing on the "little details" that have a valuable meaning for the Person and that make a difference in his/her health experience, and this corresponds to a second critical milestone. Also, nurses

promote the establishment of a relationship with the Person by adjusting their attitudes, particularly in terms of nonverbal communication, which displays that they are available and that they can “be with” said Person, even when time seems limited. The nurses’ conception of the relationship with the Person integrates the transient feature of moments they share together (i.e. reciprocity), which corresponds to the third critical milestone underlying the two above-stated developmental indicators.

At this stage, a fourth critical milestone is related to nurses’ demonstration of clinical reasoning in nursing, particularly as they take more the Person's concerns and priorities into account, which also modifies the resulting interventions. A fifth critical milestone is an understanding of the contribution of humanization of care to the Person’s safety. In this regard, experienced nurses realize that the Person is more likely to open up and share data that could help them ensure his/her safety.

Stage 5: Mastery of a Humanistic Approach in the Work Environment

The fifth and last developmental stage of the “humanistic caring” competency appears about five years after graduation and is mainly characterized by the mastery of a humanistic approach in the work environment. Seven critical milestones are concretized into 17 developmental indicators. It is during this stage that there is a transformation of accomplished nurses’ ideal of humanistic practice into an imperative, which corresponds to a first critical milestone. This transformation is manifested in the form of accomplished nurses’ “obligation” to maintain their humanistic approach by coping with the various barriers that are opposed to it, specifically the work overload that they still recognize its existence in the clinical settings.

Aiming at promoting humanization of care in their work environment, accomplished nurses further deploy their clinical nursing leadership, a second critical milestone. This deployment is manifested when accomplished nurses embody a humanistic approach in their relationships with their peers in order to inspire them to humanize care. A third critical milestone is the creation of cognitive shortcuts between the vast and orderly repertoire of prototypical clinical situations and interventions to humanize care. When clinical expertise is reached, the matrix of clinical situations encountered by nurses over the course of their career is henceforth structured in a complex, yet organized, repertoire. Concretely, this allows accomplished nurses to intervene proactively by anticipating and validating the Person's concerns and priorities, acting ahead of them in order to ensure comfort and well-being.

A fourth critical milestone is the achievement of a maturity in relation to the existence and death of human beings. This milestone is reflected in the accomplished nurse's ability to find the appropriate words to reply to delicate matters verbalized by the Person and his/her family. The following excerpt, which is also an exemplar, reveals this developmental indicator:

"So, we [patient's mother and the nurse] went out [of the room] and she said: 'Mihaela, I can't, I can't tell him [dying son] that he can leave.' And then for me it was like 'she really needs to talk', and I asked her: 'Do you think that's what he [the son] needs to hear?' And she said: 'Yes, because he told me, when he was well, that I was going to feel too saddened if he left, but I want to remove that burden from him, and let him know that it's okay.' But the mother said: 'I'm not ready, I'm not capable.' I just replied: 'Why don't you just tell him that?' And she asked: 'Do you think it's okay to do that?', and I

answered, 'Why wouldn't it be?' […] And that is what she did in the end." (Mihaela, an accomplished nurse)

Discussion

In Figure 1, the metamorphosis of a caterpillar into a butterfly symbolizes the cognitive transformations (critical milestones) that ensured the development of the "humanistic caring" competency in five stages. This developmental trajectory is illustrated by an arrow that wraps itself around the loop and the two twisted ribbons. This highlights the close ties that remained between the competency's development and the ideal of humanistic practice, as well as its integration into nursing care, which will be further explained in the following paragraphs.

Overall, communication skills played a significant role in the development of the competency mostly because of their link with the students' conception of humanistic caring. In Figure 1, the two ends of the lace forming a loop indicate the humanistic approach and nursing care. Initially, these two extremities are distant from each other in order to illustrate the gap noted in this study in relation to the conception of the "humanistic caring" competency with nursing care. This conception echoes with the results of an exploratory-descriptive study (28) in which Scottish nursing students perceived a clear relationship between compassionate care and communication with patients. In the present study, students learned humanism and caring theoretically at the second stage and started transferring this theoretical understanding into practice at the third stage. Rather than being conceptualized as isolated from other nursing activities and focused primarily on communication, the approach that results from the "humanistic

caring" competency was integrated into nursing care at the fourth stage (the two ends of the lace in Figure 1 progressively moving closer until forming a loop).

In addition, the entire developmental trajectory was interspersed with critical milestones and developmental indicators related to several realizations, for instance the potential benefits of humanization of care for the Person and for the nurse (stage 1), the meaning and satisfaction at work, and the gratitude that is expressed to him/her. These findings contrast with the nursing literature where the sense of fulfillment at work was connected to the caring competency only in the last developmental stage, this fulfillment being described as the "ultimate achievement of the nurse" by Paragas (17). Even if second-year students (stage 2) could understand the virtuous cycle between humanization of care and its potential benefits, it is only the experienced nurses (stage 4) that could operationalize this cycle by tapping into meaning and satisfaction to humanize care. This finding is akin to the results of a grounded theory study (29) in which Iranian nurses' energy to humanize care was renewed as the consequence of receiving the reward of such care (i.e. appreciation and recognition).

During the competency's development, the ideal of humanistic practice that awakened mainly at the second stage evolved and distanced itself from the reality of clinical practice of the newly graduated nurse at the third stage. In Figure 1, this is illustrated by the two twirling ribbons, one being the ideal of humanistic practice and the second the actual practice, gradually moving away from each other to reach their paroxysm at the third developmental stage. Even third-year students had fears of losing touch with their ideal of humanistic practice after graduation, a finding that corroborates the results of an interpretive study conducted with British students (30). In the present study, the

distancing emerged from a tension between newly graduated nurse's desire to embrace humanistic caring with what they managed to practice. The newly graduated nurse seemed to struggle with a full nurse's workload, and this ordeal led him/her to subordinate humanistic caring because he/she perceived it as time-consuming. In this respect, the subordination of humanistic caring that was observed in this study at the second and third stages was also revealed by British nurses in a grounded theory study (31). Indeed, these participants described caring as the "extra mile" that they no longer had time for, a perception that resonates with the findings of the present study. The duality that was observed at the third stage resolved at the fourth (the two ribbons of Figure 1 meeting together), and it is at the fifth that an ideal of humanistic practice was transformed into an imperative.

Other features of the development include relations between humanistic caring and the "act in a professional manner" competency at the first two stages. Indeed, the "humanistic caring" competency's development appeared intertwined with the understanding of the nursing code of ethics regarding the nurse-patient relationship. More specifically, several first-year students feared to cross the "professional boundaries" as a result of being "too close" to their patients. Australian nursing students shared the same concern in a grounded theory study (32) in which they were uncertain about professional boundaries and the degree of emotional involvement with patients required for a compassionate practice.

At the fourth stage, relations arose between humanistic caring and the "clinical reasoning in nursing" competency with respect to the Person's concerns and priorities, as well as his/her safety. In their collaborative research, Boyer, Tardif (33) pointed out that the third

and last developmental stage of students' nursing clinical judgment involved fostering a collaborative nurse-patient relationship. The same authors argued that this relationship resulted in actively soliciting the patients' views, which reciprocally modified the students' clinical judgment. This evolution was outlined in the findings of the current study, suggesting that patients' concerns and priorities became more important in the clinical reasoning of experienced nurses. The results also emphasized that developing relationships with patients through humanization of care was indirectly aimed at ensuring their safety.

Other relations are also present at the fourth stage with the "clinical reasoning leadership" competency, but the last is really deployed at the fifth stage with the accomplished nurses' embodiment of a humanistic approach with their peers. In parallel with this finding, the CLM of clinical leadership that Pepin, Dubois (34) developed in their phenomenologically inspired study outlined that active leadership with the nurse's team emerged mainly in expert nurses (stage 4). One of the distinctive features of clinical leadership in the present study was that accomplished nurses mobilized their colleagues through their humanistic approach, and this was specifically intended to humanize care.

In terms of practice implications, the CLM of the "humanistic caring" competency highlights the importance of harmonizing the entry into practice after training. Humanizing care in current healthcare settings seems to be a challenge for most nurses, but this challenge appears even more difficult for new graduates. Having to assimilate the role and responsibilities of a nurse, fairly quickly, leaves little room for integrating humanization of care into their practice. As mentioned earlier, the development of the "humanistic caring" competency can be easily compromised by its devaluation coming

from nurses who accompany new graduates, whose ideal of humanistic practice remains vulnerable at this stage. It is also important that the feedback offered to new graduates by these nurses avoid focusing only on the biophysical and procedural dimensions of nursing. Otherwise, newly graduated nurses may mistakenly assume that humanization of care is not concretized in clinical practice, that it is not encouraged, or that it is of no value in the workplace. In our view, providing such feedback does not require more time, but requires nurses to be more attentive to this dimension of nursing care when accompanying new graduates.

Study Limitations

A first limitation stems from the cross-sectional design that was chosen to understand the development of the “humanistic caring” competency. Because of time constraints in a doctoral program, it was not possible to conduct a longitudinal study and interview the same participants over the years of their academic and clinical training, which would have been most likely ideal to capture their progression in terms of humanistic caring. However, it is possible that a longitudinal design would have jeopardized the recruitment of participants because of their increased involvement in the study.

A second limitation emerges from the moderately instrumental use of phenomenology in this study. As opposed to a “pure” phenomenological design, this work primarily aimed at understanding the lived experiences in its broader meaning and focused less on the description of how these experiences gave themselves to the consciousness of the participants (35). This could be seen as a methodological limitation because it attributes a secondary nature to the experience, losing the original sense of phenomenology (35). In order to attenuate this limitation, the PI strived to understand and respect the

philosophical underpinnings of interpretive phenomenology (24, 36) and he was supervised by a researcher (CC) who had extensive academic experience with phenomenological studies.

Conclusion

The findings of the study revealed that humanistic caring is developed in stages through nursing education and clinical practice. Certainly, this is the first CLM to reveal relationships between the development of the "humanistic caring" competency and other nursing competencies such as "act in a professional manner", "clinical reasoning in nursing", and "clinical nursing leadership". This finding illustrates how nursing students and nurses develop their competencies synergistically and in an integrated manner instead of compartmentalizing each of them separately. Nonetheless, students and the newly graduated nurse made a clear distinction between humanistic caring and other nursing care, and the connection between the two only sprung forth late in their career. The lack of integration of humanistic caring into nursing care appeared to worsen the newly graduated nurse's disenchantment with his/her practice, feeling that time constraints prevented humanization of care. This belief was further amplified due to humanistic caring being highly synonymous with nurse-patient communication. Despite this conception, there were chaotic work environments described by participants that appeared significantly detrimental to humanistic caring. However, as suggested by Pearcey (31), humanistic caring might require "extra efforts", but not necessarily "extra time". Consequently, the present authors invite educators, of both academic and clinical settings, to insist on the fact that humanistic caring is an approach, hence its

omnipresence in nursing care, rather than being solely an intervention purely based on communication.

However, this clarification alone will most likely not resolve the slowdown observed in the competency's development for the newly graduated nurse. If humanistic caring is to be a professional requirement as argued by most nursing regulatory bodies and professional associations, and based on the findings reported in this study, the present authors strongly invite the members of the discipline to improve the nurses' working conditions. Assuredly, the study's findings demonstrate that preparing nursing students to face these conditions alone may not be sufficient to sustain humanistic caring after graduation.

References

1. Létourneau D, Cara C, Goudreau J. Humanizing nursing care: An analysis of caring theories through the lens of humanism. Int J Hum Caring. 2017;21:32-40.

2. Watson J. Human caring science: A theory of nursing. 2 ed. Sudbury, MA: Jones & Bartlett Learning; 2012.

3. Hunter D, McCallum J, Howes D. Compassion in emergency departments. Part 2: Barriers to the provision of compassionate care. Emerg Nurse. 2018;26(3):28-33.

4. Hunter D, McCallum J, Howes D. Compassion in emergency departments. Part 3: Enabling and supporting delivery of compassionate care. Emerg Nurse. 2018;26(4):28-31.

5. Logan KA. Meta-synthesis of caring within nursing education [Thèse de doctorat]2017.

6. Curtis K, Gallagher A, Ramage C, Montgomery J, Martin C, Leng J, et al. Using appreciative inquiry to develop, implement and evaluate a multi-organisation 'Cultivating Compassion' programme for health professionals and support staff. J Res Nurs. 2017;22:150-65.

7. Wiechula R, Conroy T, Kitson AL, Marshall RJ, Whitaker N, Rasmussen P. Umbrella review of the evidence: What factors influence the caring relationship between a nurse and patient? J Adv Nurs. 2016;72:723-34.

8. Chen CS, Chan SW-C, Chan MF, Yap SF, Wang W, Kowitlawakul Y. Nurses' perceptions of psychosocial care and barriers to its provision: A qualitative study. The Journal of Nursing Research. 2017;25(6):411-8.

9. Enns CL, Sawatzky J-AV. Emergency nurses' perspectives: Factors affecting caring. J Emerg Nurs. 2016;42:240-5.

10. Christiansen A, O'Brien MR, Kirton JA, Zubairu K, Bray L. Delivering compassionate care: The enablers and barriers. Br J Nurs. 2015;24:833-7.

11. Cara C, Gauvin-Lepage J, Lefebvre H, Létourneau D, Alderson M, Larue C, et al. Le Modèle humaniste des soins infirmiers – UdeM : perspective novatrice et pragmatique. Rech Soins Infirm. 2016;125:20-31.

12. National Research Council. Knowing what students know. The science and design of educational assessment. Washington, DC: National Academies Press; 2001.

13. Boyer L. Coconstruction d'un modèle cognitif de l'apprentissage d'une compétence en vue d'assurer la validité et l'équité de son évaluation : le cas de la compétence « Exercer un jugement clinique infirmier » [Thèse de doctorat]2013.

14. Tardif J. L'évaluation des compétences. Documenter le parcours de développement. Montréal, Québec: Chenelière Éducation; 2006.

15. Haag-Heitman B. Developing the Clinical Practice Development Model at St. Luke's Medical Center. In: Haag-Heitman B, editor. Clinical practice development using Novice to Expert theory. Gaithersburg, MD: Aspen Publishers; 1999. p. 43-64.

16. Norman V, Rutledge DN, Keefer-Lynch AM, Albeg G. Uncovering and recognizing nurse caring from clinical narratives. Holist Nurs Pract. 2008;22:324-35.

17. Paragas ED. “The upward spiral staircase of caring”: A hermeneutic phenomenology study of the caring competency of Filipino nurses grounded in competency-based education. Journal of Competency-Based Education. 2019;4:1-11.

18. Létourneau D, Goudreau J, Cara C. Facilitating and hindering experiences to the development of humanistic caring in the academic and clinical settings: An interpretive phenomenological study with nursing students and nurses. Manuscrit soumis pour publication.2019.

19. Benner P. Interpretive phenomenology: Embodiment, caring, and ethics in health and illness. Thousand Oaks, CA: SAGE; 1994.

20. Goudreau J, Boyer L. Dix ans de mise en oeuvre d'un programme de 1er cycle universitaire en sciences infirmières basé sur l'approche par compétences : toujours des enjeux d'évaluation. In: Poumay M, Tardif J, Georges F, editors. Organiser la formation à partir des compétences Un pari gagnant pour l'apprentissage dans le supérieur. Louvain-la-Neuve, Belgique: De Boeck Supérieur; 2017. p. 63-80.

21. Faculté des sciences infirmières de l'Université de Montréal. Référentiel de compétences. Baccalauréat en sciences infirmières. 2 ed. Montréal, Québec: Auteur; 2015.

22. Gray JR, Grove SK, Sutherland S. Burns and Grove's The practice of nursing research: Appraisal, synthesis, and generation of evidence. 8 ed. Saint-Louis, MO: Elsevier; 2017.

23. Graber DR, Mitcham MD. Compassionate clinicians: Take patient care beyond the ordinary. Holist Nurs Pract. 2004;18:87-94.

24. Munhall PL. Nursing research: A qualitative perspective. 5 ed. Sudbury, MA: Jones & Bartlett Learning; 2012.

25. Crist JD, Tanner CA. Interpretation/analysis methods in hermeneutic interpretive phenomenology. Nurs Res. 2003;52:202-5.

26. Whittemore R, Chase SK, Mandle CL. Validity in qualitative research. Qual Health Res. 2001;11:522-37.

27. Sandelowski M. The problem of rigor in qualitative research. Adv Nurs Sci. 1986;8(3):27-37.

28. Hunter D, McCallum J, Howes D. Compassion in emergency departments. Part 1: Nursing students' perspectives. Emerg Nurse. 2018;26(2):25-30.

29. Khademi M, Mohammadi E, Vanaki Z. A grounded theory of humanistic nursing in acute care work environments. Nurs Ethics. 2017;24:908-21.

30. Pearcey P, Draper P. Exploring clinical nursing experiences: Listening to student nurses. Nurse Educ Today. 2008;28:595-601.

31. Pearcey P. 'Caring? It's the little things we are not supposed to do anymore'. Int J Nurs Pract. 2010;16:51-6.

32. Curtis K. Learning the requirements for compassionate practice: Student vulnerability and courage. Nurs Ethics. 2014;21:210-23.

33. Boyer L, Tardif J, Lefebvre H. From a medical problem to a health experience: How nursing students think in clinical situations. J Nurs Educ. 2015;54:625-32.

34. Pepin J, Dubois S, Girard F, Tardif J, Ha L. A cognitive learning model of clinical nursing leadership. Nurse Educ Today. 2011;31:268-73.

35. van Manen M. Phenomenology in its original sense. Qual Health Res. 2017;27:810-25.

36. Heidegger M. Being and time. 2 ed. New York, NY: HarperCollins; 2008.

Table 1

Sociodemographic characteristics of participants (*n* = 26)

Characteristics	Students (*n* = 18)	Nurses (*n* = 8)
Progression in program		
First year of education program completed (or in the process of)	3	-
Second year of education program completed (or in the process of)	9	-
Reached the end of the third year	6	-
Clinical Experience		
6-18 months (newly graduated nurse)	-	1
2-4 years (experienced nurses)	-	3
5+ years (accomplished nurses)	-	4
Gender		
Identified as female	17	7
Identified as male	1	1
Age		
Mean age (years)	24	30
20-29 years old	16	2
30-39 years old	2	6

Table 2

Concretization of Benner's phenomenological data analysis in five phases

Phases	Concrete data analysis
Phases 1 and 2: Lines of inquiry, central concerns, and exemplars	• Individual analysis • Naming meaning units in ATLAS.ti • Understanding participants' central concerns embedded in their experiences • Summarization of central concerns in a document in which exemplars are added (exemplars are salient verbatim representing a similar or divergent dimension about participants' experience) • Creation of individual interpretive summaries
Phase 3: Shared meanings	• Interparticipant analysis • Uncovering shared meanings one group at a time • Refinement of shared meanings in interpretative group summaries
Phase 4: Final interpretations	• Intergroup analysis • Comparison of the six interpretive group summaries • Delimitation of the "humanistic caring" competency's developmental stages • Identification of critical milestones • Creation of a preliminary version of a cognitive learning model (CLM) of the competency
Phase 5: Dissemination of the interpretation	• Refinement of the CLM through numerous iterations • Removal, modification, and combination of critical milestones • Concretization of critical milestones into developmental indicators

	• Feedback obtained from three independent experts regarding the 13th version of the CLM (i.e. competency's progression, clarity and precision of both critical milestones and developmental indicators) • Adjustment of the CLM according to experts' feedback

Table 3

Critical milestones and developmental indicators of stage 1

Critical milestones	Developmental indicators
Conceptualization of the Person as a human being Realization of potential benefits of humanization of care for both the Person and the nurse	Cares for the Person as a human being Is concerned to respect the Person's human dignity Considers, in the organization of care and procedures, the Person's existence and preferences Chooses interventions by putting self in the Person's shoes Identifies benefits for both the Person and self resulting from humanization of care Notices dehumanization of care in clinical practice Questions the links between work overload and dehumanization of care
Sufficient mastery of active listening	Actively listens to what is verbally shared by the Person Inquires about the state of the Person

Understanding of the nursing code of ethics regarding the relationship with the Person	Seizes opportunities to develop a relationship with a Person by demonstrating authenticity and respecting the nursing code of ethics
Understanding of the influence of factors on the development of a relationship with the Person	Is attentive to his/her own and the Person's verbal and nonverbal communication

Table 4

Critical milestones and developmental indicators of stage 2

Critical milestones	Developmental indicators
Reconciliation of the importance given to the learning of communication skills with that of procedures and assessment of biophysical health Understanding of the main impacts of a health experience for the Person and his/her family Openness to understand the impacts of dehumanization of care for the Person	Takes time to communicate with the Person by asking open and systemic questions Manifests sensibility and empathy toward the health experience lived by the Person and his/her family Explains impacts of dehumanization of care for the Person
Foundation of professional identity and ideal of practice on humanization of care Realization of the virtuous circle between humanization of care and its potential benefits	Describes the ideal nursing practice in relation to the one he/she manages to put into action Identifies issues surrounding humanization of care for his/her future practice as well as the circumstances that contribute to his/her satisfaction and meaning at work

Theoretical understanding of humanism and caring	Explains humanism and caring on the theoretical level
Realization that a humanistic approach must be integrated into nursing care	Gets to know the Person beyond his/her health problem
Reconceptualization of the relationship between the nurse and the Person regarding relational proximity	Takes the time to explain his/her interventions to the Person
	Demonstrates flexibility in the organization of care in order to move closer to a partnership with the Person
	Recognizes the existence of the Person's family
	Distinguishes a relational proximity from a breach to the nursing code of ethics regarding the relationship with the Person

Table 5

Critical milestones and developmental indicators of stage 3

Critical milestones	Developmental indicators
Integration of the reality of clinical practice into an ideal of humanistic practice	Explains his/her professional role from an ideal of humanistic practice Identifies opportunities for humanization of care with a full workload of a nurse
Integration of the relational dimension of nursing into the conception of humanism and caring Understanding of the potential benefits of the nurse's authentic presence for the Person and his/her family	Highlights the Person's growth potential Manages to establish a relationship with the Person Considers exploring the meaning given by the Person to his/her health experience while choosing interventions Reassures the Person and his/her family when they manifest this priority Attempts to respond to the Person's choices and wishes when they are verbalized

Table 6

Critical milestones and developmental indicators of stage 4

Critical milestones	Developmental indicators
Conceptualization of humanization of care as the nurse's professional duty	Recognizes the humanization of care of his/her peers Opens a dialogue with his/her peers about dehumanizing practices Tap into the meaning and satisfaction at work in order to humanize care
Prioritization of the "little details" that humanize care Integration of the transitory feature of moments of reciprocity in the conception of the relationship with the Person	Seeks to achieve the "little details" that make a difference in the Person's health experience Offers availability to the Person by an authentic presence despite work overload Promotes the establishment of the relationship with the Person by adjusting his/her humanistic approach, by modulating his/her attitude, and by dealing with environmental barriers

	Demonstrates compassion through the appropriate use of therapeutic touch with the Person
Integration of humanization of care in the process of clinical reasoning in nursing Understanding of the contribution of humanization of care to the Person's safety	Prioritizes and interprets the collected data in light of the Person's concerns and priorities Designs the care according to the Person's concerns and priorities Ensures the Person's safety by sustaining a relationship with him/her

Table 7

Critical milestones and developmental indicators of stage 5

Critical milestones	Developmental indicators
Transformation of an ideal of humanistic practice into an imperative Deployment of clinical nursing leadership to promote humanization of care in the work environment	Maintains his/her humanistic approach by coping with the various barriers that are opposed to it Embodies a humanistic approach in his/her relationships with his/her peers in order to inspire them to humanize care Seeks help from various actors in the workplace and is creative in choosing interventions to address the Person's concerns and priorities
Creation of cognitive shortcuts between the vast and orderly repertoire of prototypical clinical situations and interventions to humanize care	Intervenes proactively by anticipating and validating the concerns and priorities of the Person living a prototypical clinical situation
Mastery of the mobilization of affective resources such as receptivity, sensibility, empathy, and attitudes	Perceives and interprets, with accuracy and ease, the furtive signs in the Person's verbal and nonverbal communication

	Modulates his/her attitude and interventions, spontaneously in the present moment, according to the concerns, priorities, and his/her interpretation of the Person's furtive signs Establishes easily a relationship with the Person and his/her family by getting to know them in a friendly way rather than mechanically Accompanies each member of the same family simultaneously according to their respective concerns and priorities
Achievement of a maturity in relation to the existence and death of the human being	Finds the appropriate words to reply to delicate matters verbalized by the Person and his/her family Manifests ease in exploring the Person's wishes in an end-of-life situation Is an advocate of the Person's wishes even if his/her own values are disturbed Accompanies the Person in finding meaning to his/her health experience

	Seizes and engages in moments of reciprocity with the Person
Conceptualization of the exploration of the Person's concerns and priorities as a time-saving strategy	Prioritizes his/her assistance to the Person whose concerns and priorities are most urgent Begins the care by exploring the Person's concerns and priorities
Realization of the necessary equilibrium between caring for oneself and others in order to prevent burnout	Pays attention to his/her feelings Reserves moments outside of his/her professional life to practice activities that contribute to his/her well-being

Figure 1. Illustration of a cognitive learning model of the “humanistic caring” competency.